Client Record # _____

Consent Forms:

_____ (Initial here once informed) **Restrictive Interventions**

I, give permission to the above mentioned agency to perform restrictive intervention on when all other methods have been exhausted when trying to deescalate the above mentioned consumer. Following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with to eliminate or reduce the probability of the future use of restrictive interventions. I understand that this consent is only valid for unplanned restrictive interventions and is not invalid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Suspension and Expulsion from Service**

I , understand the if I do not comply with the rules outlines by the agency and becomes a possible threat to others served within this agency he/she maybe possibly suspended or expulsed from services. I understand that this would be the agency's last result before assessing the client to see if he/she meets the criteria to discharge. However, if it results in discharge the agency will follow its due process procedure before exhausting all other means.

_____ (Initial here once informed) **Search and Seizure**

I understand that each client shall be free from unwarranted invasion of privacy. However, I understand that searches of me/my child's living area may occur. I, also give permission to the agency to perform random planned or unplanned searches and seizures on me/my child's belongings, or property in his/her possession. I understand that each search will be documented to include; scope of search, reason for search, procedures followed in the search, description of any property found and an account of the disposition of seized property.

_____ (Initial here once informed) **Carolina Legal Assistance**

I understand a written summary of client rights shall be made available to each client and legally responsible person. I have been informed of his/her right to contact The Carolina Legal Assistance who assumed the role of the (GACPD) , the state wide agency designated under federal and state law to protect and advocate the rights of person with disabilities.

_____ (Initial here once informed) **Admissions into Services Agreement**

I understand that I shall be informed of services rendered by this agency upon admission or entry into services.

_____ (Initial here once informed) **Agency Rules**

I understand the rules that I am/my child is expected to follow and possible penalties for violation of the rules.

_____ (Initial here once informed) **Consent regarding Disclosure of Confidential Information**

I understand that the agency will follow its policy as it relates to protecting my rights regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56.

_____ (Initial here once informed) **Consent regarding Treatment**

I give permission to **Precious Haven, Inc.** to obtain a copy of my/my child's treatment / Habilitation plan and/or other information that relates to him/her in order for the agency to adequately serve.

_____ (Initial here once informed) **Fee Assessment**

I understand that I will be responsible for fees assess by my/my child that Medicaid does not cover as it relates to the treatment of me/my child. I understand that the agency will do everything possible to avoid collection from me/my child on behalf of treatment/habilitation services rendered.

Precious Haven, Inc.	Rights of the Person
Policy and Procedure Manual	**Approved:** December 3, 2011
Section # 1.k; 2.a; 2.c; 2.d; 2.e; 2.e(2); 2.f; 5.a; 5.b; 5.c; 5.d; 8.c(3); 8.d; 8.e; 9.b(2f)	

Client Record # _____

_____ (Initial here once informed) **Grievance Procedures**

I understand that I/my child has the right disclose any grievances that he/she may have as it relates to the agency. I understand that **Precious Haven, Inc.** will be provided a description of the assistance that the agency will be provided. I understand that the agency will be provided the results of any grievance submitted on behalf of my/my child. I understand that he/she will be given a chance to dispute the results of his/her grievance if the findings are not to his/her satisfaction. I understand that I can contact Carolina Legal Assistance who replaced (GACPD)/or the Local Mental Health LME.

_____ (Initial here once informed) **Informed of Client Rights**

I understand and have been informed and received a copy of the Client Rights handbook. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent. I have received, and had been explained my Rights to Privacy. **Precious Haven, Inc.** gave me a copy of the Client Rights handbook and I understand these rights which are designed to protect the privacy of me/ and/or my child.

_____ (Initial here once informed) **Social Integration**

I give **Precious Haven, Inc.** my permission to allow me/my child to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. I /my child shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62 (e).

_____ (Initial here once informed) **Emergency Medical Treatment**

I give **Precious Haven, Inc.** my permission to seek emergency care for me/my child from a hospital or physician. I also give **Precious Haven, Inc.** the consent to seek and sign consent for preventive and emergency medical care for my child in my absence. It is understood that **Precious Haven, Inc.** will attempt to contact me, or another designated responsible adult as soon as possible in the event of an emergency.

_____ (Initial here once informed) **Disaster and Risk Management Plan**

I have been informed and received a copy **Precious Haven, Inc.** Disaster Preparedness Plan and Risk Management Practices. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent.

_____ (Initial here once informed) **Financial Release**

I have been informed and received a copy **Precious Haven, Inc.** may use confidential information about me to bill and be paid for services. I hereby consent **Precious Haven, Inc.** to release information to Value Options (the State of NC managed care vendor) and/or the referring Area Program.

_____ (Initial here once informed) **Transport**

I have been informed and received a copy **Precious Haven, Inc.** to provide transportation to my child, and agree to hold **Precious Haven, Inc.** harmless for any accident/injury that results from the provision of transportation.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

(Date of expiration, if less than one year) (Event, if less than one year)

_____ _____ _____

Signature of Client Date Witness (required if symbol or mark is used by client)

_____ _____

Signature of legally responsible person Date

Client Record # _____

This authorization form implements the requirements for client authorization to use and disclose information protected by the federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C).

Client Name: _____ **Record Number:** _____
Date of Birth: _____ **Social Security #:** _____

I, _____ authorize ***Precious Haven, Inc.*** to use or disclose to with _____
(Name of Agency or person to whom the requested use or disclosure will be made (include address/if applicable)

This data shall include (client is encouraged to initial beside data to be used or disclosed)

____ Assessments ____ Service Notes ___ Substance Abuse/Treatment
____ Psychiatric Evaluations ____ Service Plans/Goals ___HIV/Aids Information
____ Diagnosis ____ Discharge Summary ___ Social History
____ Developmental History ____ Financial/Reimbursement ___ Medical History
____ PCP ____ Other: _____

Purpose of Use or Disclosure (client is encouraged to initial beside data to be used or disclosed)
____ At the request of the individual ____ Assessment/Evaluation
____ Coordination of Service ____ Court Proceedings ____ Determination of Benefits

Information requested should be mailed to this address:
_____

REDISCLOSURE:
Since information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When we disclose mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION:
I understand that, with certain exceptions, I have the right to revoke this authorization at any time. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Area Program/LME's Notice of Privacy Practices, a copy of which has been given to me.

If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

_____
(Date of expiration, if less than one year) (Event, if less than one year)

Notice of Voluntariness:
I understand that I may refuse to sign this authorization form. I understand that **Precious Haven, Inc.** will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____ _____
Signature of Client Date Witness (required if symbol or mark is used by client or LRP)

_____ _____
Signature of legally responsible person Date

Please explain LRP authority to act on behalf of the client:
___ Power of Attorney ____ Guardian
___ Other: _____

_____
Staff Signature

Client Record # _____

Provider Choice Agreement

Consumer Name: _____

I have received information regarding services which I am eligible to receive. I have been informed of providers from whom I am eligible to receive such services. Based upon this information, I have made an informed choice of the services and providers.

I, understand that by completing and signing this form, I choose, ***Precious Haven, Inc.*** as my services provider (service specified below):

____ Residential Treatment Level IV

____ Residential Treatment Level III

____ Therapeutic Foster Care Placement Level I and II

____ Diagnostic Assessment

____ Outpatient Treatment Services

_____ _____
Consumer Signature Date

_____ _____
Legally Responsible Person Signature Date

Client Record # _____

Face Sheet

_____
First Middle Last

Social Security # _____ Date of Birth: _____

Race: _____ Gender: _____

Marital Status: _____(s-single; m-married; d-divorced)

Admission date: _____ Discharge date: _____

Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Screening and Assessment date: _____ (if available)

Treatment/Habilitation Plan date received: _____ (if available)

_____ _____
Client Signature: Date:

_____ _____
Legally Responsible Person Signature: Date:

_____ _____
Witnessed By: Date:

Client Record # _____

Emergency Contact Information:

Consumer Information:

First Name Middle Name Last Name

Address City State

Person to be Contacted:

Telephone Numbers (of person to be contacted in case of sudden illness)

Name of Person to be contacted

Address of Person to be contacted

Client's Preferred Physician Information:

Name of Physician

Address of Physician

Telephone Number of Physician

Client Record # _____

Admissions Assessment:

_____
First Middle Last

Social Security # _____

Date of Birth: _____ Race: _____ Gender: _____

Client's Presenting Problems: _____

Client's Needs: _____

Client's Strengths: _____

Diagnosis:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Pertinent Social/Family/ Medical History: _____

Evaluations or Assessments (i.e. psychiatric, substance abuse, medical or vocational): _____

Strategies to address client's presenting problems: _____

_____ _____
Client Signature: Date:

_____ _____
Legally Responsible Person Signature: Date:

Client Record # _____

_____ _____
Witnessed By: Date

Discharge Plan

Client Name:	Discharge Summary: To be completed within 30 days following discharge.
Reason for Admission:	
Strengths:	Needs:
Significant Findings:	
Conditions on Discharge: (check all that apply) ___ Worse ____ Marked Improvement ____ No Change ___ Mild Improvement ___ Moderate Improvement ___ Expired ___ Unknown	
Concerns Identified:	
Reason for Discharge:	
Follow-up Plan(Transition Plan):	

Axis:	Code:	Diagnosis:

Consumer Signature:	Date:
Parent/Guardian Signature:	Date:

Client Record # _____

Case Manager Signature:	Date:
Person Completing form (signature/title):	Date:

Treatment Team

Client Name: _____ Current Date: _____

I. Clinical Information: Diagnosis
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

II. Upcoming and Previous Appointment (since last visit):
1. _____ 2. _____
3. _____ 4. _____

III. Review of goal alteration/continuation: (please note any changes)
1. _____
2. _____
3. _____
4. _____

IV. Family Issues (Please list all family contact) – Visits/Passes/Contacts

---

V. Recommendations Noted:
_____ Stay in Therapy _____ Increase Family Contact ____ Decrease Home Visits
_____ Remain In Current Placement

VI. Client Concern/Complaint/Grievance's:

_____

_____

VII. Discharge/Transitional Planning: ___ Step up ___ Step down (Services identified) _____

_____

VIII. Person Centered Plan: _____ No Changes _____Update _____Revision

IX. Authorization Review: _____Updated (_____) _____Expired _____ Pending

X. Medical Necessity: _____Physician Order (Updated _____) _____Continue Services _____ Discontinue Services

Miscellaneous Business (Incidents/ Substance Abuse Services/Sex Offenders Services):

_____

_____

Treatment Team Recommendations:

_____

_____

Treatment Team Members: Date: Approve : Disapprove:

Client Record # _____

_____

_____

_____

Next Treatment Team Date: _____

North Carolina
Department of Health and Human Services
Division of Medical Assistance
Clinical Policy and Programs
2501 Mail Service Center - Raleigh, N.C. 27699-2501

DMA Certification Of Need For Medicaid Inpatient Psychiatric Services In A Psychiatric Residential Treatment Facility (PRTF) For A Recipient Under The Age Of 21

Recipient Name: _____ Facility Name: _____

Medicaid ID #: _____ Provider #: _____

Date of Birth: _____ Admission Date: _____

Type of Certification: (check 1 item)
☐Pre-admission/elective

Medicaid Eligibility Status: (check 1 item)
☐Medicaid eligible on admission
☐Pending Medicaid on admission
☐**No evidence of Medicaid on admission**
☐Applied for Medicaid during stay
☐Applied for Medicaid after discharge

At the time of admission, the interdisciplinary team certifies the following:

1. Ambulatory care resources in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's condition requires services on an inpatient basis under the direction of a physician.
3. The inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

_____	_____	_____
Physician Team Member	Print Name/Title	Date (Mo/Day/Yr)
_____	_____	_____
Other Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)

Please submit to the appropriate UR Vendor when completed.
The Durham Center (Durham County): 919-328-6011
Eastpointe LME (Duplin, Lenoir, Sampson, and Wayne Counties): 910-298-7184
ValueOptions (All Other Counties): 877-339-8763