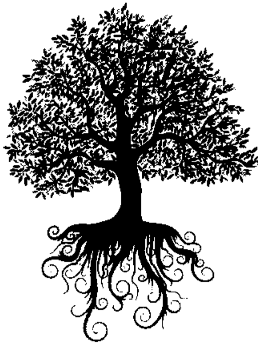


Harvest of Wilmington

773 S. Kerr Avenue • Wilmington, NC 28403
Phone: (910) 793-0566 • Fax: (910) 793-4255
NC DWI Facility #: 50296
www.harvestofwilmington.com
"Building strong roots for a more fruitful life"

Thank you for choosing Harvest of Wilmington for your Case Management needs. In order for us to complete services for you, we will need the following information:

- **Completed Demographics Form (attached).** Please fill out the top portion only. Please provide a current phone number and email address so we may contact you.

- **Completed Consent for the Release of Confidential Information Form (attached).** Please check any boxes that apply. Please provide the full name and contact information for Attorney, Treatment Provider, Probation Officer, Assessment Facility, Treatment Facility, Counseling Facility. This is necessary information in order to contact them and complete Case Management services for you.

- **Client Rights/Grievance Policy (attached).** Please read, check the three boxes that you have read and understand, sign and date on the signature line.

- **Case Management Fee of $110.** The fee can be paid by calling our office with a credit card, visit our website www.harvestofwilmington.com and use our convenient PayPal option, or stop by our office. We accept cash, credit cards or debit cards for payment.

- **Driving Record(s).** for any state you have been licensed in outside of North Carolina.

- **Impaired Driving Judgment**. This is the document that the judge signed when you were convicted if you do not have a copy, contact your attorney or the Clerk of Court in the county of your arrest.

Once we receive all necessary information we will review your file. If all requirements for assessment and treatment have been successfully completed we can submit your information to the North Carolina Department of Motor Vehicles. Once the information is submitted they require 5 **BUSINESS** days to review the information and approve it. If you would like to check the progress you may contact the North Carolina Department of Motor Vehicles in Raleigh at **919-715-7000. If your DWI was in another state, we will send information to the state involved.**

If you have questions regarding the Case Management process, please contact us and we will be happy to answer any questions you have.

DATE: ______________________

NCDL#:______________________

DOB: ____________________ EDUCATION: ________ EMPLOYMENT STATUS:______________

NAME: ____
(LAST) (FIRST) (MIDDLE)

ST ADDRESS: ____

CITY:____________________ STATE:________ ZIP:_______ COUNTY OF ARREST___________

RACE: _____ SEX: _____ MARITAL STATUS: _____ SS#: ______________________

HPHONE: ____________________________ CPHONE:____________________________
May we leave a message at this number? Y N May we leave a message at this number? Y N

EMAIL: ____

EMERGENCY CONTACT:

Name ____________________________ Relationship _______________ Phone________________

******FOR OFFICE USE ONLY******

NCDWI:_____ OSDWI:_____ SAEVAL:_____ FREE CONSULT:_____ TRANSFER IN: _____

ATTORNEY: ___ PROBATION:__ TASC:___ OTHER: ___ NAME:__________________________

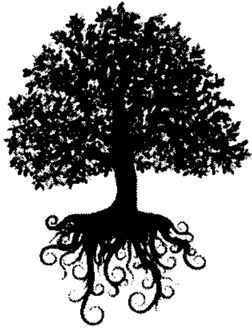
PRE: _____ POST:_____ #PRIOR DWI:_____ BAC:_______ #PRIOR TX:________________

ADETS:_______ 20/30:_______ 40/60:_______ 90/90:______ INPT:______ A/C:_____

PO: ______ OFFICER NAME:____

COMMENTS:____

DOCKET NUMBER: __________________________
ARREST DATE:_____________________________
CONVICTION DATE:__________________________
ARREST COUNTY:___________________________
DIAGNOSIS:________________________________



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Client Rights / Grievances Policy

Client Rights:

☐ I understand my basic rights as a client. These rights include:

- I have the right to have written information about fees, payment methods, number of sessions, and cancellation policies before beginning therapy.
- I have the right to ask for and receive clarification on anything I am not sure about or do not understand.
- I have the right to a treatment plan that describes general goals of therapy and specific objectives I will work on in order to achieve my goals.
- I have a right to receive an explanation of services in accordance with my treatment plan.
- I have a right to participate voluntarily in and to consent to treatment, and to object to, or terminate, treatment.
- I have a right to receive clinically appropriate care and treatment that is suited to my needs and skillfully, safely, and humanely administered with full respect for my dignity and personal integrity.
- I have a right to be treated in a manner which is ethical and free from abuse, discrimination, mistreatment, and/or exploitation.
- I have the right to request and receive information about my therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization and limitations.
- I have the right to report grievances regarding services or staff to a supervisor.
- I have the right to have records protected by confidentiality and not be revealed to anyone without my written authorization.
- I have the right to know the limits of confidentiality and the circumstances in which my therapist is legally required to disclose information to others.
- I have the right to request and receive a summary of my file, including the diagnosis, my progress, and the type of treatment.

Grievance Policy:

☐ I understand that if I have a complaint/grievance, I should contact the Clinical Director, Carrie Knox, by calling (910)793-0566 or by addressing an email to her at harvestofwilmington@yahoo.com.

☐ I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance:

State Office of DWI Services www.ncdhhs.gov/mhddsas/dwi
3008 Mail Service Center Raleigh, NC 27699-3008
Ph: 919-733-0566 Fax: 919-508-0963
Lynn B. Jones – lynn.b.jones@dhhs.nc.gov
Jason Reynolds – jason.reynolds@dhhs.nc.gov
Donna Brown- donna.m.brown@dhhs.nc.gov

Disability Rights NC www.disabilityrightsnc.org
2626 Glenwood Avenue, Suite 550, Raleigh, NC, 27608
(877) 235-4210 or (919) 856-2195
Email: info@disabilityrightsnc.org

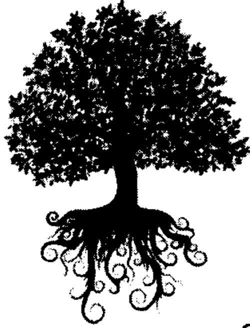
North Carolina Division of Mental Health / Developmental Disabilities / Substance Abuse Services
www.ncdhhs.gov/mhddsas
Advocacy and Customer Service Section: 919-715-3197
DHHS CARE-LINE: 1-800-662-7030 (Voice/Spanish)

NC Substance Abuse Professional Practice Board
www.ncsappb.org
P.O. Box 10126 Raleigh, NC 27605
Ph: 919-832-0975 Fax: 919-833-5743
Barden Culbreth, Executive Director

I certify that I have read and understand this Client Rights/Grievance Policy.

Client's Signature: ______________________________ Date: ____________

Counselor's Signature/Credential: ______________________________ Date: ____________



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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

CRIMINAL JUSTICE SYSTEM REFERRAL

I, ______________________________ DOB: ______________ authorize:
(Printed name of defendant)

Name or general designation of program making disclosure: **Harvest of Wilmington**

Check all that apply:

- ☑ NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services
- ☑ NC Division of Motor Vehicles
- ☐ NC Department of Community Corrections (Probation): ______________________________
- ☐ Treatment Provider: ______________________________
- ☐ Attorney: ______________________________
- ☐ Other: ______________________________

to communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

- ☑ my diagnosis, urinalysis/breathalyzer results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and
- ☐ ______________________________

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

[*Specify the date, event or condition upon which this consent expires. This could be one of the following*:]

- ☑ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or
- ☐ ______________________________
(Specify other time when consent can be revoked and/or expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form: ______________________________ Date: ______________
(Signature of Patient)

Signature of person signing form if not the patient: ______________________________ Date: ______________
(Signature)

Describe authority to sign on behalf of patient: ______________________________