RESTORED BRIDGES

AUTHORIZATION FOR RELEASE OR EXCHANGE OF INFORMATION

_____ _____

(Client Name) (Date of Birth)

I authorize the release and/or exchange of pertinent information including substance abuse, and/or psychiatric with:

RESTORED BRIDGES, LLC.

(Person or Agency or Organization to receive or exchange information)

for the purpose of CASE MANAGEMENT / TREATMENT / PLANNING/ AFTERCARE AND FOLLOW UP

to expire 90 days AFTER DISCHARGE

(Date, event or condition of expiration)

Information to be exchanged:

____ Evaluation Summary
____ Admission / Discharge Dates
____ Psychological History
____ Drug /Alcohol Information
____Clinical Information
____ Legal Information
____ HIV / AIDS Information
____ Employment/Loss of Employment Verification
____ Academic Records / PPT
____ Special Education Information
____ Psychological Testing
____ Family History Information
____ Court Records
____ Physical Exam Reports
____ Laboratory Results
____ Other (Specify)

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time except to the extent that action has already taken place in reliance upon it. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____ _____

Client /Parent/Legal Guardian Signature Date

Notary Public of _____County, _____ State, I certify that the following _____ personally appeared before me this

North Carolina General Statutes § 122C-52 Right to confidentiality
(a) Except as provided in G.S. 1325 and G.S. 122C31(h), confidential information acquired in attending or treating a client is not a public record under Chapter 132 of the General Statutes.
(b) Except as authorized by G.S. 122C53 through G.S. 122C56, no individual having access to confidential information may disclose this information.
(c) Except as provided by G.S. 122C53 through G.S. 122C56, each client has the right that no confidential information acquired be disclosed by the facility.
(d) No provision of G.S. 122C205 and G.S. 122C53 through G.S. 122C56 permitting disclosure of confidential information may apply to the records of a client when federal statutes or regulations applicable to that client prohibit the disclosure of this information.
(e) Except as required or permitted by law, disclosure of confidential information to someone not authorized to receive the information is a Class 3 misdemeanor and is punishable only by a fine, not to exceed five hundred dollars ($500.00). (1955, c. 887, s. 12; 1963, c. 1166, s. 10; 1965, c. 800, s. 4; 1973, c. 47, s. 2; c. 476, s. 133; c. 673, s. 5; c. 1408, s. 2; 1979, c. 147; 1983, c. 383, s. 10; c. 491; c. 638, s. 22; c. 864, s. 4; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 11; 1987, c. 749, s. 2; 1993, c. 539, s. 920; 1994, Ex. Sess., c. 24, s. 14(c); 2009299, s. 5.)

_____day, of _____, 20_____ acknowledging to me that he or she voluntarily signed the foregoing document for the purpose stated therein.

Notary's printed or typed name: _____

Notary Public *Official Seal:*

Official Signature of Notary: _____

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APPLICATION FOR SERVICE / INTAKE STUDY

TO (Name of Agency): Restored Bridges, LLC

Application For:

Independent Living/IDD Adult Residential (Ages 22 and up)_____

Transitional Living/Foster Care (Ages 18-21) Residential _____

FROM (person/agency making application):_____

_____
(Print name of person making application and name of agency he/she represents)

This complete application, with supporting documentation, provides the information necessary to decide whether to admit the member. If the member is admitted, the documents relating specifically to admission will be required. If additional space is needed for any question, add an extra sheet or write on the back of the application (be sure to give question number for reference).

I. FAMILY INFORMATION

MEMBER:

1) Member's Full Name:_____

2) Prefers to be called:_____

3) Date of Birth:_____

4) Verified? Yes No

5) Sex: Male Female Other:_____

6) Race:_____

7) Social Security Number:_____

8) Place of Birth (city):_____ (county):_____

(state or country):_____

9) Currently Living With: Biological Parents Relative Family. Friends

Other (Specify):_____

BIOLOGICAL PARENTS:

10) Father's Full Name:_____

11) Social Security Number:_____

12) Address:_____

City:_____ State:_____ Zip:_____

13) Phone Number: _____

14) Date of Birth: _____ **15)** Date of Death: _____

16) Marital Status: _____

17) Race: _____ **18)** Religion: _____

19) Mother's Full Name:_____

20) Social Security Number:_____

21) Address:_____

City:_____ State:_____ Zip:_____

22) Phone Number: _____

23) Date of Birth: _____ **24)** Date of Death: _____

25) Marital Status: _____

26) Race: _____ **27)** Religion: _____

CURRENT PARENTAL RELATIONSHIPS: (The persons, if other than biological parents, who will be working in a parental capacity with member while in care):

28) Full Name:_____

29) Social Security Number:_____

30) Date of Birth: _____

31) Relationship to Member: Step Adoptive Other (Specify): _____

32) Address:_____

City:_____ State:_____ Zip:_____

33) Phone Number: _____

34) Full Name:_____

35) Social Security Number:_____

36) Date of Birth: _____

37) Relationship to Member: Step Adoptive Other (Specify):_____

38) Address:_____

City:_____ State:_____ Zip:_____

39) Phone Number: _____

40) Does the member have a POA or LRP? Yes No

41) Has this member been adopted? Yes No

42) MEMBER'S SIBLINGS (Include all half siblings, step siblings, adoptive siblings)

Name:____ Date of Birth:__________________________

Address:____

City:________________________________ State:_____________________ Zip:_______________

Phone Number: ____

Relationship:_________________________________ Presently Living With:____________________________

Name:____ Date of Birth:__________________________

Address:____

City:________________________________ State:_____________________ Zip:_______________

Phone Number: ____

Relationship:_________________________________ Presently Living With:____________________________

Name:____ Date of Birth:__________________________

Address:____

City:________________________________ State:_____________________ Zip:_______________

Phone Number: ____

Relationship:_________________________________ Presently Living With:____________________________

Name:____ Date of Birth:__________________________

Address:____

City:________________________________ State:_____________________ Zip:_______________

Phone Number: ____

Relationship:_________________________________ Presently Living With:____________________________

43) OTHER RELATIVES:

Name:____ Date of Birth:__________________________

Address:____

City:________________________________ State:_____________________ Zip:_______________

Phone Number: ___________________________ Relationship:_______________________________

Name:____ Date of Birth:__________________________

Address:____

City:________________________________ State:_____________________ Zip:_______________

Phone Number: ___________________________ Relationship:_______________________________

Name:____ Date of Birth:__________________________

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Relationship:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Relationship:_____

II. CUSTODY

44) Name of Legal Custodian:_____

45) Phone Number:_____

46) Address:_____

City:_____ State:_____ Zip:_____

47) Name of Contact Person:_____

48) Phone Number:_____

49) Is a Voluntary Placement Agreement or CARS Agreement in effect? Yes No

If yes, give expiration date:_____

50) Check if there is any physical, medical, developmental, psychological problem which will require special attention in caring for this member. Attach a description of each problem checked.

51) Name any medications this member is now taking, and for what condition(s):_____

_____

_____

52) Name of member's physician:_____

53) Phone:_____

54) Address:_____

55) Name of member's dentist:_____

56) Phone:_____

57) Address:_____

City:_____ State:_____ Zip:_____

III. EDUCATIONAL INFORMATION

(If this form is completed between school terms, please give the information pertaining to the previous school year. If assistance is needed in completing the form, please consult the member's school.)

58) Member's highest level of education completed: _____

59) Did the member receive a diploma, certificate of completion or other? Please

explain:_____

60) Please describe any current involvement or aspirations this member may have for an educational, work or trade program (i.e. Does the member want full or part time employment, learn a trade, or obtain their GED?):

_____

_____

_____

61) Education setting: Regular Class, Special Education, Other (Specify):_____

62) Has member been classified as special needs? Yes No

If yes specify classification(s): _____

_____

63) Member's appointed Surrogate Parent:
Name:_____

64) Phone:_____ **65)** Address:_____

City:_____ State:_____ Zip:_____

66) Name of Current/last school attended:_____

67) Phone:_____ **68)** Address:_____

City:_____ State:_____ Zip:_____

69) School Transcript: Attached: Yes No Promised by date:_____

70) Latest Evaluation Information:

Achievement Evaluation (ex: Woodcock Johnsibm etc.)

Date: _____ Assessment/Test:_____

Results:_____

Psychological Evaluation (ex: WISC-III, etc,)

Date: _____ Assessment/Test:_____

Results:_____

71) Attendance record for last school year attended:

Number of days in attendance:_____ Number of excused absences:_____

Number of unexcused absences (suspension, expulsion, truancy, etc):_____

Explain:_____

72) Academic strengths:_____

73) Academic weaknesses:_____

74) School behavioral strengths:_____

75) School behavioral weaknesses:_____

76) Recommended school information pertinent to this application:_____

_____

77) Recommended educational plan/program (IEP, etc.):_____

_____

78) Other special needs/talents, including extra-curricular activities and interests:_____

_____

_____

79) Additional school information pertinent to this application:_____

_____

IV. SOCIAL HISTORY / ASSESSMENT

The following information will help agency staff understand the member's and family's needs and how best to meet these needs. If a written social history is available, it may be substituted for Section IV (questions 80-90). Answer any of the questions below which are not addressed in the social history.

80) Tell what is going on in the family at this time. Describe the significant events which effect this family

and member:_____

_____

_____

_____

_____

81) Give a brief description of this family's:

Strengths:_____

_____

Weaknesses:_____

82) Give a brief description of the member's:

Strengths:_____

Weaknesses:_____

83) What and/or who makes this member:

Glad?_____

Sad ?_____

Mad?_____

Fight?_____

Run?_____

84) From what agencies/professionals has the family sought or been given help? Specify services and results:_____

85) What religious resources/support systems are available to this member and family? (Name/phone of contact person)_____

86) Please explain why this member needs assistance living independently?

87) Out-of-Home Placements:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Dates of Care: _____

88) Is there history of illegal behavior? Yes No If yes, attach description including history of core involvement and a copy of any court order currently in effect.

89) Is this member actively or have a history of being suicidal? Yes No

_____

_____

_____

90) Identify the current needs of the member and family to which the agency is asked to respond:

_____

_____

_____

_____

V. PLANNING

This section requires equal attention to the family and the member in answering the questions. If the member is under the guardianship of DSS, or has a POA, attach a current copy of the documentation.

91) What is the permanent plan for this member?

_____

_____

92) Is there a current need to revise the permanent plan? Yes No If yes, explain:_____

_____

_____

_____

93) State the goals toward which the family and member are working to achieve the permanent plan:

_____

_____

_____

_____

94) What specific services of the agency are being requested on behalf of this family and member:

_____

_____

_____

95) How will the requested services help the family and member achieve their permanent plant?

_____

_____

_____

96) Identify <u>in the order of your priority</u> all agencies to which this application is being made:

1:_____

2._____

3:_____

4._____

97) Give the name/role of other volunteers/professionals assigned to this member (Guardian ad Litem, Member Advocate, Court Counselor, etc.):

_____

_____

_____

VII. SIGNATURE(S)

I (we), the undersigned, hereby apply to the (Name of agency) for services named above on behalf of the named member for whom I (we) hold legal custody and/or placement authority. I (we) certify that the information contained in this application and the attachments is true and accurate to the best of my (our) knowledge. I (we) agree to share additional information pertinent to this application as requested by the agency. I (we) also agree to cooperate with the agency and to support the plan of service to which we mutually agree.

_____ Date:_____
Print First and Last Name of Member

_____ Date:_____
Signature of Member

_____ Date:_____
Print First and Last Name of Guardian, or Legal Custodian

_____ Date:_____
Signature of Guardian, or Legal Custodian

RESTORED BRIDGES, LLC
Transitional and Independent Living Programs

Birth Certificate
Social Security Card
Court Orders
Medical Insurance Card
Immunization records
M**edical records** (Diagnosis and Medications Administered)
Physical (Required for clients before admission)
TB Test (Required for clients before admission)
CCA/Psychological Assessment/PCP/other related records

*Insert documentation behind this form

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

(If multiple parties and/or agencies will be receiving this information, specify each party/agency below that will be receiving this information.)

I, _____, authorize

_____ to disclose to
(Provider of Confidential Information)

_____ Department of Social Services
(County name)
_____ Judicial District
(Court district number)
_____ Guardian ad Litem Program
(Court district number)

_____
(Other: List specific agency or person(s) or relationship)

_____
(Other: List specific agency or person(s) or relationship)

_____
(Other: List specific agency or person(s) or relationship)

the following information:

(Client needs to initial each category that applies.)

_____ my name and other personal identifying information
_____ substance abuse records
_____ mental health records
_____ assessment
_____ dates of services
_____ recommendations for treatment
_____ progress notes
_____ progress and compliance with treatment
_____ attendance
_____ date of discharge and discharge status
_____ discharge plan
_____ other _____

This otherwise confidential information will be used for the following purpose(s):
(**Client needs to initial each category that applies)**

_____ Monitor my progress or lack of progress in treatment.
_____ Provide appropriate services and referrals for me.
_____ Provide appropriate services and referrals for my family.
_____ Update my Treatment team of my progress or lack of progress in treatment.
_____ Update the Court and parties to my case about my progress or lack of progress in treatment.
_____ Other_____
_____

_____ Other_____
_____

For Substance Abuse Clients: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may revoke this consent at any time.

For Mental Health Clients**:** I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may revoke this consent at any time.

Protected Health Information:
I understand that my health information is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160& 164, but once this information is disclosed pursuant to this form, it may no longer be protected by HIPAA and further redisclosure may occur. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on the consent.

I understand that generally _____
(Name of treatment program)
may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

If I do not revoke this consent, it expires automatically as follows:

1. Upon closure of my Protective Services/In-Home Services/Out of Home Services case; or
2. One year from the date this consent is signed; whichever occurs first.

_____ _____
Date signed Client's signature

_____ _____
Date signed Legally Responsible Person

_____ Client has received a copy of this consent form for his/her records.

Restored Bridges, LLC
Independent and Transitional Living Programs

ACKNOWLEDGEMENT

OF

RESIDENT HANDBOOK

Violations of the following rules will result in immediate dismissal from the program:

1. Possession of weapons of any kind.
2. Violence against other residents or staff, including verbal threats of violence.
3. Possession or use of drugs, alcohol, or tobacco products.
4. Having sex or sexual relations with other residents.
5. Continuous AWOL behaviors and lack of involvement in program activities.
6. Involvement in criminal activity of any kind.
7. Destruction of, or damage to, or threats of damage to any shelter property or property belonging to residents or staff.
8. Being under the influence of alcohol (drunk) or illegal drugs (high) while a resident.

If you break it, you will have to pay for it.

Restored Bridges will press charges for any criminal activity against the agency, its residents or staff.

Residents who leave the home without permission and return within 24 hours may be re-admitted on a case-by-case basis.

Dismissals may be appealed. Appeals will be reviewed by the Facility Director, on a case-by-case basis.

By signing below I _____ (MEMBER NAME) have received the resident handbook, and agree to follow the rules implied within the handbook.

_____ _____

Resident Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Restored Bridges, LLC
Independent and Transitional Living Programs

_____	_____
Staff Signature	Date

EMERGENCY CONTACT INFORMATION
AUTHORIZATION TO OBTAIN ROUTINE AND EMERGENCY TREATMENT

Client Name: _____

Date of Birth: _____

Emergency Contact

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cellular Phone: _____

Preferred Licensed Medical Provider

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Routine Medical & Dental Treatment:
I hereby give permission to the staff of Restored Bridges, LLC to seek routine medical and dental treatment on behalf of the above-named client.

Emergency Medical Treatment:
In case of sudden illness/accident/emergency, I hereby give permission to the staff of Restored Bridges, LLC to seek emergency treatment on behalf of the above-named client should the need arise. It is understood that a licensed medical provider and/or hospital emergency room personnel will provide this treatment. In addition, a copy of current medications, known medical conditions and allergies may be released. Efforts will be made to contact a person named below prior to treatment, should this be possible.

The above consent has been read by me or to me and explained to me by an employee of Restored Bridges, LLC. I agree with the above consents as evidenced by the signature below.

_____ _____
Consumer/Guardian Signature Date

_____ _____
Agency Representative Signature Date

Gaston-Lincoln-Cleveland NC-509 NC HMIS
CLIENT RELEASE OF INFORMATION

Many North Carolina shelters and helping programs use the North Carolina Homeless Management Information System (NC HMIS) to keep information about the people that they help. We collect personal information from you that we need to help us, help you. We have strict rules about sharing your information.

Why do we collect information about you?

- Allow us to provide services to you.
- Help case managers work together for you.
- Allow us to be paid for our work with you and to help us apply for additional dollars that can be used to help you.
- Help us meet our legal obligations.

SECTION 1 – Basic Identifying Information

So that agencies that use our NC HMIS system can find your record, agencies can see the following basic identifying information about you:

- Your name
- Your gender
- The last four digits of your Social Security Number
- Your year of birth
- Your veteran status

We use this information to select the correct record and to better coordinate services for you. All persons using NC HMIS are trained and certified in privacy.

If you have a specific reason why other NC HMIS agencies shouldn't be able to find your record in NC HMIS, you can ask to have this basic identifying information secured so that only our agency can see it.

PLEASE NOTE: If you have received services from other agencies who use NC HMIS we may not be able to secure this information. PLEASE TALK WITH YOUR CASE MANAGER for more information. A separate document has been attached).

I have reviewed the attached document named **"Securing Basic Identifying Information."**
I understand the implications and I am asking that my client profile be secured.
Do not initial here unless you have discussed this with your case manager
Please initial here to secure this basic identifying information _____

SECTION 1 – Acknowledgement of Rights

Many agencies also use the system to improve services delivered to you. The following are your rights concerning your data. Please review and initial in the box next to **each right to show that you understand it. If you have questions, please discuss them with your case manager.**

____	I have received a copy of the Agency's Privacy Notice/script that explains NC HMIS and my rights and responsibilities. It explains how information is kept and shared through this system.
____	**I understand that the confidentiality of my records is protected by law**. I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Coordination of Care Sharing Plan or as required by law, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR, Parts 160 & 164 as revised by the Health Information Technology for Economic and Clinical Health Act of 2009 aka the HITECH Act), and certain North Carolina laws.
____	I can withdraw my consent to share at any time, but any information already shared with another agency cannot be taken back. If sharing information on the system poses an imminent health or safety risk, I will talk with my case manager.
____	I understand that I have the right to see my information, request changes, and to get a copy of my information by written request. An agency can refuse to change my record but must provide a written explanation of why they refuse the change within 60 days. Agencies may charge for reproducing a record.
____	I understand that my name and other identifying information may be used to match records through a trusted partner for academic research purposes. Prior to academic research being done, my identifying information will be removed, before data analysis takes place.

SECTION 4 – Outreach Sharing Plan

We partner with North Carolina community programs to see if you might qualify for housing or income supports. **Please read each statement below and circle your response.**

1. **Veteran Affairs:** If you have served in the military, the VA Medical Center may contact you about potential housing. With your permission, they may use the information you give this agency to contact you.

   Information that will be shared includes: Name, date of birth, homeless status, veteran status, military service information, housing history, contact information, chronically homeless status

   Yes - I agree to share my HMIS data for the Veteran's Project: (circle response): Yes/No/NA

2. **Income and Benefits:** Income and benefits are important to staying housed. Some programs may assist with obtaining Social Security Income and/or other state benefits, if you qualify. (For example, through the SOAR program.) With your permission, they may use the information you give this agency to contact you, if you are eligible for benefits.

   Information that will be shared includes: Name, date of birth, coordinated assessment information, homeless status, housing history, contact information, chronically homeless status

   Yes - I agree to share my HMIS data for the Social Security or other state benefits: (circle response): Yes/No/NA

3. **Housing Review Committee/Housing Prioritization:** If you are homeless, you may be eligible for housing in our community. We have a housing review committee made up of representatives from our service providers. To participate in this process, these providers may need to see your information. With your permission, an agency may contact you if your information shows that you may be eligible for local housing services.

   A list of service providers involved in this process is available on request.

   Information that may be shared includes: Name, coordinated assessment information, homeless status, chronically homeless status, veteran status, disability and any additional information that may be used to connect you with appropriate housing options.

   Yes - I agree to share my information with the housing review committee: (circle response): Yes/No/NA

SECTION 4 – Outreach Sharing Plan (continued)

Sharing Plan to improve outreach to individuals who may qualify for benefits

4. **Homeless history:** We may need to document your homeless history throughout the state of North Carolina to see if you are eligible for specific community programs. Your case manager may contact the Michigan Coalition Against Homelessness (MCAH, the NC HMIS lead agency) to view data recorded in HMIS to complete a housing history document. With your permission, MCAH will complete the document and give it to your case manager. This document may be uploaded to your client record and shared according to the coordination of care sharing plan.

   Information that will be shared includes: HMIS number, name, and a 3-year statewide homeless history that includes service provider names and dates of service

   Yes - I agree that MCAH may share data with my Case Manager: (circle response): Yes/No/NA

This Release is active for one year effective the date of Signature.

Client signature (head of household): _____, Date: _____/_____/_____

Adult Household Member signature: _____, Date: _____/_____/_____

Adult Household Member signature: _____, Date: _____/_____/_____

Adult Household Member signature: _____, Date: _____/_____/_____

Signature of guardian or authorized-representative (when required): _____

Relationship to client: _____ Date signed by guardian/authorized representative: _____

Restored Bridges, LLC
CLIENT GRIEVANCE POLICY

POLICY:

All members have a right to due process in filing a grievance if they feel they have not received fair treatment by the staff of Restored Bridges or if there has been mistreatment. Clients will not be harassed in the event a member exercises this right. The following procedure will be followed:

PROCEDURE:

1. Client will talk to Program Coordinator or designee about the grievance within 40 hours of the incident.

2. If the Program Coordinator or designee and member cannot resolve the grievance issue, the member must send the grievance in written form or present orally to the Facility Director; the Program Coordinator must also present the Facility Director with a written summary of his/her attempts to resolve the grievance. The Facility Director will review the grievance and investigate the issues and will respond to the member in writing of the decision regarding the grievance within five (5) business days of receiving the grievance.

3. If the grievance relates to termination of residential services, the member may be allowed to remain within the residential program during the review period, unless such a stay poses an imminent danger to the staff and/or other residents of the program. Residents in this situation shall comply with all the program's rules and regulations or be subject to immediate termination. If the Facility Director concurs with the Program Coordinator's decision to terminate services, the member must leave the facility, even if he/she chooses to continue the grievance process outlined in step 4. Should one of the parties in step 4 or step 5 decide to override the Facility Director's decision to terminate services, the member will be reinstated to the program at the next available opening.

4. If the member still is not satisfied with the resolution of the grievance, his/her designee may submit his/her written grievance or present orally to the Chairman of the Board of Restored Bridges, Llc. within five (5) business days from the date of the decision of the Facility Director. The Chairman will review the grievance and investigate the issues and will respond to the member in writing of the decision regarding the grievance within ten (10) business days of receiving the grievance.

5. If the member is not satisfied with the decision of the Chairman, the member may submit the grievance in writing or orally present to the full Board of Directors for final

resolution, within ten (10) days of the Chairman's decision. The Board of Directors will review the grievance and investigate the issues and will respond to the member in writing of their decision with fifteen (15) business days of receiving the grievance. The Facility Director will carry out recommendations of the Board of Directors.

6. A copy of the complaint and the resolution will be maintained in the member's record.

7. If the member is Limited English Proficiency (LEP), he/she may attempt to find someone to write down the grievance for him/her or call the Program Coordinator to schedule an appointment and present the grievance verbally. The Program Coordinator will then put it into writing.

Resolution of Grievance: The member who is allowed to remain in the program will receive written reprimand, be placed on probationary status (terms outlined in the reprimand) and be required to follow the terms and conditions in the reprimand. Program staff and participants will determine terms and conditions. Clients who do not agree to those terms will not remain in the program.

I agree that I have both read and understand this policy.

_____

Client Signature **Date**

_____

Program Staff **Date**

Name and/or address to mail grievance/appeals/final resolution:

_____

_____

Restored Bridges, LLC.

401 Hawthorne Lane
310-312
Charlotte, NC 28204

Statement of Agreement Regarding Confidentiality

Restored Bridges, LLC. acknowledges that policies related to confidentiality have been provided and explained to all staff. Restored Bridges, LLC. understands that information about clients and their families will be shared for the purpose of case management and providing residential care services. Restored Bridges, LLC. also understands that this information is shared with others only when there is a need to know and when there is a written working agreement between agencies, or a specific signed release for information has been executed. Restored Bridges, LLC. also understands that this information cannot be shared with individuals and/or agencies that have no direct need for the information.

Client Signature: _____

LRP/Legal Guardian Signature: _____

Staff Signature: _____

Date: _____

LIABILITY CONTRACT
For
DESTRUCTION OF RESTORED BRIDGES, LLC PROPERTY

The POA/Legal Guardian accepts financial responsibility for any damages, vandalism and or destruction of property that the member causes or participates in while a resident at Restored Bridges Independent and Transitional Living Programs.

POA/Legal Guardian Signature and Date:

_____

Member Signature:

_____

Staff Signature and Date:

_____

Restored Bridges LLC

401 Hawthorne Lane Ste 110-312 Charlotte NC 28204 United States
(980) 522-8260

INVOLUNTARY COMMITMENT AGREEMENT

GENERAL INFORMATION

Member's Full Name: _____ Date of Birth: _____

Home Address: _____

Legal Custodian: _____ Phone #:_____

Address: _____

Emergency Contact: _____Phone#_____

Medical Doctor: _____ Phone #:_____

Dentist: _____ Phone #:_____

MEDICAL INSURANCE INFORMATION

Name of Policy: _____

Policy Number: _____

Policy Holder: _____

Contact Person for Medical Insurance: _____ Phone #:_____

I, the legal guardian/custodian understand that Restored Bridges, LLC. will in the event of a life threatening situation regarding a member in placement, call 911.

I, the legal guardian/custodian understand that Restored Bridges, LLC. will if a member is thought to be a danger to himself/herself and/or to others, the member will be taken to Emergency Services for a Behavioral Health Assessment.

I hereby consent to the placement of _____ with Restored Bridges, LLC. This member is in the custody of _____. As the Placing Authority my relationship to this member is:
mother; father; guardian; legal custodian; other (specify)
_____.

This member will be placed in an Adult Care Facility licensed by the North Carolina Division of Social Services under the auspices of Restored Bridges, LLC.

Restored Bridges LLC
401 Hawthorne Lane Ste 110-312 Charlotte NC 28204 United States
(980) 522-8260

Date of Placement: _____ Time of Placement: _____

Governing Law:
The terms and provisions of this agreement shall be governed by the laws of the State of North Carolina, INVOLUNTARY COMMITMENT N.C.G.S. CHAPTER 122C, ARTICLE 5.

§ 122C-201. Declaration of policy.
It is State policy to encourage voluntary admissions to facilities. It is further State policy that no individual shall be involuntarily committed to a 24-hour facility unless that individual is mentally ill or a substance abuser and dangerous to self or others. All admissions and commitments shall be accomplished under conditions that protect the dignity and constitutional rights of the individual.

It is further State policy that, except as provided in G.S. 122C-212(b), individuals who have been voluntarily admitted shall be discharged upon application and that involuntarily committed individuals shall be discharged as soon as a less restrictive mode of treatment is appropriate. (1973, c. 723, s. 1; c. 726, s. 1; c. 1084; c. 1408, s. 1; 1977, c. 400, s. 1; 1979, c. 915, ss. 2, 11; 1983, c. 638, s. 1; c. 864, s. 4; 1985, c. 589, s. 2; 1995 (Reg. Sess., 1996), c. 739, s. 2.)

Defined:
Mental Illness (Adults)
(33a) Severe and persistent mental illness. -A mental disorder suffered by persons of 18 years of age or older that leads these persons to exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long term or indefinite duration. This disorder is a severe and persistent mental disability, resulting in a long-term limitation of functional capacities for the primary activities of daily living, such as interpersonal relations, homemaking, self-care, employment, and recreation.

Dangerous to self:
Within the relevant past, the individual has:

1. Acted in such a way as to show that
    a. He/She would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and
    b. There is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given. Behavior that is grossly irrational, actions that the individual is unable to control, behavior that is grossly inappropriate to the situation, or other evidence of severely impaired insight and judgment creates an inference that the individual is unable to care for himself; or

2. Attempted suicide or threatened suicide and there is a reasonable probability of suicide unless adequate treatment is given; or
3. Mutilated himself or attempted to mutilate himself and there is a reasonable probability of serious self-mutilation unless adequate treatment is given.

Previous episodes of dangerousness to self, when applicable, may be considered when determining the reasonable probability of serious physical debilitation, suicide, or serious self-mutilation.

Dangerous to others:
Within the relevant past the individual has:

1. Inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another and there is a reasonable probability that this conduct will be repeated, or
2. Acted in a way that created a substantial risk of serious bodily harm to another and there is a reasonable probability that this conduct will be repeated, or
3. Engaged in extreme destruction of property and there is a reasonable probability that this conduct will be repeated.

Previous episodes of dangerousness to others, when applicable, may be considered when determining the reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is evidence of dangerousness to others.

Parent/Legal Guardian Signature: _____ Date:_____

Restored Bridges Intake Staff Signature: _____

Date: _____

RESTORED BRIDGES TRANSITIONAL AND INDEPENDENT LIVING

PROGRAM CONTRACT

1. I understand that if I am attending regular school, that a staff member will monitor and assist my progress.
2. I agree to follow the rules of whatever educational, trade or school program I am involved in within and outside of the Restored Bridges Transitional and Independent Living Program.
3. **I agree to follow all rules of all programs I am involved in.**
4. I agree to take responsibility for my behavior during my program involvement.
5. **I agree to respect peers, staff; and myself** and to do my best to set a good example for the other students.
6. I understand that if I am failing or struggling in an at school, work or my trade program- a Restored Bridges staff member may intervene and assist me with supports to help me get back on track.

Client Signature: _____

LRP/Legal Guardian Signature: _____

Staff Signature: _____

Date: _____

Restored Bridges, LLC.
CONSENT FORM

PERMISSION FOR ADMINISTERING NON-PRESCRIPTION MEDICATION

As the physician/parent/guardian/custodian of _____ I agree to allow the staff and foster parents of Restored Bridges, LLC. to administer the following non-prescription medications only as needed for periodic treatment of condition as described below:
(signature of physician is required if the client is currently taking prescription medication)

EXTERNAL

Medication	For Treatment of
1. Neosporin or antibiotic ointment	Minor burns, cuts, abrasions
2. Calamine lotion (with or without Phenol)	Allergic rashes (poison ivy, poison oak, etc.)
3. Rubbing alcohol	Insect bites
4. Betadine scrubs or soap and water	Cleaning area of minor injury

INTERNAL

1. Acetaminophen tablets (Tylenol, Datril, Panadol, etc.)	Headache or minor pain
2. Pepto Bismol liquid	Upset stomach
3. Kaopectate liquid	Diarrhea
4. Chlortrimeton tablets Chlorpheninamine (antihistamine)	Common cold or minor allergic reaction to insect bites
5. Dextromethorphan (lozenge and spray form)	Cough
6. Cepacol or chloraceptic lozenge	Sore throat
7. Mineral oil	Constipation
8. Milk of Magnesia	Constipation
9. Benedryl capsules	Allergic reaction (bee stings)
10. Ipecac syrup	Induce vomiting (clear with doctor and/ or emergency room before administering)

Please X out above if the member has a known allergy to any of these medications or you have an objection to the administration of any of these medications.

_____
Signature of Physician
(Signature of Physician is required if the client is currently taking prescription medication)

_____
Date

_____
Signature of Parent, Guardian, or Custodian

_____
Date

Non-prescription medicines are to be administered according to package directions and only for symptoms listed on the package labeling.
If symptoms persist, the client's physician will be consulted.

CONSENT FORM

PERMISSION FOR ROUTINE AND OVERNIGHT TRAVEL

During the course of placement, the client may require ROUTINE AND OVERNIGHT travel and transportation to appointments, school, various activities, community outings, and trips both in and out of the State of North Carolina. The parent/guardian of _____ gives permission for Restored Bridges, LLC. staff and contracted staff to transport _____ by use of personal or agency vehicle. This consent is valid until discharge from the program or by written termination of permission by LRP/guardian.

Emergency Contact	Address	
Home telephone #	Work telephone #	Cellular telephone #

I have read this consent or it has been read and explained to me.
I agree with the above consent as evidenced by my signature below.

_____ _____
LRP/Guardian Signature Date

_____ _____
Witness Signature Date

CONSENT FORM

VIDEOTAPE / PHOTOGRAPH / RESEARCH

I hereby authorize Restored Bridges, LLC to MAKE and USE the following of _____
(check all boxes consumer authorizes by this consent) (client's name)

_____ Audio-Visual recordings

_____ Photograph of my image

The agency will use these recordings for the purpose of identification, promotional and public awareness.
I understand that this authorization will be time-limited until discharge from the program and that I have the right to change or revoke this consent at any time.

OR

I decline authorization of audio-visual recordings and/or photographic imaging of

_____ _____
(client's name) initial here

_____
_____

I hereby authorize _____ to participate in research being conducted
(client's name)
on behalf of Restored Bridges, LLC
I understand that this authorization will be time-limited until discharge from the program and that I have the right to change or revoke this consent at any time.

OR

I decline authorization for _____ to participate in research being
(client's name)
conducted on behalf of Restored Bridges, LLC

_____
Client signature (required if age 12 or older)

_____
Date

_____
Parent, guardian or legal custodian signature

_____
Date

RESTORED BRIDGES TRANSITIONAL AND INDEPENDENT LIVING

AWOL CONTRACT

This contract is between _____ (client's name) and Restored Bridges, LLC. The Client agrees not to go AWOL and to comply with all rules and regulations, until time of release from program. If I feel the urge to go AWOL and or feel stress in any way, I agree to let to let a trusted staff member know and to discuss my feelings. I am also aware that any rules that I break can result in my immediate discharge as a resident/client of the Restored Bridges Transitional and Independent Living program.

Client Signature: _____

LRP/Legal Guardian Signature: _____

Staff Signature: _____

Date: _____

Restored Bridges Transitional and Independent Living

Search and Seizure Policy

No resident will be allowed admission in the Restored Bridges Transitional and Independent Living unless PART II is signed by the client and/or LRP.

PART II

Consent to Search

I, _____, as the client, LRP, or legal guardian give my consent to staff of Restored Bridges, LLC. and law enforcement to search the person and personal belongings of, _____, during their stay at Restored Bridges, LLC.

_____ _____

Client Signature Date

_____ _____

LRP or Guardian Signature Date

Resident Name _____ Date Completed _____

Date of Birth _____

Physical Examination

This form is to be completed by a primary physician, certified nurse practitioner, registered nurse, certified nurse- midwife or physician assistant. Questions noted with an asterisk are “triggers” for awake overnight staff.

1.* Current Medical and Psychiatric History. Briefly describe recent changes in health or behavioral status, suicide attempts, hospitalizations, falls, etc., within the past 6 months.

2.* Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

3. Allergies. List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem (e.g., rash, anaphylactic reaction, GI symptom, etc.). Please enter medication allergies here and also in Item 12 for medication allergies.

Resident Name _____ Date Completed _____

Date of Birth _____

4. Communicable Diseases. Is the resident free from communicable TB and any other active reportable airborne communicable disease(s)? Yes No (Check one) Yes No If "No," then indicate the communicable disease: _____

Which tests were done to verify the resident is free from active TB?

PPD Date: _____ Result:_____mm

Chest X-Ray (if PPD positive or unable to administer a PPD)

Date: _____ Result_____

5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc.?

(a) Substance: OTC, non-prescription medication abuse or misuse

1. Recent (within the last 6 months): Yes No
2. History: Yes No

(b) Abuse or misuse of prescription medication or herbal supplements

1. Currently Yes No
2. Recent (within the last 6 months) Yes No

(c) History of non-compliance with prescribed medication

1. Currently Yes No
2. Recent (within the last 6 months) Yes No

(d) Describe misuse or abuse: _____

_____

6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply): orthostatic hypotension osteoporosis gait problem impaired balance confusion Parkinsonism foot deformity pain assistive devices other (explain)

_____

—

7.* Skin condition(s). Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders.

Resident Name _____ Date Completed _____

Date of Birth _____

_____
__

8.* Sensory impairments affecting functioning. (Check all that apply.)

(a) Hearing:

Left ear:	Adequate	Poor	Deaf	Uses Corrective Aid
Right ear:	Adequate	Poor	Deaf	Uses Corrective Aid
(b) Vision:	Adequate	Poor	Blind (L or R)	Uses Corrective Lenses

(c) Temperature Sensitivity: Normal **Decreased sensation to:** Heat or Cold

9. Current Nutritional Status. Height: _____ Weight: _____
(a) Any weight change (gain or loss) in the past 6 months? Yes No
(b) How much weight change?____ lbs. in the past: ____ months (check one) Gain Loss
(c) Monitoring necessary? (Check one.) Yes No
If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur:
_____

_____
__

(d) Is there evidence of malnutrition or risk for undernutrition? Yes No
(e)* Is there evidence of dehydration or a risk for dehydration? Yes No
(f) Monitoring of nutrition or hydration status necessary? Yes No
If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur:
_____

_____
__

(g) Does the resident have medical or dental conditions affecting: (Check all that apply)

_____Chewing _____Swallowing _____Eating_____ Pocketing food _____Tube feeding
(h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets

Resident Name _____ Date Completed _____

Date of Birth _____

restricted):

_____

_____

__

(i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids):

_____

_____

__

(j) Is there a need for assistive devices with eating (If yes, check all that apply):

Yes No Weighted spoon or built up fork Plate guard Special cup/glass

(k) Monitoring necessary? (Check one.) Yes No

If items (g), (h), or (i) are checked, please explain how and at what frequency monitoring is to occur:

_____

__

10.* Cognitive/Behavioral Status.

1. Is there evidence of dementia? (Check one.) Yes No
2. Has the resident undergone an evaluation for dementia? Yes No
3. Diagnosis (cause(s) of dementia):
4. Alzheimer's Disease Multi-infarct/Vascular Parkinson's Disease

   Other: _____

5. Mini-Mental Status Exam (if tested) Date _____ Score _____

10(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details.

Item 10(e)	A	B	C	D	Comments
I. Disorientation	Never	Occasional	Regular	Continuous	
II. Impaired recall	Never	Occasional	Regular	Continuous	

Resident Name _____ Date Completed _____

Date of Birth _____

(recent/distant events)					
III. Impaired judgment	Never	Occasional	Regular	Continuous	
IV. Hallucinations	Never	Occasional	Regular	Continuous	
V. Delusions	Never	Occasional	Regular	Continuous	
VII. Anxiety	Never	Occasional	Regular	Continuous	
VIII. Depression	Never	Occasional	Regular	Continuous	
IX. Unsafe behaviors	Never	Occasional	Regular	Continuous	
X. Dangerous to self or others	Never	Occasional	Regular	Continuous	
XI. Agitation (Describe behaviors in comments section)	Never	Occasional	Regular	Continuous	

10(f) Health care decision-making capacity. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, indicate this resident's highest level of ability to make health care decisions.

_____ (a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, and risks of proposed treatment).
_____ (b) Probably can make limited decisions that require simple understanding.
_____ (c) Probably can express agreement with decisions proposed by someone else.
_____ (d) Cannot effectively participate in any kind of health care decision-making.

Resident Name _____ Date Completed _____

Date of Birth _____

11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his/her own medications safely and appropriately.

_____(a) Independently without assistance
_____(b) Can do so with physical assistance, reminders, or supervision only (c) Need to have medications administered by someone else

12. Do you have any reservations regarding this resident's ability to live independently without 24/7 care/supervision? Yes No Maybe Explain: _____

_____

_____ _____
Health Care Practitioner Print First and Last Name Date

_____ _____
Signature of Health Care Practitioner Date

Restored Bridges, LLC.

401 Hawthorne Lane
310-312
Charlotte, NC 28204

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Client Signature: _____

Parent/Legal Guardian Signature: _____

Staff Signature: _____

Date: _____

VISITATION and CONTACT PLAN

For each resident, state type, time, level of supervision, frequency, duration, location of visits, and transportation arrangments. Revise as often as necessary. Please include visitors, DSS workers, court counselors and others.

Resident Name:	

This plan with	**is effective**	**through**

Supervision Required: ☐ **Yes** ☐ **No**	**By Whom:**
Place of visit:	
Frequency of visits:	
Hours:	
Length of visits:	
Transportation Arrangements:	
Special Considerations:	
Phone Calls Allowed: ☐ **Yes** ☐ **No**	
With Whom:	**Monitoring Needed:** ☐ **Yes** ☐ **No**
	Monitoring Needed: ☐ **Yes** ☐ **No**
Mail/Email Allowed: ☐ **Yes** ☐ **No**	
From Whom:	**Monitoring Needed:** ☐ **Yes** ☐ **No**
	Monitoring Needed: ☐ **Yes** ☐ **No**
Send All Mail/Email to:	

Signatures:

Resident Name _____ Date _____

Parent(s) _____ Date_____

Social Worker_____ Date _____

Others _____ Date_____

Restored Bridges Transitional and Independent Living Programs

Residential Rate Contractual Agreement

THIS AGREEMENT, made and entered into this _____ day of _____ (month)
By and between Restored Bridges, LLC., a for-profit organization with its principal office located in Mecklenburg County, North Carolina, that offers an independent residential living program for adults ages 22+ and a transitional living residential program for young adults ages 18-21, hereinafter referred to as the "Contractor", and the Department of Social Services of _____ County, hereinafter referred to as the "Contractee".

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth, the contractor does hereby contract to the Contractee, certain services herein after described and subject to the following conditions:

1. **Services:**
Full services rendered by the contractor to include full domicile, group individual and family counseling, recreation, education, medical, social services and other referrals.

2. **Term:**
This contract shall be in effect for a minimum period of _____**(21) days** _____**30 days** _____ **1 year** _____**2 years** from the date of the signing. Extensions must have the expressed approval of the Facility Director.

3. **Fees & Charges:**
The contractee agrees to pay the contractor the Residential Rate for _____client due monthly according to the North Carolina Department of Health and Human Services, Division of Social Service Cost Model Rates as Restored Bridges is a Participating Provider.

4. **Termination of Contract:**
The contractee may terminate the contract for any reason upon 24 hours verbal notice to the contractor. The contractor may terminate this contract for any reason upon 24 hours verbal notice to the contractee.

5. **Binding Effect:**
This contract shall be binding on all the parties hereto, their successors, by merger or otherwise or assigns, if applicable.

6. **Governing Law:**
The terms and provisions of this contract shall be governed by the laws of the State of North Carolina.

Contractor Signature: _____ Date: _____
Restored Bridges, LLC. Intake Staff

Contractee Signature: _____ Date: _____
Dept. of Social Services Social Worker