JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

Member's Name	Sex	Race	Citizenship	Date of Adm.	SS#	Consumer Record#/LME-MCO

Admitted From:	School Grade	Color Hair: Color Eyes: Identifying Marks:
Current Address:		Phone Number:

Birth Date	Age at Adm.				Co. of Residence

Religious Choice	Primary Language	Marital Status	Referred By
Insurance Data	Medicaid #	Prior Approval #	Medicare #

Legal Postal Contact & Address	Phone (area code)	Relationship

Mother's Name	Mailing Address	Phone (area code)	Date & Co. of Birth
Father's Name	Mailing Address	Phone (area code)	Date & Co. of Birth
Mother's Employer & Add.	Phone (area code)	Father's Employer & Add	Phone (area code)

			___Parent ___Legal Guardian ___Friend ___Family Member
			___Parent ___Legal Guardian ___Friend ___Family Member
			___Parent ___Legal Guardian ___Friend ___Family Member

Diagnosis

Services Client is Receiving:
CST _______ OPT_______ Med Management ______ Day Tx________ PSR__________ CAP ___________

Care Coordinator: Phone (area code) LME/MCO:

Physician's Name and Address	Phone (area code)

Medications

Name	Dosage	Frequency
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Allergies:	Treatment Plan: Start Date: ________________ End Date ___________

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

Member Referral and Screening Form

REFERRAL INFORMATION

Date of referral:
Referring Person:
Agency:
Phone Number:
Reason for referral:

CONSUMER INFORMATION

Member's Name:		DOB:
Race:	Gender:	Marital Status:
Insurance:	Ins. #:	Expiration Date:
Home Phone #: Work #:	Cell#:	
Address:		
# in household:		
Name of Guardian:		Annual Income:
Guardian's Address:		Relationship to Member:
Guardian's Phone #:		

MEDICAL/EMERGENCY INFORMATION (UPDATE ANNUALLY)

Person to contact in case of emergency:	
Emergency contact relationship to member:	
Emergency contact phone #:	
Emergency contact address:	
Member's allergies:	■None Known
Member's medical condition:	
Member's PCP:	
PCP Address:	PCP phone #:
Member's medications:	

WHAT OTHER AGENCIES/SERVICE PROVIDERS ARE INVOLVED WITH MEMBER:

Name of Agency/Provider	Contact Name	Contact Phone Number
Name of Member's School	**Contact Name**	**Contact Phone Number**

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

Member Referral and Screening Form

PRIMARY CONCERNS

Behavior Problems (Please describe briefly).
Emotional Problems (Please describe briefly).
Academic/employment problems (Please describe briefly).
Other Problems (Please describe briefly)
Treatment History (Please describe briefly)

CAN JCSS, INC. HELP?

■ Yes
■ No, your needs appear to be outside the scope of our agency capacity at this time. See Referrals

REFERRALS – PLACES THAT CAN HOPEFULLY MEET YOUR NEEDS (AGENCY & CONTACT INFORMATION

1.
2.
3.

■ Copy of form given to Member/Guardian at intake Date: ____________

■ Copy of form mailed to Member/Guardian Date: ____________

PLEASE FAX TO (252) 520-0024

____

Person Completing Form

____

Date

Revised 7/22/2015

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

Member Name: ____________ DOB: _________ MID: _______________ Record: _______________

Multiple Consent Form

INITIAL ALL THAT APPLY. MARK "N/A" TO ALL THAT DO NOT APPLY.

____**CONSENT FOR TREATMENT / SERVICES:** This Agency provides services to persons who have mental health, developmental disability, and/or substance abuse issues and problems. The staff is trained to provide appropriate services in partnership with clients as needed, to meet each individual's expressed problems and desired outcomes. I agree to treatment and services as offered by the Agency for :

____MYSELF ____MY CHILD ____THE PERSON FOR WHOM I AM LEGAL GUARDIAN / CUSTODIAN

Unless I have been court-ordered to attend this service, I understand that my participation is voluntary and I may withdraw from services at any time. If I do not withdraw this consent, it shall be valid for the entire length of my treatment. The treatment that will be provided may include the following:

____**INDIVIDUAL THERAPY** ____**GROUP THERAPY** ____**FAMILY THERAPY** ____ **MED MANAGEMENT** ____**PSR** ____**DT**
____**CST** ______ **INNOVATION WAIVER** _______ **SACOT**_______ **PEER SUPPORT** _______**SCHOOL OUTPATIENT THERAPY (child can receive therapy at school without parent/guardian being present** _______ **OTHER**

____**MEMBER RIGHTS AND RESPONSIBILITIES:** I have **REVIEWED THE CLIENT RIGHTS POLICY,** and have had my rights explained to me in a way that I can understand. I understand that it is my right and responsibility to ask questions if I need clarification or have concerns. I understand that I have the right to complain and/or file a grievance at any time, as outlined in the explanation of my rights. I have also received my ***Notice of Privacy Practices*** (on or After April 14, 2003) and understand that it is my right and responsibility to ask questions if I need clarification or have concerns.

____**CONSENT FOR EMERGENCY CARE:** I authorize the Agency to seek emergency medical or dental care if I (the member) become ill or have an accident while participating in treatment/services. This shall include emergency first aid rendered by the Agency's personnel. If emergency care beyond first aid is required, the agency will call 911 for evaluation and transportation to the local hospital if needed; and will notify the emergency contact person listed below to meet me at the hospital. The Agency may further authorize emergency medical treatment if the emergency contact person cannot be reached. I will hold harmless the Agency and its personnel against any liability caused using these emergency procedures. I agree to this emergency care process. I will assume full responsibility of all incurred emergency treatment expenses.

EMERGENCY MEDICAL INFORMATION

EMERGENCY CONTACT:	**ADDRESS:**	**PHONE #:**
MEMBER'S DOCTOR:	**ADDRESS:**	**PHONE #:**
CAREPROVIDER (if applicable):	**ADDRESS:**	**PHONE #:**
CAREPROVIDER (if applicable):	**ADDRESS:**	**PHONE #:**

____**CONSENT TO PARTICIPATE IN OFF-SITE ACTIVITIES, INCLUDING TRANSPORTATION:** During the course of treatment, clients may participate in outings. During these times, I agree to release the Agency from all liability and responsibility for myself/ my child/ my ward. This consent also includes consent to allow the Agency to transport me/ my child/ my ward to these off-site activities. This consent is valid until the member's separation from the program or until it is revoked in writing by the client/ parent/ guardian.

1501 North Queen Street, Kinston, NC 28501• Phone 252-520-2001• Fax 252-520-0024

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

Member Name: ____________ DOB: ________ MID: ______________ Record: ______________

Multiple Consent Form

____**CONFIDENTIALITY AND DISCLOSURE OF INFORMATION:** In accordance with state and federal laws, information maintained about you at this agency will be protected from unauthorized disclosure. Information will not be released unless there is a signed disclosure form detailing what is to be released or to whom. This form will be valid for one year. No information will be sent to your employer, family members, friends, or anyone else, unless it is discussed with you ahead of time and your permission is obtained. Disclosure is permitted under state and federal laws for situations which may be applicable to you, such as: 1. In the interest of public safety (life threatening situations); 2. In response to a court order; and 3. Where state laws require that information be disclosed to the appropriate authorities (e. g., suspected abuse or neglect of children or disabled adults, communicable diseases, etc.) All HIPAA Guidelines are followed.

I understand that the Company policies require that I receive appropriate treatment and continuity of care. In order to provide quality care, information may be shared between treating agencies. This information can be shared without my consent.

The N. C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services requires reporting of non-identifying client information. This information is stored in a computerized record system for statistical, program planning, research, evaluation, and funding purposes.

Client records relating to Substance Abuse are protected by more stringent Federal Confidentiality rules. Rules regarding disclosure of substance abuse information must be strictly followed. Consent forms must specify in writing what substance abuse information is being released. A general authorization for the release of medical or other information IS NOT sufficient for this purpose.

____**CONSENT FOR PHOTOGRAPHING &/OR VIDEOTAPING:** I consent to being videotaped as a part of treatment, and also to being photographed, if appropriate. I understand that I will not be identified by name. These images, if produced, will be used only for treatment purposes and will not be published. This consent is valid until the client's separation from the program or until it is revoked in writing by the client/ parent/ guardian.

CURRENT MEDICATIONS – Please list all medications you currently take:

____

____

____

____

ALLERGIES: - Please list all known allergies to medications and/or foods:

____

____

____

____

BY MY SIGNATURE, I CONSENT TO THE ABOVE-NAMED SERVICES AND TREATMENT. IF I DID NOT CONSENT TO A SERVICE, I MARKED THIS AREA "NA". I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS SIGNED MULTIPLE CONSENT FORM.

MEMBER/PARENT/GUARDIAN SIGNATURE:	**DATE:**
STAFF SIGNATURE:	**DATE:**

1501 North Queen Street, Kinston, NC 28501• Phone 252-520-2001• Fax 252-520-0024

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.
VERIFICATION OF PROVDER CHOICE

Name:____________________ **MID:**________________

Rec#:____________________ **DOB:** ____________

DIRECTIONS: This form is to be completed by the consumer, parent, or legal guardian for all treatment services.

I am a:

____ consumer ____ parent ____legal guardian

And am receiving this information:

____in person ____ by telephone ____ other (please specify) ______________

I am seeking services through, the ___ Trillium ___ Eastpointe ___ Sandhills ___ Alliance ___ Cardinal ___ for the treatment of the above named member. As a member/ parent/ legal guardian (circle one), I have been informed of my right to select the clinically appropriate provider of my choice from the LME/MCO provider network and/or provider list for provision of this service, based on my identified need and Level of Care criteria. JCSS staff has provided me with relevant, objective information about these providers, including, when applicable, those with expertise in the areas I require. I understand that this choice extends to physicians, nurses, case manager, therapists and support care staff. I fully understand that the choice is mine, although there are times when medically unsuitable choices cannot be honored. Request to change contracted providers will be reviewed with my Treatment Team.

Provider List

Port Human Services
Waynesboro Family Clinic
Dixon Social Interactive Service
Living Your Dream
Lucille's Behavior
Joseph's Community Support Services, Inc.
NOVA, Inc.
Pride in Carolina
Yelverton's

I confirm that I have received information referencing Eastpointe ME/MCO provider list on service provider agency that are providing services in the area where I live. I understand I may change providers at any time and can do so by calling the Care management Unit of Eastpointe LME at 1800-513-4002. If I decide I want to change agency reasonable notice will be given. The choices have been made from a selection of appropriate providers and I feel that the selection made today best suits the treatment needs of the consumer named above. Upon request, I can receive a copy of this provider choice form.

My signature confirms that I have reviewed the clinically appropriate choices and have made the selection that I feel best suits my/the above-named consumer's treatment needs.

Signature Consumer/ Parent/ Legal Guardian: ____________________ Date: ____________

Signature of Staff/ Witness: ____________________ Date: ____________

JOSEPH'S COMMUITY SUPPORT SERVICES, INC

HIPAA (Privacy Notification)

This information shall be accessed only by those who have a need to know and only on a professional basis. All persons who are privileged to this information shall be bound by the Confidentiality and HIPAA Act. The doctrine of informed consent has been explained to me, and I understand the contents to be released and the need for the information. Once Information is disclosed pursuant to this signed au thorization, I understand that the federal health privacy law (42 C.F.R. Part 164) protecting health information may not apply to the recipient of the Information therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. I also understand substance abuse records are covered under Federal Regulations (42 CFR, Part 2) and that there are statues and regulations protecting the confidentiality of my information, and that the information cannot be re-disclosed. I further understand that the information released may include drug and/or alcohol use, and/or HIV/AIDS diagnosis *only* with my specified consent. I hereby acknowledge that this consent is truly voluntary and is valid until 1-year.

I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

Your Right to Medical Information Confidentiality

HIPAA is an acronym that stands for Health Insurance Portability and Accountability Act that was made into law in 1996. By the law, if you are 18 years or older, you have the right to strict confidentiality regarding your medical records. In order to release any information you have to consent to release to the authorized provider listed on this form.

______________________________ ______________________

Consumer/Guardian Date

______________________________ ______________________

JCSS Representative Date

JOSEPH'S COMMUITY SUPPORT SERVICES, INC

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME:______________________________________ Record # _______________DOB:______________

Medicaid #______________________________________Social Security Number: XXX-XX-________

I, ___________________________ hereby authorize Joseph's Community Support Services, Inc

(Person Receiving Services or Personal Representative)

and ____ to release, exchange and/or communicate with

(Recipient)

one another the information that is listed below.

This data shall include: ("Y" to those that apply and "N" to all that do not. All boxes must be marked.)

________Psychological Evaluation

________Psychiatric Evaluation of

________Progress Notes from ____to________

________Intake Assessment

________Diagnosis

________Service Plan/Service Order

________Screening/Contact Assessment Form

________Other/Disclosure made regarding:____

__________HIV/AIDS

__________Alcohol/Drug Treatment*

__________STD

__________Hepatitis

__________Tuberculosis

__________Medication Information

__________Financial/Reimbursement

The purpose of the disclosure is for:

Service Delivery_____ Continuity of Care_____ Referral_____ Other______________________________

I understand that this authorization will expire on the following date, event, or condition:__________________________ I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however if this information is protected by the Federal Substance Confidentiality Regulations (42 C.F.R., Part 2) the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

Joseph's Community Support Services, Inc. has revised the Authorization for the Disclosure and Reciprocal Exchange of Information form to address the protection of HIV/AIDS information. The form reflects the statement; Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. I understand that my information is protected and will not be released without my written consent unless legal imperatives require information to be released. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to HIV infection, AIDS or AIDS related conditions. The revised form will replace the existing disclosure forms in the intake package and be available for use whenever there is a need for consent of disclosure. All current members/guardians will sign the revised form to bring all member records into compliance. To ensure ongoing compliance with consents, quarterly the General statues and Administrative rules will be reviewed to stay abreast on all updates and changes. The Quality Management Director will be responsible for ensuring compliance.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related condition, alcohol/drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that Joseph's Community Support Service has not conditioned my treatment on signing this authorization and I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I further understand that I may request a copy of this authorization.

A clear and legible photocopy of this consent for release of information shall be considered to be as valid as the original.

______________________________________ and/or ______________________________________

(Person Receiving Services) (date) (Personal Representative) (date)

____

(Witness-If Required) (date)

*Person receiving services must sign whether a child or adult, information protected by Federal Regulation 42 CFR part 2.

JOSEPH'S COMMUITY SUPPORT SERVICES, INC

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME:_______________________________ Record # ______________ DOB:______________
Medicaid #______________________________ Social Security Number: **XXX-XX-**________
I, ___________________________ hereby authorize Joseph's Community Support Services, Inc.
(Person Receiving Services or Personal Representative)
and ____ to release, exchange and/or communicate with
(Recipient)
one another the information that is listed below.

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________Psychological Evaluation	
________Psychiatric Evaluation of	________HIV/AIDS
________Progress Notes from ____to________	________Alcohol/Drug Treatment*
________Intake Assessment	________STD
________Diagnosis	________Hepatitis
________Service Plan/Service Order	________Tuberculosis
________Screening/Contact Assessment Form	________Medication Information
________Other/Disclosure made regarding:______________________	________Financial/Reimbursement

The purpose of the disclosure is for:

Service Delivery_____ Continuity of Care_____ Referral_____ Other_______________________

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_______________________________ and/or _______________________________
(Person Receiving Services) (date) (Personal Representative) (date)

____
(Witness-If Required) (date)

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AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

JOSEPH'S COMMUITY SUPPORT SERVICES, INC

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME:______________________________ Record # ____________ DOB:____________

Medicaid #______________________________ Social Security Number: XXX-XX-

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(Person Receiving Services or Personal Representative)

and ______________________________ to release, exchange and/or communicate with
(Recipient)

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________Other/Disclosure made regarding:______________________________

________HIV/AIDS
________Alcohol/Drug Treatment*
________STD
________Hepatitis
________Tuberculosis
________Medication Information
________Financial/Reimbursement

The purpose of the disclosure is for:

Service Delivery_____ Continuity of Care_____ Referral_____ Other______________________

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______________________________ and/or ______________________________
(Person Receiving Services) (date) (Personal Representative) (date)

____
(Witness-If Required) (date)

*Person receiving services must sign whether a child or adult, information protected by Federal Regulation 42 CFR part 2.

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

JOSEPH'S COMMUITY SUPPORT SERVICES, INC

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME:_______________________________________ Record # _______________DOB:_______________

Medicaid #_______________________________________Social Security Number: XXX-XX-_______________

I, ______________________________ hereby authorize Joseph's Community Support Services, Inc. _______________

(Person Receiving Services or Personal Representative)

and ____ to release, exchange and/or communicate with

(Recipient)

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________Other/Disclosure made regarding:______________________________

________HIV/AIDS

________Alcohol/Drug Treatment*

________STD

________Hepatitis

________Tuberculosis

________Medication Information

________Financial/Reimbursement

The purpose of the disclosure is for:

Service Delivery_____ Continuity of Care_____ Referral_____ Other______________________________

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______________________________________ and/or ______________________________________

(Person Receiving Services) (date) (Personal Representative) (date)

____

(Witness-If Required) (date)

*Person receiving services must sign whether a child or adult, information protected by Federal Regulation 42 CFR part 2.

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

JOSEPH'S COMMUITY SUPPORT SERVICES, INC

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME:________________________________ Record # ______________ DOB:______________

Medicaid #________________________________ Social Security Number: XXX-XX-__________

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(Person Receiving Services or Personal Representative)

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(Recipient)

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________Other/Disclosure made regarding:____

__________HIV/AIDS
__________Alcohol/Drug Treatment*
__________STD
__________Hepatitis
__________Tuberculosis
__________Medication Information
__________Financial/Reimbursement

The purpose of the disclosure is for:

Service Delivery_____ Continuity of Care_____ Referral_____ Other______________________________

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______________________________________ and/or ______________________________________
(Person Receiving Services) (date) (Personal Representative) (date)

____
(Witness-If Required) (date)

*Person receiving services must sign whether a child or adult, information protected by Federal Regulation 42 CFR part 2.

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

JOSEPH'S COMMUITY SUPPORT SERVICES, INC

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME:______________________________________

Medicaid #______________________________ Record # _______________ DOB:_______________

I, ______________________________ Social Security Number: XXX-XX-________

______________________________ hereby authorize Joseph's Community Support Services, Inc.

(Person Receiving Services or Personal Representative)

and ____

(Recipient) ______________________ to release, exchange and/or communicate with one another the information that is listed below.

This data shall include: ("Y" to those that apply and "N" to all that do not. All boxes must be marked.)

________Psychological Evaluation
________Psychiatric Evaluation of
________Progress Notes from ____to________
________Intake Assessment
________Diagnosis
________Service Plan/Service Order
________Screening/Contact Assessment Form
________Other/Disclosure made regarding:______________________________

__________HIV/AIDS
__________Alcohol/Drug Treatment*
__________STD
__________Hepatitis
__________Tuberculosis
__________Medication Information
__________Financial/Reimbursement

The purpose of the disclosure is for:

Service Delivery______ Continuity of Care______ Referral______ Other______________________

I understand that this authorization will expire on the following date, event, or condition:______________________
I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however if this information is protected by the Federal Substance Confidentiality Regulations (42 C.F.R., Part 2) the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

Joseph's Community Support Services, Inc. has revised the Authorization for the Disclosure and Reciprocal Exchange of Information form to address the protection of HIV/AIDS information. The form reflects the statement; Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with G.S. 130A-143. I understand that my information is protected and will not be released without my written consent unless legal imperatives require information to be released. Whenever authorization is required for the release of this information, the consent shall specify that the information to be released includes information relative to HIV infection, AIDS or AIDS related conditions. The revised form will replace the existing disclosure forms in the intake package and be available for use whenever there is a need for consent of disclosure. All current members/guardians will sign the revised form to bring all member records into compliance. To ensure ongoing compliance with consents, quarterly the General statues and Administrative rules will be reviewed to stay abreast on all updates and changes. The Quality Management Director will be responsible for ensuring compliance.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related condition, alcohol/drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that Joseph's Community Support Service has not conditioned my treatment on signing this authorization and I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I further understand that I may request a copy of this authorization.

A clear and legible photocopy of this consent for release of information shall be considered to be as valid as the original.

______________________________________ and/or ______________________________________
(Person Receiving Services) (date) (Personal Representative) (date)

____
(Witness-If Required) (date)

*Person receiving services must sign whether a child or adult, information protected by Federal Regulation 42 CFR part 2.

AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

Search and Seizure of Personal Possessions Policy

Joseph's Community Support Services prohibits unwarranted search of a consumer's person or belongings. All consumers served by JCSS have a right to privacy; however, searches may take place if JCSS staff members have a reliable cause to believe a person may have property or possessions that are dangerous, illegal or prohibited by the agency. Searches may also take place when staff members have witnessed drinking or drug abuse. All warranted searches will be performed in the consumer's presence and if feasible, with an additional staff person available.

JCSS Staff shall document any search or seizure in the Consumer Record and in an Incident Report. Documentation shall include the following:

1. Date, Time and Location
2. Scope of search
3. Reason for search
4. Procedures followed in the search
5. A description of any property seized, date/time/location
6. An account of the disposition of the property seized (i.e. returned to proper owner, placed in locked file cabinet)

Suspension/Expulsion From Services Policy

Each consumer has a right to express his or her concerns without fear of reprisal. Each consumer will be free from threat or fear of unwarranted suspension or expulsion from services. It shall be the policy of Joseph's Community Support Services to use the following criteria for the suspension of a consumer:

If a situation develops that warrants suspension from services, the LME shall be notified to discuss the situation and make recommendations on behalf of the consumer. Suspension documentation will be completed that include:

1. Conditions at the time decision was made
2. Recommendations of ways to improve the situation
3. Duration of suspension
4. Consumer name and Legal Guardian name
5. Efforts made by JCSS staff to identify alternative services to meet the consumer's needs

Situations that may lead to suspension includes, but is not limited to:

1. Property Damage
2. Insult or injury to self or others
3. Sale, use or possession of illegal substance
4. Inability to obtain funding
5. Change in level of functioning requiring a more intense level of care
6. Individual desire

It is not the policy of JCSS to expel consumers from services; however, if the consumer's current level of functioning indicates the need for a more intense level of care or if the consumer no longer wishes to be served by JCSS, the agency will utilize its Discharge Policy to facilitate the transition to a higher level of care or an alternate service provider.

By my signature, I understand the above policies as they have been explained to me.

______________________________ __________________

Signature of Consumer/Legal Guardian Date

______________________________ __________________

JCSS Staff Signature Date

JOSEPH'S COMMUNTY SUPPORT SERVICES, INC.

Consumer Acknowledgement of Rights and Rules and Receipt of Information

___ I have received a copy of **JCSS Consumer Handbook** and I have been informed of the **rights** to which I am entitled.

___ I have had **JCSS' Client Rights** and **Grievance Policies** explained to me and I understand my rights as given.

___ I have received a copy of the **JCSS Notice of Privacy Practices** which summarized the way my identifiable health information may be used and disclosed by my Provider and states my rights with respect to my medical information. I understand my Provider has the right to revise the information practices and to amend the Notice of Privacy Practices. I have been informed that in the event my Provider revises its information practices, a revised Notice will be mailed to my place of residence and that I may obtain a current Notice of Privacy Practices at any time from the office located at 1501 N. Queen Street, Kinston, NC 28501.

___ I have had the **Crisis Response Policy and Procedure** explained to me in a way that I can understand. I understand that it is my right and responsibility to ask questions if I need clarification or have concerns. Have been informed that Joseph's community Support Services, Inc provided a twenty-four hour, seven days a week emergency telephone number (252) 520-2001 for the use of persons served or family members in crisis situations. The individual answering this phone number will be qualified to provide crisis intervention face-to-face services. Furthermore, I have been given this number and encouraged to post it for emergency accessibility when needed.

___ I have received, and/or signed the following forms that have been explained to me in a way that I can understand:

- **Provider Choice Form**
- **Consent for Treatment**
- **Consumer's Emergency Information**
- **Code of Ethics**
- **Consent for Release of Information and HIPAA Notification**
  - The information you provide during screening, admission, treatment, placement and discharge is considered confidential by: Joseph's Community Support Services, Inc., contractual providers, and any other service providers. This information, however, may be shared, when deemed necessary, with each other in order to provide you with the highest quality of treatment and services available. Under the following conditions, release of information outside of Joseph's Community Support Services is permitted and/or required by law and stringent ethical standards when:
    - Joseph's Community Support Services has received a signed authorization from you or your legal guardian/representative – **Consent for Release of Information.**
    - There is a medical or psychiatric emergency involving your health and safety or the safety of others
    - Joseph Community Services is required by law to report incidents of suspected or substantiated neglect or abuse
    - Responding to a court order in a commitment proceeding.
  - Each release of information will be documented in your service record. These will be authorized by the Legal Guardian/Case Manager whenever practical. All identifying information is removed when computerized information is sent out regarding statistical, financial, and/or medical information. It is your right to fully understand all regulations pertaining to confidentiality. It is important to Joseph's Community Support Services, Inc., that you feel safe while using our services. If you need further clarification, please ask your primary care giver.

___ I have received, and/or signed, the following policies and procedures that have been explained to me in a way that I can understand:

- How to receive a copy of my service plan
- Fees charged and collection of those fees for treatment provided
- Suspension and expulsion from services
- Search and Seizure of personal possessions policy and procedure

___ I understand the benefits, potential risks, and possible alternative methods of treatment

___ I understand I have a right to refuse treatment at any time, but choose to consent to treatment at this time. I further understand my refusal will not be used as sole grounds for termination of services unless the treatment is the only viable option available at Joseph's Community Services, Inc.

___ I understand the right to be free from harm, abuse, neglect and exploitation

I certify the above information is current and has been explained to me clearly for my understanding. I certify that I had the opportunity to ask questions and had all my questions answered and concerns addressed. I further acknowledge receipt if the above information in writing, upon my admission date.

______________________________ ______________
Consumer signature: Date

______________________________ ______________
Legal Guardian Signature (if applicable) Date

______________________________ ______________
JCSS Representative Date

Original to be kept in consumer medical record file, a copy to be given to consumer and legal guardian (if applicable)

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC 1501 North Queen Street, Kinston, NC 28501

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

It is the responsibility of Joseph's Community Support Services to provide you with an orientation to services provided by the agency. The items listed below will be provided for you in one of the following methods: verbally and in the consumer handbook. Your signature below will serve as acknowledgement that you have been provided, understand, and agree to the items identified below.

I have discussed the consumer handbook, which has information about the following:

Services provided:
Services provided are Community Support Team, Day Treatment, Outpatient Therapy, CAP, PSR, Medication Management. Clinical Comprehensive and Medication Assessment.

Hours of operation:
9:00am -5:00pm

Access to after-hour services:
Consumers are informed of crisis phone number and given the crisis procedure

Code of Ethics and Confidentiality policy:

Consumers are given a copy of the Code of Ethics and Confidentiality policy during Orientation.

My rights and responsibilities as a person receiving services:
Consumers are given a copy of their Rights and Responsibilities during Orientation

Person Centered Plan
Member is informed of how the PCP is developed and how they can receive a copy.

How my input can be given regarding quality of care, achievement of outcomes, satisfaction as the person served:
Consumers complete surveys once per quarter and encouraged to give input.

Grievance and appeal procedure:
Consumers are given a copy if the Grievance and appeals procedure during Orientation

Suggestion box and feedback/input process:
Suggestion box is located in the front office at the corporate office

Orientation to facilitate where I receive services:
Orientation occurs at the site that services will be provided, if applicable.

Rules, regulations and program expectations:
Rules, regulations, and program expectations are explained to consumers during Orientation

Responsible person identified for service coordination:
Informed of responsible person in relation to services being provided.

Transition and discharge criteria and procedure:
Provided specifics on transitioning and being discharged in accordance to service definition.

Overview of premises in addition to health and safety tips including but not limited to emergency exits and/or shelter, fire suppression equipment, and first aid kits:
Safety procedures orientation provided addressing emergencies

Program policies for use of seclusion or restraint:
Reviewed during Orientation

Smoking:
Smoking is only allowed at designated areas.

Legal/illegal drugs and weapons brought into the program:
Reviewed during orientation that no drug or weapons are allowed.

_______________________________ _______________
nsumer/Parent/Legal Guardian Signature Date

_______________________________ _______________
esentative Signature Date

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC.

MEMBER FINANCIAL AGREEMENT

Joseph's Community Support Services, Inc. will accept the following insurances for services rendered:

1. Medicaid
2. Health Choice

Client Name: ______________________________ MR #: ____________________

Address: ____

City: ________________________ State: ________ Zip Code: __________

County: ______________________________________ Phone: ____________

SSN: ____ DOB: ____________

I have the following insurance (please attach a copy of insurance card):
__Medicaid __Health Choice

In understand that because I receive Medicaid, my minimum payment is zero for all Medicaid covered services.
Initial: ________

I understand that because I receive Health Choice, my minimum payment is zero for all Health Choice covered services.
Initial: ________

I agree to notify Joseph's Community Support Services, Inc. when there is a change in my insurance coverage or county of residence immediately.
Initial: ________

I understand that if there is a termination of my insurance for any reason, Joseph's Community Services, Inc. will be unable to continue rendering services.
Initial: ________

I agree to notify Joseph's Community Support Services, Inc. at least 24 hours in advance if I cannot make a scheduled appointment.
Initial: ________