Member's Name		Corr		CONTRACTOR OF					70.70
		Sex	Race	Citize	enship	Date of Adm.	SS#		Consumer Record#/LME-MCO
Admitted From:		School Grade			Color	r Hair: r Eyes:			
Current Address:		- State				tifying Marks: ne Number:			
Birth Date	Age:	at Adm.	T						
Religious Choice								Co.	of Residence
		Frima	ary Langua	age.		Marital Status		Ref	erred By
Insurance Data		Medic	aid#			Prior Approval	#	Me	dicare#
Legal Postal Contac	t & Addr	ess	Phone	ie (area co	ode)		Relat	ionship	
Mother's Name		Mailir	ng Address	s	\neg	Phone (area cod	le)	Dat	te & Co. of Birth
Father's Name		Mailir	ng Address	s	\neg	Phone (area cod	e)		e & Co. of Birth
Mother's Employer			(area cod	**************************************	- 1	Father's Employ			one (area code)
		PALARY WEST	18 12 ve 198		Contract Contract	78 - 1504 A	-1- 1- 11111111		
Mineral vary									Parent Legal Guardian Friend
				,					Family Member Parent Legal Guardian Friend
					-				Friend Family Member Parent
Diagnosis									rarent Legal Guardian Friend Family Member
				5. Care 100 con 100 co					заниу меньег
Services Client is Rec CST OPT Care Coordinator:	ceiving:	Med Man:	agement		Dov T				
Care Coordinator:			-	Pho	one (ar	ea code)		CAP	
Physician's Name and	d Addres	is				Phone (area code		NEW IVE	.
*					-	Hone (area coue)		//
Medications Name			Dos	sage					
			-				Free	quency	
			_						
Allergies:					Treatm Start D	nent Plan: Date:		T. I Data	
						4		ind Date	

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC. Member Referral and Screening Form

REFERRAL INFORMATION

1,1				
Date of referral:				
Referring Person:				
Agency:				
Phone Number:				
Reason for referral:				
. 7				
CONTRACTOR				
CONSUMER INFORMATION				
Member's Name:				
Race:	Cit	DOB:		
Insurance:	Gender:		Marital Sta	his:
Heme Phone #: Work #:	Ins. #:		Expiration 1	
Address:		Cell#:		
# in household:				
Name of Guardian		Annua	Income:	
Guardian's Address:		Relation	nship to Mer	nber:
Guardian's Phone #:				
MEDICAL/EMERGENCY DIRO	225			
MEDICAL/EMERGENCY INFO	KMATION (UPD)	ATE ANNUALLY)		
Person to contact in case of en	nergency:			
cinergency contact relationship	p to member:			
Emergency contact phone #:				
Emergency contact address:				
Member's allergies:			- Nīono	7
Member's medical condition:			None	Known
Member's PCP:			PCD.	phone #:
PCP Address:			101	Mone #:
Member's medications:				
•				
1				
WHAT OTHER AGENCIES/SER	VICE PROVIDE	RS ARE INVOLVED W	TII beriber	
Name of Ages - B			I II MEMBER	
Name of Agency/Provider		Contact Name		Contact Phone Number

Number
Number
- 22

Member Referral and Screening Form

Behavior Problems (Please describe briefly).	
Emotional Problems (Please describe briefly).	
Academic/employment pmbl. (D)	
Academic/employment problems (Please describe brie	fly).
Other Problems (Please describe briefly)	
Freatment History (Please describe briefly)	
(I sease describe briefly)	
AN JCSS, INC. HELP?	
<u>:</u>	
Yes	
Yes	our agency capacity at this time. See Referrals
Yes No, your needs appear to be outside the scope of o	
Yes No, your needs appear to be outside the scope of o	
Yes No, your needs appear to be outside the scope of o	
Yes No, your needs appear to be outside the scope of o	
Yes No, your needs appear to be outside the scope of o	
Yes No, your needs appear to be outside the scope of o	
Yes No, your needs appear to be outside the scope of o	TR NEEDS (AGENCY & CONTACT INFORMATION
Yes No, your needs appear to be outside the scope of o REFERRALS - PLACES THAT CAN HOPEFULLY MEET YOU Copy of form given to Member/Guardian at intake	
Yes No, your needs appear to be outside the scope of o REFERRALS - PLACES THAT CAN HOPEFULLY MEET YOU L.	JR NEEDS (AGENCY & CONTACT INFORMATION Date:
No, your needs appear to be outside the scope of or REFERRALS - PLACES THAT CAN HOPEFULLY MEET YOU. Copy of form given to Member/Guardian at intake	TR NEEDS (AGENCY & CONTACT INFORMATION
Yes No, your needs appear to be outside the scope of o REFERRALS - PLACES THAT CAN HOPEFULLY MEET YOU Copy of form given to Member/Guardian at intake	JR NEEDS (AGENCY & CONTACT INFORMATION Date:

<u> </u>	
Person Completing Form	Date
Revised 7/22/2015	

	Member Name:	DOB:	MID:	Re	cord:
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		···aicibic (-Unsent F	Offi	
7	INITIAL A	LL THAT APPLY	·		
-		LE MAI APPLI	• 80/	ARK "N/A" TO ALL TI	HAT DO NOT APPLY.
1					
1	CONCERN TO THE TOTAL TOT				
_	CONSENT FOR TREATMENT / SE	RVICES: This Agency	provides servi	s to persons who have me	ental health, developmental disability, and/or
2	The formalist 11	one is named in the	MOE SODICIONATE	sonince in northweship with	ania neatin, developmental disability, and/or clients as needed, to meet each individual's
0	1 200001100.	I agree to treatment and	l services as offe	red by the Agency for:	and the state of t
-	MY CHILL	DT	HE PERSON FO	R WHOM LAM LEGAL CHAR	RDIAN / CUSTODIAN
U	less I have been court-ordered to attend	this service, I understand	d that my nartici	nation is voluntary and I may	. detd
W		. Characteristic of titly (1681	ment. The treat	ment that will be received man.	Sandrada Han Sattan Co
4	GKOO	FINERAPYFAI	MILY THERAPY	MED MANAGEMENT	DOD
4	THE MOUNT IN THE PROPERTY OF T	ek saco	T PE	ER SUPPORT ec	
re	ceive therapy at school without parentig	Juardian being present	от	IER	THE OUT THE OUT (CING CAN
_	MEMBER RIGHTS AND RESPONSE	BILITIES: I have REVIE	WED THE CLIE	NT RIGHTS POLICY, and hav	e had my∡ights explained to me in a way that
~	The state of the s	TABLE OF THE SECOND STORED IN	o ask questions	if I peed derification or how a	manama timberetiri da iki iki iki iki iki iki iki iki iki ik
- 1.	in the management of the first	, as occurred it the expla	ination of my rich	the I have also monitored —. I	Markan at Pater and the control of
14	, 2003) and understand that it is my right a	nd responsibility to ask o	questions if I nee	d clarification or have concerns	s.
_	CONSENT FOR EMERGENCY CARE	: Lauthorize the Agona			
wi	tile participating in treatment/services. T	his shall include emerge	y to seek emerge	ancy medical or dental care if I	(the member) become ill or have an accident onnel. If emergency care beyond first aid is
re	guired, the agency will call 911 for evalua	tion and transportation t	on the local boer	idered by the Agency's personital if posted and will a city.	onnel. If emergency care beyond first aid is the emergency contact person listed below to
m	eet me at the hospital. The Agency may	further authorize emen	Dency medical t	reatment if the ecomognic	ne emergency contact person listed below to intact person cannot be reached. I will hold
ha	mless the Agency and its personnel again	nst any liability caused u	usina these eme	mency nucedimes. I same to	or this emergency care process. I will assume
fu	responsibility of all incurred emergency to	eatment expenses.		goney processings. Tagget &	o use emergency care process. I will assume
		EMERGE	NCY MEDICAL	INFORMATION	
E	HERGENCY CONTACT:		DRESS:		PHONE #
M	EMBER'S DOCTOR:				
	·		DRESS:		PHONE #:
C	AREPROVIDER (if applicable):	ADI	DRESS:		PHONE #:
C	AREPROVIDER (if applicable):	ADI	DRESS:		
					PHONE &
	CONSENT TO DADTICIDATE IN API	P AIR I AMP III			
	itings During these times I same to when	r-she activities, inc	CLUDING TRAN	ISPORTATION: During the c	course of treatment, clients may participate in
all	ow the Agency to transport and any about	se use Agency from all lia	ability and respon	nsibility for myself/ my child/ my	y ward. This consent also includes consent to
-	woked in writing by the client/ parent/ guard	my ward to these off-site	activities. This	consent is valid until the memi	ber's separation from the program or until it is
	and an animal of the cheath batetin ansur	udi.			
-			1		

Member Name:	DOB:	MID:	Record:
	Multipl	e Consent Form	
from: This form will be valid for lead of time and your permission interest of public safety (life the propriate authorities (e. g., suspinderstand that the Company placed between treating agencies in N. C. Division of Mental Heat formation is stored in a computer interest records relating to Substatemation must be strictly followers of medical or other information.	one year. No information will be an is obtained. Disclosure is per incentening situations); 2. In nepected abuse or neglect of childrodicies require that I receive applications in the information can be share with all pevelopmental Disabilities arized record system for statistical receive are protected by read. Consent forms must specification IS NOT sufficient for this perspection.	e sent to your employer, familitied under state and feder sponse to a court order; and ren or disabled adults, commispropriate treatment and control without my consent. In and Substance Abuse Serial, program planning, research program planning, research program planning, research in writing what substance a surpose.	te and federal laws, information maintained about you at this ager to is a signed disclosure form detailing what is to be released or ily members, friends, or anyone else, unless it is discussed with you all laws for situations which may be applicable to you, such as: 1. d. 3. Where state laws require that information be disclosed to the unicable diseases, etc.) All HIPAA Guidelines are followed: timulty of care. In order to provide quality care, information may be vices requires reporting of non-identifying client information. The ch, evaluation, and funding purposes. Indentiality rules. Rules regarding disclosure of substance abust buse information is being released. A general authorization for the order of treatment, and also to being photographed,
propriate. I understand that I was some of the client is consent is valid until the client in the cl	t's separation from the program	or until it is revoked in writing	part of treatment, and also to being photographed, will be used only for treatment purposes and will not be published by the client/ parent/ guardian.
LERGIES: - Please list all know	n allergies to medications and/o	or foods:	
MY SIGNATURE, I CONSEN REA "NA". I ACKNOWLEDGE EMBERIPARENTIGUARDIAN S	WALL THE PERSON A CO	ERVICES AND TREATMEN DPY OF THIS SIGNED MUL	IT. IF I DID NOT CONSENT TO A SERVICE, I MARKED THE TIPLE CONSENT FORM.
[AFF SIGNATURE:	OWNE:		DATE:
			DATE:
		2	

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, or legal guardian for all treatment services
parentlegal guardian	
And am receiving this information:	
in person by telephone other (plea	se specify)
am seeking services through at	
clinically appropriate provider of my choice from the Libervice, based on my identified need and Level of Care cribout these providers, including, when applicable, those extends to physicians.	guardian (circle one), I have been informed of my right to select the ME/MCO provider network and/or provider list for provision of this iteria. JCSS staff has provided me with relevant, objective information with expertise in the areas I require. I understand that this choice and support care staff. I fully understand that the choice is mine as cannot be honored. Request to change contracted providers will be
Provider List	
ort Human Services	
Vaynesboro Family Clinic	
Dixon Social Interactive Service iving Your Dream	
ucille's Behavior	
oseph's Community Support Services, Inc.	
ride in Carolina	
'elverton's	
	pointe ME/MCO provider list on service provider agency that are nay change providers at any time and can do so by calling the Care I decide I want to change agency reasonable notice will be given. e providers and I feel that the selection made today best suits the est, I can receive a copy of this provider choice form.
fy signature confirms that I have reviewed the clinically any/the above-named consumer's treatment needs	ppropriate choices and have made the selection that I feel best suits
ignature Consumer/Parent/Legal Guardian:	Date:
gnature of Staff/ Witness:	Date:

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

AUTHORIZAȚION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Medicaid #	
Medicaid #	<u> </u>
Person Possition Continue therei	by authorize Joseph's Community Support Services, Inc.
, herei Person Receiving Services or Personal Repand	presentative)
(Recipient)	to release, exchange and/or communicate with
one another the information that is listed belongs data shall include (200)	low.
Psychological First with those that apply	ow. y and "N" to all that do not. All boxes must be marked.)
Psychiatric Evaluation of	HIV/AIDS
Progress Netse from	Alcohol/Drug Treatment*
Progress Notes from to Intake Assessment	STD
Diagnosis	Hepatitis
Service Plan/Service Order	Tuberculosis
Screening/Contact Association	Medication Information
Screening/Contact Assessment Form	Financial/Reimbursement
Other/Disclosure made regarding:	
The purpose of the discussion	
he purpose of the disclosure is for:	
Service Delivery	
Service Delivery Continuity of Care	Referral Other
understand that this authorization	
understand that if I fail to specify an expire on the fa	following date, event, or condition:
urpose for up to one year annual s	c or condition, this authorization is valid for the period of the
nderstand that I may revoke this authorisms	101 Illiancial Tansactions wherein the cust
and announced at any	time and that I will be add, whatehi the animorization is valid indefinitely. I al
further understand that any action taken on this author	time and that I will be asked to sign the Revocation Section on the back of this for
action taken on this author	time and that I will be asked to sign the Revocation Section on the back of this for prization prior to rescinded date is level and binding.
understand that my information maken on this author	time and that I will be asked to sign the Revocation Section on the back of this for prization prior to rescinded date is legal and binding.
understand that my information may not be protected	time and that I will be asked to sign the Revocation Section on the back of this for prization prior to rescinded date is legal and binding. d from re-disclosure by the requester of the information is valid indemnitely. I all the back of this formation is valid indemnitely. I all the back of this formation is valid indemnitely. I all the back of the information is valid indemnitely. I all the back of this formation is valid indemnitely. I all the back of this formation is valid indemnitely. I all the back of the bac
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understand that my information may not be protected protected by the Federal Substance Confidentiality ithout my further written authorization unless otherwiseph's Community Support Services, Inc. has revised address the protection of HIV/AIDS information. The fection, AIDS or AIDS related and this	time and that I will be asked to sign the Revocation Section on the back of this for prization prior to rescinded date is legal and binding. d from re-disclosure by the requester of the information; however if this information Regulations (42 C.F.R., Part 2) the recipient may not re-disclose such information provided for by state or federal law. d the Authorization for the Disclosure and Reciprocal Exchange of Information for the form reflects the statement. Confidential information reflects the statement.
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AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME:		D		
Medicaid #		_ Record #	DOB:_	
	hambur	Social Security No	umber: XX	X-XX-
Person Receiving Services or	Personal Deservation	rize Joseph's Community	Support Servi	ces Inc
and	reisonal Representa	tive)		305, IIIC.
(Recipient)		to release, excha	nge and/or o	Ommunicate with
one another the information the	A in line			
This data shall include: ("Y" to the property of the property	ir is listed below.			
Psychological Evaluation	inee mat abbly and "No	to all that do not. All boxes m	ust he marked	13
Psychiatric Evaluation of		HIV/AIDS	act ac tiles ven	-1
Progress Notes from	to	Alcohol/Drug Tr	eatment*	
intake Assessment	_;0	STD		
Diagnosis		Hepatitis		
Service Plan/Service Orr	le r	Tuberculosis		
Screening/Contact Asset	ssment Form	Medication Info	mation	
Other/Disclosure made n	eusugiper Sourchit LOIIII	Financial/Reimb	Dursement	
inde it	egarding:			
The purpose of the disclosure	a io fam			
Service Delivery Continui	tv of Care			
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AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

		Record #	DOD:
Medicaid #			_DOB:
l,	hereby author	Social Security Numb	er: <u>XXX-XX-</u>
(Person Receiving Services o	r Personal Representa	rize Joseph's Community Supr	ort Services, Inc.
and		idae)	
(Recipient)		to release, exchange	and/or communicate with
one another the information the	act in linta at the s		
This data shall include: ("V" to	those that and below.	to all that do not. All boxes must b	
Psychological Evaluation	urose trait apply and "N"	to all that do not. All boxes must b	e marked.)
Psychiatric Evaluation	on of	MIVIAIDS	
Progress Notes from	or to	Alcohol/Drug Treatm	ent*
Intake Assessment		STD	
Diagnosis		Hepatitis	
Service Plan/Service O	and a	Tuberculosis	
Screening/Contact Ass	order	Medication Informat	ion
Other/Disclosure made	essment rom	Financial/Reimburse	ment
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The purpose of the disclosu	re is for		
Service Delivery Continue		erralOther	
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understand that if I fail to specify	an expiration data	date, event, or condition: ition, this authorization is valid for the cial transactions, wherein the cont.	
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AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME: Medicaid # I,	Kecord #
	DOB:
(Person Receiving Services or Person	hereby authorize Joseph's Community Support Services, Inc.
and	nal Representative)
(Recipient)	to release, exchange and/or communicate with
One another the information the com-	
This data shall include: (50% to 45 to 15	ted below. at apply and "N" to all that do not. All boxes must be marked.)
Psychological Fundament	at apply and "N" to all that do not. All hoves must be maded.
Psychiatric Evaluation of	HIV/AIDS
Progress Notes Some	
Progress Notes from to Intake Assessment	STD STD
Diagnosis	Hepatitis
Sorries Planton :	Tuberculosis
Service Plan/Service Order	
Screening/Contact Assessment	Form Financial/Reimbursement
Other/Disclosure made regarding	ig:i mandankeimbursement
The purpose of the disclosure is	
The purpose of the disclosure is fo	r.
Service Delivery Continuity of C	- .
understand that this authorization will expire understand that if I fail to specify an expira	
understand that if I fail to specify an expire	on the following date, event, or condition: Ition date or condition, this authorization is valid for the period of time needed to fulfill Closures for financial transactions, wherein the authorization is mild in the following the surface of the condition of t
OUTDOSE for up to one year and	ation date of condition, this authorization is valid for the period of circumstance of condition, this authorization is valid for the period of circumstance of condition, this authorization is valid for the period of circumstance of condition, this authorization is valid for the period of circumstance of condition, this authorization is valid for the period of circumstance of conditions.
nderstand that I may revoke this authorization	n at any time and that I will be a wherein the authorization is valid indefinitely. I al
further understand that any action taken on the	closures for financial transactions, wherein the authorization is valid indefinitely. I all n at any time and that I will be asked to sign the Revocation Section on the back of this for this authorization prior to rescinded date is legal and hinding.
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Authorit my nirther written authorization unless	protected from re-disclosure by the requester of the information; however if this information ratiality Regulations (42 C.F.R., Part 2) the recipient may not re-disclose such information so therwise provided for by state or federal law.
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AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

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Medicaid #	R	ecord#	DOB:
<u> </u>		Social Security Nu	ımber: XXX-XX-
(Person Receiving Services or Pe	nereby authorize	Joseph's Community	Support Services Inc
and	sisonal Representative)		110.
(Recipient)		to release, excha	nge and/or communicate with
one another the information that	in Hata A		
This data shall include: ("Y" to the Psychological Evaluation	is listed below.		
Psychological Evaluation	se that apply and "N" to a	il that do not. All boxes m	ust be marked \
Psychiatric Evaluation of		ITIVINUS	
Deservan Mata	to —	Alcohol/Drug Tr	eatment*
Intake Assessment		STD	
Diagnosis		Hepatitis	
Service Plan/Service Orde	_	Tuberculosis	
Screening/Contact Assess	mont Form	Medication Info	mation
Other/Disclosure made reg		Financial/Reimb	ursement
	arding:		
The purpose of the disclosure	- 6		
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Service Delivery Continuity	of Co		
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understand that if I fail to specify an opurpose for up to one year, except for inderstand that I may revoke this author.	disclosures for financial a	this authorization is valid	for the period of time needed to fulfil
understand that I may revoke this author. I fuirther understand that any action taken	on this authorization prior to	will be asked to sign the Re	vocation Section on the back of this fo
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AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Medicaid #	Pacami #
	LK 785
hereby outh	Social Security Number: XXX-XX- porize Joseph's Community Support Services, Inc. to release explanation of the release explanatio
(Person Receiving Services or Personal Representation	ionze Joseph's Community Support Services Inc
and	lauve)
(Recipient)	to release, exchange and/or communicate with
ONE ADDRES the information at the con-	
This data shall include: (50% to 15)	
This data shall include: ("Y" to those that apply and "N ———————————————————————————————————	I" to all that do not All hoves must be see !
Psychiatric Evaluation of	HIV/AIDS
Progress Netse Service	
Progress Notes from to Intake Assessment	Alcohol/Drug Treatment*
Diagnosis	Hepatitis
Service Plan/Service Order	Tuberculosis
Screening/Contact Assessment Form	Medication Information
Other/Disclosure made regarding:	Financial/Reimbursement
he purpose of the disclosure is for:	
Service Delivery Continuity of Care Ref	formal Out an
undamin data a d	charOther
understand that this authorization will expire on the following understand that if I fail to specify an expiration date or com-	I date event an analysis
traces for up as it is all to specify an expiration date or con-	dition this authorises
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Search and Seizure of Personal Possessions Policy

descrites Community Support Services prohibits unvironanted search of a consumer's person or belongings. All consumers served by JUSS have a right to privacy, however, searches may take place if JUSS staff members have a reliable cause to believing person may have properly or possessions that are dangerous, illegal or prohibited by the agency. Searches may also take place when shall members have winessed draking or drug abuse. All warranted searches will be performed in the consultar's presence and if feasible, with an additional staff person available.

ICSS Staff etical document any search or seizure in the Consumer Record and in an Incident Report. Documentation shall

- 1. Date. Time and Location
- 2. Scope of search
- Reason for search
 4. Procedures followed in the search
- 5. A description of any property seized, date/time/location
- 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 apparatus has a right to express his or her concerns without lear of reprisal. Each consumer will be free from threat or particularities into a upon at suppose insure its concerns whereat our or represent surporties whereas its distribution of support services. It shall be the policy of Joseph's Community Support Services to

If a spiration develops that mananic 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:

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

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

- 1 Property Damage
- 2. Insultion injury to self or others
- 3. Sufe, use or possession of slegal substance
- di instilly to obtain function
- Change in level of functioning requiring a more intense level of care
- 'intribut desire

It is that the policy of JOSS to expel consumers from services; however, if the consumer's current level of functioning indicates the pand his a more intense level of care or it the consumer no longer wishes to be served by JCSS, the agency will office its Dischinge Policy to facilitate the transition to a higher level of care or an alternate service provider.

By revisionature, I understand the above policies as they have been explained to me. Signature of Consumer/Legal Guardian Date JCSS Staff Signature Date TOSENTS COMMUNITY SUPPORT SERVICES, INC. 1591 North Green Street, Kinston, NC 28591

Consumer Acknowledgement of Rights and Rules and Receipt of Information

Consumer Acknowled	gement of Rights and Rules and Receipt of Information
	months it is a second of mileting the second of mileting the second of t
I have had <u>JCSS' Client Rights</u> and G	umer Handbook and I have been informed of the rights to which I am entitled.
South Regins and G	inevance Policies explained to me and lunderstand musicular
and disclosed by my Provider and sta	Ofice of Privacy Practices which summarized the use and the use
information practices, a revised Notice any time from the office located at: 150	will be mailed to my place of residence and that I may obtain a current Notice of Privacy Practices at 11 N. Queen Street, Kinston, NC 28501
responsibility to ask questions #1	by and Procedure explained to me in a way that I can understand. I understand that it is my right and also a week concerns. Have been informed that Joseph's community Support Contents.
1	idual answering this phone number will be qualified to provide crisis intervention face-to-face services.
Provider Choice Form	wing forms that have been explained to me in a way that I can understand:
Consent for Treatment Consumer's Emergency Inf	
 Consent for Release of Info 	emation and HIPAA Notification
by: Joseph's Com	munity Country screening, admission, treatment, placement and discharge in
however, may be s	munity Support Services, Inc., contractual providers, and any other service providers. This information, rices available. Under the following conditions, release of information provider service providers.
Support Services is	states, when deemed necessary, with each other in order to provide you with the highest quality of spermitted and/or required by law and stringent ethical standards when
 Joseph's 	Community Community
guardian	representative Company to a low leading a signed authorization from you or your
Joseph C abuse	Community Services is required by law to report incidents of suspected or substantiated reclect as
Respond	ing to a court order in a commitment proceeding.
 Each release of it 	Pframedia
pertaining to confidence our services. If you	information will be documented in your service record. These will be authorized by the Legal inager whenever practical. All identifying information is removed when computerized information is statistical, financial, and/or medical information. It is your right to fully understand all regulations tentiality. It is important to Joseph's Community Support Services, Inc., that you feel safe while using need further clarification, please ask your primary care giver.
How to receive a conv of much state of the follows: How to receive a conv of much state of the follows:	wing policies and procedures that have been explained to me in a way that I can understand:
Suspension and expulsion from Search and Sointen of the searc	m services
Search and Seizure of person	al possessions policy and procedure
I understand the benefits, potential risks,	, and possible alternative methods of treatment
i understand I have a right to end.	
	opposit available at Joseph's Community
understand the right to be free from har	m, abuse, neglect and exploitation
Certify the above information is a	een explained to me clearly for my understanding. I certify that I had the opportunity to ask questions addressed. I further acknowledge receipt if the above information in writing, upon my admission date.
Consumer signature:	
	Date
Legal Guardian Signature (if applicable)	
· · · · · · · · · · · · · · · · · · ·	Date

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

Date

JOSEPH'S COMMUNITY SUPPORT SERVICES, INC

JCSS Representative

1501 North Queen Street, Kinston, NC 28501

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

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

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

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 Safety procedures orientation provided addressing emergencies

Program policies for use of seclusion or restraint:

Reviewed during Orientation

Smoking is only allowed at designated areas.

egal/illegal drugs and weapons brought into the program: 'eviewed during orientation that no drug or weapons are allowed.

•	
usumen/Parent/Legal Guardian Signature	Date
esentative Signature	Date

MEMBER FINANCIAL AGREEMENT

Joseph's Community Support Services, Inc. will accept the following insurances for services 1. Medicaid

- 2. Health Choice

Client Name:	MR#:			
Address:				
City: State:				
County:	<u> </u>			
SSN:	DOB:			
I have the following insurance (please attach a copy of insurance card):				
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.				
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, Incaraot make a scheduled appointment. Initial:	c. at least 24 hours in advance if I			