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Client Admission Checklist

This information is <u>required PRIOR</u> to Admission

SOCIAL AND DEVELOPMENTAL SUMMARY

_____ Social History describing Family Structure and Relationships*
_____ Current DSM-V Diagnosis *(Axis I-IV)**
_____ Previous Treatment/Placement History *(Reports, Discharge Summary, Treatment Plans, Psychological/Psychiatric Evaluations, etc.)**
_____ Current Behavioral Functioning: Strengths, Talents and Problems/Issues
_____ Documentation for Need of Care; apart from the Family Setting
_____ Custody Status—Names, Addresses, Social Security Number and Marital Status of Parents/Guardians, Copy of Court Order and other Documentation Establishing Custody
_____ Names, Ages and Gender of Siblings

PHYSICAL EXAMINATION

_____ COVID-19 Rapid Test Results in Last 24 Hours- ***Copy of Results Required at Admission***
_____ Immunization Record
_____ Visual and Auditory Condition
_____ General Physical Condition

- Documentation of Freedom from Communicable Disease including TB
- Allergies, Chronic Conditions, and Handicaps; *if any*

_____ Nutritional Requirements including Special Diets, *if any*
_____ Restriction of Physical Activity, *if any*
_____ Recommendations for further Treatment, Immunizations & Other Examinations Indicated
_____ Date of last Physical and Dental Exam

MEDICAL HISTORY

_____ Serious Illness or Chronic Condition of Individual's Parents or Siblings, *if known*
_____ Previous Serious Illnesses, Infectious Diseases, Serious Injuries and Hospitalizations
_____ Results of Psychological, Psychiatric and Neurological Evaluations, *if applicable*
_____ Names, Address, and Phone Numbers of Individual's Physicians and Dentist, *if known*
_____ Medication Administration Record (MAR), *if applicable*
_____ Information pertaining to sources of funding, including copies of ID, Medicaid and/or Insurance Cards

EDUCATION

_____ Current Grade, Final Grades through date of Withdrawal from Previous School, Transcripts
_____ Education Evaluation and Test Scores (IQ), *if any*
_____ School Disciplinary Record, *if any*
_____ Student's Eligibility for Special Education Placement, *if any*
_____ Individualized Education Program (IEP), if identified as Special Education

****** Once approved for Program Admission, the following consents must be completed, signed and returned to the Director of Admissions prior to your arrival on our campus.**
Failure to abide to this requirement will delay admission of client, until received ****

Financial Agreement

Level I & II Residential, Harbor at the Lake Emergency Shelter and Lake House Programs

I, ____agree to pay Boys and Girls Homes of North Carolina, Inc. the North Carolina State approved rate that will begin on admission date: ____________________; for

Name of Client: ____ ***DOB:*** ____________________

Program Admittance: ____

I understand that, as the legal guardian I will receive a bill each month by the Financial Department of Boys and Girls Homes of NC with a net term of 15 days. Payments should equal or exceed the maximum allowable State Foster Care Board Rate (FCBR) for this youth. I understand that, after the child's stay at ***The Harbor at the Lake,*** the child may transfer to a ***Level I*** on our residential campus. ***When this happens, the rate will change to the monthly DSS Standard Board Rate.***

Service Provided	Age of Child	Billing Rate
The Harbor at the Lake *(Emergency Shelter)* **Level I** *(Residential Campus)*	6-12	$153.27 per day (Harbor) $4598 Monthly (Level I)
	13+	$156.40 per day (Harbor) $4692 Monthly (Level I)

***** I understand that, as Legal Guardian of a Teen Mother placed in the Lake House Program, it is the responsibility of the County Department of Social Services to pay the board rate for the infant/child of the teen mother even when the Department of Social Services is not legal guardian of infant/child. *****

Service Provided		Age	Billing Rate
The Lake House *(Teen Mom and Baby Program)*	Mother	12 13+	$4598 Monthly $4692 Monthly
	Infant/Child	0-5	$4506 Monthly

This financial agreement will remain in force for the above-named client for the duration of his/her stay at Boys and Girls Homes of North Carolina. Final billing for youth services provided by Boys and Girls Homes of NC is based on the date of discharge.

If juvenile detention, involuntary commitment, hospitalization, or extended family leave becomes necessary for the client, his/her placement at Boys and Girls Homes of North Carolina will be secured for up to 10 days after removal.
I understand that during this period, the Department of Social Services who serves as the client's legal guardian will receive a bill as usual. After 10 days, the secured bed will be release and the client discharged. Billing will resume if/when the client returns to the programs of care at Boys and Girls Homes of North Carolina. Any requests to hold the bed beyond the 10-day period must be made in writing and will be billed accordingly.

________________________________**County Department of Social Services**

Billing Contact Person: ____

Billing Email Address: ____

Social Worker: ____
(Print Name) ***(Signature)*** ***(Date)***

SW Email and Telephone: ____

Authorized DSS Signature: ____

Billing inquiries directed to:
Business System Department
(910)646-3083 ext. 257
crystal.coyle@bghnc.org

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Application of Service

_____ Harbor at the Lake: *Emergency Shelter* _____ Level I _____ Level II _____ Lake House: *Teen Mom & Baby*

I. YOUTH INFORMATION

Date:	**Full Name:**	**DOB:**	**Age:**	**Gender:** M F
Address:		**City:**	**State:**	**Zip:**
County:	**Race:**	**Ethnicity:** Non-Hispanic _____ Hispanic _____	**Specific Cultural Preferences:**	
Medicaid #:		**Social Security #:**		
Gender Preferences (CIRCLE ONE) HE/HIM/HIS SHE/HER/HERS				
Current Plan:		**Guardian ad Litem Contact:**		

II. REFERRAL INFORMATION

Referral Source:	**Relationship to Child:**
Contact Number:	**Email:**
County:	**Date Placement Needed:**

Reason for Referral

____ **Neglect**	____ **Physical Abuse**	____ **Previous Placement Disruption**
____ **Emotional Abuse**	____ **Substance Abuse**	____ **Homeless**
____ **Dependency**	____ **Improper Supervision**	____ **Mental Health/Higher Level of Care**
____ **Sexual Abuse**	____ **Unsafe Living Environment**	

Please detail the events that led to the child-needing placement; this includes all CPS history, Prior Placements, etc.

III. Legal Guardian Information

Legal Guardian:	**Relationship to Child:**
Address:	**Phone No.**

Parent Information

MOTHER'S NAME:		**FATHER'S NAME:**	
◻ *ALIVE*	◻ *DECEASED* *Date of Death:* ______________	◻ *ALIVE*	◻ *DECEASED* *Date of Death:* ______________
ADDRESS:		**ADDRESS:**	
PHONE NO. H:	W:	**PHONE NO.** H:	W:
MARITAL STATUS: ◻ *SINGLE* ◻ *MARRIED* ◻ *DIVORCED*		**MARITAL STATUS:** ◻ *SINGLE* ◻ *MARRIED* ◻ *DIVORCED*	
Mental Health Diagnosis:		**Mental Health Diagnosis:**	
Strengths: **Needs:**		**Strengths:** **Needs:**	
Employed: Y N	**Grade Level Completed:**	**Employed: Y N**	**Grade Level Completed:**

IV. Medical History

Date of Last Physical:	**Height:** ______ **Weight:** ______	**Immunizations up to date: Y N** **Dental up to date: Y N**

Physician Information:	**Allergies:** Y N *If yes, please list:*
Medical Diagnosis: Y N ***If yes, please list medical diagnosis:***	
Special Needs: Y N ***If yes, include detail of child's needs:***	

List *ALL* current *ACUTE* medical conditions---- *Ex: Viral, Bacterial, Fungi, and Parasite Infections, Head Lice, Broken Bones, etc.*

____

____

____

MEDICATIONS *This includes medications taken within the last 30 days*

Medication Name	Dosage	Reason for Prescribed Medication

V. Mental Health History

Therapeutic/Clinical/Case Management Services In Place: Y_____ N_____

If so, with Where and What Services: ____________________________________

Comprensive Clinical Assessment been completed? Y _____ N _____ If yes, Attach Copy of CCA to this document

Psychiatric/PRTF Hospitalizations: Y _____ N _____

Name of Facility	Admission-Discharge Date	Reason

V. SCHOOL PERFORMANCE

Currently enrolled in school? ▫ YES ▫ NO		**Name/Location of last school attended:**
Grade:	**IEP: Y_____ N_____ Last Update: __________**	**504: Y_____ N_____ Last Update: ______________**

Educational/Cognitive Delays:

School Behaviors:

VI. DELINQUENT & LEGAL INFORMATION

Is child currently on probation: Y_______ N_______
If yes, what is the offense:

Probation Restrictions:

Probation Officer Name:	**Contact Info:**	
Pending/Past Allegations	**DATE**	**Offense**

Has client ever been placed in secure custody? Y _______ N _______
If yes, explain events

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Admissions Consents and Agreements

Level I & II Residential, Harbor at the Lake Emergency Shelter & Lake House Programs

Client Name: ______________________________ **DOB:** ________________

Consent for Placement, Placement Goals and Discharge Planning

I, ______________________________ legal guardian of the above named client, give my consent for his/her placement at Boys and Girls Homes of North Carolina, Inc. beginning on ____________________.

In ______________________________ Program.

Boys and Girls Homes of North Carolina is a 24-hour, 7 day per week youth placement agency. Boys and Girls Homes has licensed trauma informed therapist on staff that will provide the client with a comprehensive clinical assessment during their time in placement; as this will set the course for placement goals during their placement.

I understand when clients placed in **Harbor at the Lake Emergency Shelter**; the projected discharge plan is within a 45-day period. This plan is subject to a transfer of placement in our **Level I or Level II Residential Program,** which at that time the projected discharge plan will be re-evaluated.

Responsibilities to Client and Services

I, as legal guardian of the above named client, understand that ***Boys and Girls Homes of NC*** will be responsible for providing me with information about this child's ***medical, dental, educational, developmental, psychological care, and progress*** while he/she is in placement at ***Level I, Level II Residential, The Harbor at the Lake Emergency Shelter or Lake House Programs.***

I understand that; I will be kept involved by phone or mail in making decisions in these areas subject to the below signed releases and that I will be invited to care plan reviews which will occur every 30 days before the end of the assessment period.

I understand that; Boys and Girls Homes of NC has a contract with *Pride, Inc.* to provide medication management services, and I give permission for educational requirements to meet in this manner.

I have received information about ***Boys and Girls Homes of North Carolina,*** which includes the Program Policies covering Family Time, Mail, Gifts, Personal Possessions, Money, Telephone Calls, Discipline Techniques, Behavior Management *including searches and physical restraints*, Program Overview of Religious Involvement, Educational Resources, Daily/Seasonal Schedules, Client Rights and Grievance Procedures. I understand that participation in therapeutic services is a vital piece to our mode of care and that active participation is an expectation. Therapeutic services include psychotherapy services such as individual, groups, recreational therapy and educational tutoring.

Consent for Drug and Alcohol Screening

As legal guardian of client, I give my permission for Boys and Girls Homes of NC to conduct urinary drug screenings at random while *he/she* is resides in any program of BGH. I understand that the results of these screenings are use for counseling and decision-making purposes only and not used in any legal proceedings; unless this is a condition through the North Carolina Juvenile Justice Department as an order of probation or conditional release set in place by a court order.

Photography/Videography Consent

I understand that photographs or videography ***(still or motion)*** taken of the client is for part of Boys and Girls Homes program activities. A photo release will be necessary to authorize any release of these photographs. *See attached.*

Medical Agreement

I agree to pay any occurred medical expenses for the above named youth during his/her stay at Boys and Girls Homes of North Carolina

Social Work Intern Acknowledgement

I understand that Boys and Girls Homes of North Carolina is a Field Placement Agency for The University of North Carolina at Wilmington and University of North Carolina at Pembroke's BSW/MSW field of study. Interns may be providing a range of clinical services such as assessments, person-centered planning, individual, group and family therapy to residents, and case management with the supervision of BGH Executive Staff. If the above client selected, the legal guardian notified at that time. I give consent for Interns under the supervision of BGHNC to provide these services.

Transportation

Boys and Girls Homes of North Carolina will assist in transporting clients to and from scheduled activities such as court dates, parental visitation and medical appointments. I agree to collaborate with the staff of Boys and Girls Homes of NC in sharing transportation duties.

As legal guardian of ______________________________; I have read and understand the Boys and Girls Homes of NC Agreements. In the event questions pertaining to the information provided to me arise, the Director of Admissions' will assist at that time.

I understand that, if a client transfers programs within our agency, all consent and agreements must be up to date.

By signing below, I give legal permission for all consents and agreements enforced effective at the date of client admission and shall be active until date client discharged from Program.

Legal Guardian Printed Name: ______________________________

Legal Guardian Signature: ______________________________

Legal Guardian Relationship to Client: ______________________________ **Date:** ________________

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Client Medical Health History

Client Name: ______________________________ DOB: ______________

Legal Guardian: ______________________________ Date: ______________

It is preferred a parent complete this form. If contact with the client' biological parent is not applicable, the Legal Custodian should complete the form. The information provided below supplements information provided by the doctors physical examination and will be helpful in caring for this client.

Client last seen the following: **Medical Doctor** ____________ **Date Last Seen:** ____________ **Reason:** ____________

Dental Provider ____________ **Date Last Seen:** ____________ **Reason:** ____________

Please answer the following questions to the best of your knowledge.

CHILD HISTORY	YES	NO	LIST/EXPLAIN IF ANSWER IS YES
Drug allergies			
Other allergies			
Surgery/Hospitalizations			
Serious Accident/Injury			
Wear/Need Glasses			
Hearing Disorder			
Tobacco Product Dependency			
Disabled/Handicap Conditions			
Child Sexual Abuse/Victim			
Current Medications			
Health Changes within the last year			

Check appropriate response for this child,

CONDITION	Frequent	Occasionally	Never
Severe Headaches			
Earaches			
Sore Throats			
Stomach Aches			
Colds			
Bedwetting			
Soil Clothing			

Does the child, any siblings, natural parents or grandparents have or been treated for any of the following?

	Family Yes	Family No		Child Yes	Child No	Explain/Relationship
HIV/ARC/AIDS						
TB						
Diabetes						
Kidney Problems						
Epilepsy/ Seizures						
Suicide/Attempted						
Mental Health Diagnosis						
Sickle Cell Anemia/Trait						
Asthma						
Heart Disease/ Stroke						
High Blood Pressure						
Cancer						
Alcohol/Drug Dependency						
Arthritis						

Completed By: ______________________ **Relationship to Client:** ______________________

COMMENTS: ____

Medical Consent and Authorization

Client's Name: ______________________________ **DOB:** ____________

As legal guardian of the client named above, I will initial all conditions in which I authorize to remain in effect during the remainder of the clients' duration in our program.

As legal custodian of client,

_______ I give my consent and authorization to Boys and Girls Homes of North Carolina, Inc. to provide any routine medical, dental, visual, psychiatric or psychological treatment, which deemed as necessary for the well-being of the above named client.

________ I understand that most hospitals require that the legal custodian/guardian be physically present in order to give written consent for major surgical procedures, even ones that are emergent in nature.

________ I understand that prior to all surgical procedures and/or treatments the legal guardian must give approval in writing.

_________ I give consent for Boys and Girls Homes of North Carolina to initiate any medication changes and adjustments that have an order by a doctor or psychiatrist. This is under medical supervision if clinically indicated as part of treatment.

Legal Guardian Signature: ______________________________

Date: ____________________

Emergency Consent to Treat

Client Name: ______________________________ **DOB:** ____________

This is an agreement giving permission to the ***Boys and Girls Homes of NC*** to seek emergency medical treatment in the event emergency arises. This agreement gives permission for any available physician, or member of a hospital medical staff to perform emergency treatment and medical procedures for the above named client, as he/she deems medically necessary, and to continue treatment and medical procedures until the undersigned dismisses he or she and/or engages another physician.

This permission includes admission to any hospital in North Carolina if the attending physician deems it medically necessary.

Legal Guardian Signature: ______________________________ Date: ____________

Relationship to Client: ______________________________

Completed by staff of BGHNC, Inc.

1. Known Allergies: ______________________________
2. Known Medical Conditions/Complications: ______________________________
3. Date of Last Tetanus Booster: ______________________________
4. Current Physician: ______________________________
5. Date of Last Physical: ______________________________

	Primary Insurance	**Secondary Insurance**
Insurance Company		
Insured Name		
Group Number		
ID/POLICY #		

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Client Contact and Visitation Authorization

Client Name: ______________________ DOB: ______________
Legal Guardian: ______________________ DOA: ______________

Please initial each authorized method. Calls that need monitoring, check ☐ for speakerphone usage.

In Person	By Mail	By Phone	Individuals authorized for Client Contact	Relationship	Telephone	Address, City, State
		☐ speaker				
		☐ speaker				
		☐ speaker				
		☐ speaker				
		☐ speaker				
		☐ speaker				
		☐ speaker				

I certify that the above named people are approved telephone contacts, mail contacts, and visitors for the client named above, during their time in our ***Level I & Level II Residential, The Harbor at the Lake Emergency Shelter, and The Lake House Programs*** *at the Boys and Girls Homes of NC.*
I understand those not listed cannot have contact this youth, unless written authorization from the undersigned as the legal guardian.

This is NOT an Authorization to Release Healthcare Information – the parties mentioned above are NOT subject to client information without a completed 'Authorization for Disclosure of Confidential Healthcare Information' on file.

Legal Guardian Signature: ______________________________

BGHNC Director of Admissions: ______________________________

Date: ________________

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Visitation and Contact Requirements

Client Name: ________________________________ **DOB:** ____________________

We support clients having contact with family and friends under the following conditions:

1. The child's legal guardian is to contact the client's case manager in advance before a visitation with approved parties' occur. This will allow the program staff to make plans around expected visits. Any visitor that arrives on Boys and Girls Homes of NC property without prior arrangements made through the legal guardian must leave.

2. Clients have the right to send and receive mail to and from his/her family and friends listed on the Client Contact Authorization. Ensuring the safety of the client and others, all mail received will be opened in the presence of the BGH staff to check for the presence of contraband

3. The staff of Boys and Girls Homes of NC highly encourages clients to have at a minimum weekly contact with *his/her* family and/or previous caregiver, *as deemed appropriate*, to help maintain a healthy family connection.

The following conditions shall give Boys and Girls Homes of NC authorization to deny contact between clients and their families/individuals:

1. If the agency receives a copy of the court order in which prohibits contact with named family members and individuals.

2. If any member of the clients family and/or individuals attempt to schedule a visit with the client at Boys and Girls Homes without seeking prior approval from the legal guardian.

3. Boys and Girls Homes of NC is a Drug and Alcohol free campus, any family member and/or individual whom suspected to be under the influence of any drug or alcohol must leave the premises immediately.

4. To promote a positive atmosphere and experience for all clients during any phone contact, staff will monitor for any behaviors that do not promote positive interaction. If behaviors and/or communication is not healthy for the client, staff will cease the contact and inform the legal guardian.

5. If any member of the clients family and/or individual presents actions with warrant any misconduct, will result in immediate vacancy of the Boys and Girls Homes of NC premises and a report completed to the legal guardian.

By Signing Below, you have read, understood, and have agreed to the conditions set forth by the Boys and Girls Homes of NC as it pertains to the above client.

Legal Guardian Signature: ____________________________________ **Date:** ______________

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Boys and Girls Homes of North Carolina, Inc. 400 Flemington Drive Lake Waccamaw, North Carolina 28450	**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION** *45 C.F.R. Parts 160 and 164; 42 C.F.R. Part 2; G.S. 122C*

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

Client's Name:	*SSN:*	*Date of Birth:*

I, ______________________________, authorize that
Legally Responsible Person(s) Representative

Boys and Girls Homes of North Carolina, Inc.,
May Obtain Information from, Release Information to, and Retain Verbal Release of Information

______________________________, *the following protected information:*
Agency/Person(s) Whom the Requested Use/Disclosure Will be Made

Provide Specific Description of Information to be Obtained and/or Disclosed:

- ☐ *Intake Assessment*
- ☐ *Person-Centered Plan*
- ☐ *Discharge Summary*
- ☐ *Health History*
- ☐ *Clinical Management Team Meeting Notes*
- ☐ *Other:* ______________________________

PURPOSE OF USE & DISCLOSURE

Describe Each Purpose of the Requested Use or Disclosure:

Purpose for which information is to be used: ______________________________

REDISCLOSURE

Once disclosure of information pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure permits required by these laws.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. If not revoked earlier, this authorization expires automatically upon or one year from the date signed, whichever is earlier.

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that **Boys and Girls Homes of North Carolina, Inc.,** *has the authority to deny and/or refuse to provide treatment.*

SIGNATURES

Signature of Client: ______________________________ *Date:*

Print Client Name: ______________________________

Signature of Legally Responsible Person: ______________________________ *Date:*

Print Name: ______________________________

Description of Acting Authority on Client's Behalf: ______________________________

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NOTICE OF PRIVACY PRACTICES

This notice describes how the any disclosure of information about the client is used and how you can get access to this information. ***Please review it carefully.***

Health Record Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, make more informed decisions when authorizing disclosure to others.

Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record
- amend your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information.

You may request that any part of your protected health information not disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. Unless your physician decide it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting the Records Department at Boys and Girls Homes of North Carolina, Inc (BGHNC) in writing. Your restriction must be specific and list the reason for the restriction.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information of payment handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Our Responsibilities at Boys and Girls Homes of North Carolina, Inc is required to:

- Maintain the privacy of your health information
- Provide you a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

For questions and additional information, you may contact Chief Compliance Officer at 910-646-3083.
If you believe a violation to your privacy, you can file a complaint with Chief Compliance Officer or the designated HIPAA Compliance Officer at Boys and Girls Homes of NC or with the Secretary of Health and Human Services in Raleigh. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once discharged from this facility.

We will use your health information for payment. A bill could come to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information used in an effort continually improve the quality and effectiveness of the healthcare and service we provide. ***Business associates:*** There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services contracted, we may disclose your health information to our business associate so that they can perform the job we asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate appropriately safeguard your information. ***Marketing:*** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. ***Fund raising:*** We may contact you as part of a fund-raising effort. ***Food and Drug Administration (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement. ***Public health***: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. ***Law enforcement***: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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Acknowledgment of Privacy Practices

Name of Client: ____ **DOB:** ______________________

I, ____, Legal Guardian of the above-mentioned client, acknowledge that, I have reviewed the **Boys and Girls Homes of North Carolina: Notice of Privacy Practices,** which provides a description of client information uses and disclosures and a copy of **Notice of Privacy Practices** offered to me.
I understand that, I have the right to request restrictions as to how health information used and/or disclosed.
I understand that, the organization is not required to agree to the restrictions I request and in such case will provide me with a written justification for denial.

Print Legal Representative's Name: ____________________________________

Legal Representative's Signature: ______________________________________

Date: ____________________

Video/Photograph/Research Authorization

Client Name: ______________________________ **DOB:** ____________

I, ______________________________, hereby ***agree*** to authorize Boys and Girls Homes of North Carolina to MAKE and USE the following:

☐ Audio-Visual recordings
☐ Photograph of my image

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

OR

I ***decline*** authorization of Boys and Girls Homes of North Carolina to make or use the following:
☐ Audio-Visual Recordings
☐ Photographic Imaging

☐ I hereby agree to authorize ______________________________ to participate in research conducted on behalf of Boys and Girls Homes of NC.

OR

☐ I hereby decline authorization for ______________________________ to participate in research conducted on behalf of Boys and Girls Homes of NC.

I understand that this authorization will be time-limited until the discharge of the program and that I have the right to change or revoke this consent at any time.

Client Signature (12+ Years Old): ______________________________

Legal Guardian Print Name: ______________________________

Legal Guardian Signature: ______________________________

Date Authorization Effective: ____________________

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Harbor at the Lake Emergency and Assessment Center

Clothing Inventory Checklist

Clients permitted a limited amount of clothing they may posses due of small amount of storage in each room.

8 Pants
8 Shirts
8 Pair of Socks
3 Sweatpants/Shorts
2 Pajamas
2 T-Shirts
2 Dress/Suit
10 Underwear
2 Tennis Shoes
1 Dress Shoes
2 Jacket
1 Hooded Sweatshirt

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Boys and Girls Homes of North Carolina, Inc.
Client Rights

All clients, parents, custodians receive a copy of the Client Rights policy upon initial admission into Boys and Girls Homes of NC campus programs. All clients above the age of 12, their legal guardians, and BGHNC staff are required to sign an acknowledgement form upon receipt and review of the Client Rights Form, and the signed acknowledgement form is uploaded in the client's case file on Extended Reach. Client Rights policies are also posted throughout the agency departments where it is accessible to the clients at BGHNC.

Name of Client: ______________________ ***DOB:*** ______________ ***DOA:*** ____________

All the clients admitted into any program through Boys and Girls Homes of North Carolina, Inc. shall have the following rights:

1. The right to reasonable access to services, regardless of race, religion, gender, sexual orientation, ethnicity, age, or mental/physical disability.
2. The right to exercise your basic human rights including the right to dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation.
3. The right to individualized treatment, including:
   - Age appropriate treatment that recognizes and respects your cultural values.
   - Provision of services in the least restrictive environment and most appropriate setting.
   - The right to refuse any service, treatment, or medication, unless such rights have been limited by law, court order or legal custodian. To be informed of the potential consequences of such refusal, ex: increase of symptoms, continuation of symptoms, or a potential change in the agency's ability to provide services.
   - The rights to participate, express opinions, and provide input in the development and periodic review of the treatment plan.
   - The right to obtain a copy of your treatment plan and the right to view information in your own client record, unless more than one professional determines that it would be harmful for client to have it.
4. The right to family time and telephone conversations with family members (unless restricted by client's legal custodian).
5. Have personal possessions and be provided space to store them.
6. The right to terminate treatment or services at any time.
7. The right for confidential information to not be released to any individual or agency without a signed Consent for Release of Information except when required by federal and state statutes listed Boys and Girls Homes of North Carolina Client Confidentiality Agreement.
8. The freedom to exercise your civil rights.
9. The right to be free from searches of personal belongings except under critical circumstances.
10. The right to be free from restraint or seclusion, unless you are a danger to you or others
11. The right to be free from pressure with regard to religious decisions.
12. The right to protect identification in connection with any publicity for on Boys and Girls Homes of North Carolina, unless agreed upon and provided written consent by legally responsible person and client.
13. The right to protection from pressure to acknowledge dependence upon or gratitude to on Boys and Girls Homes of North Carolina.
14. The right not to be visually or audio recorded without signed consent by legal custodian and client.
15. The right to a grievance procedure to ensure all rights or to express dissatisfaction with services or treatment provided.

If you feel there has been any violation to your rights in any way, or you have questions or concerns, you may:

(1) File a Grievance with Boys and Girls Homes of North Carolina, Chief Risk Management and Compliance Officer- John Cobb 910-646-3083

(2) Contact Disability Rights of North Carolina
3724 National Drive Suite 100
Raleigh, NC 27612
Toll Free: 877-235-4210; Fax: 919-856-2244

(3) Contact DHHS Office of Civil Rights: Toll Free Call Center: 1-800-368-1019

(4) Trillium Clients *may contact*: 24-Hour Access to Care 1-877-685-2415

(5) Eastpointe Clients *may contact* Access Call Center 1-800-913-6109

I have read and reviewed the Client Rights during my admission into BGHNC, and I understand the entirety of the Client Rights.

Client Signature: ______________________ **Date:** ____________
(Over 12 Y.O)

Legal Guardian Signature: ______________________ **Date:** ____________

BGHNC Director of Admissions: ______________________ **Date:** ____________

Client Review Acknowledgement

Review of Grievance Procedure

I, ____ have read and understand the Grievance Policy and my right to have my grievances reported to Administration.

I understand that,

- I can make a formal complaint about any BGH staff when I feel there is a violation of my rights in any form.
- I must follow the steps of the grievance procedure in order to resolve the issue.
- I understand that I have the right to bring my grievance to the Program Director and discuss the compliant after a ***'Client Grievance Form'*** is complete and submitted to the Director.
- Within two days of the submission of the Grievance Form, a meeting scheduled in attempt to resolve the situation.
- If the complaint is not resolved it will be given to the Director who will then meet with the parties involved within ten days to make a final decision.

Review of Rights and Responsibilities

I, ____ have read and understand the Boys and Girls Homes of NC Client Rights and Client Responsibilities. BGH staff member, ____________________ reviewed the information with me and answered any questions I had during this time.
I have received a copy of the ________________________________ Client Handbook.
I understand my rights and responsibilities as defined by the Handbook. In the event I need further review, I will inform a BGH staff member.

Client Signature: ____

Director of Admissions: ____

Director of Program: ____

Date: _________________

Client Concern or Grievance Form

Date of Complaint: ______________

So that we may contact you for further information, or to let you know the outcome of your concern or grievance, please provide us:

Print Client's Name: ____________________

Signature of person filing the concern: ________________________________

If you are a family member, advocate, etc. please provide us:

Print Your Name: ____________________ Phone Number__________________

Mailing Address: ____

Describe the issue, including who, what, where and how. (Continue on back if needed)

____

____

____

____

This portion is to be completed during resolution process.

Date Received by Privacy Officer: ________ **Date form given to Residential Director:** ________

Steps taken by BGHNC to resolve the issue.

____

____

____

____

____

____

____

___ **I agree to the resolution of my concern or grievance.**
___ **I disagree with this response and wish to proceed to the next step towards resolution.**

Signature of Person Filing Concern or Grievance	Date
Signature of Staff Member Working on Resolution	Date
Signature of Director	Date
Signature of Chief Officer	Date

Special Dietary Needs Assessment

Full Name of Client: DOB:

Part A

Food Allergies ☐ YES ☐ NO ***Specialized Diet*** ☐ YES ☐ NO ***Drug Allergies*** ☐ YES ☐ NO	***If yes, list below*** __________ __________

Part B

COMPLETE SECTION B IF RESIDENT HAS FOOD ALLERGIES AND SPECIALIZED DIET

Completed and signed by Licensed Physician during health assessment after admitted to Boys and Girls Homes of NC.

List any foods causing food *intolerance* that should be avoided:__________

List any foods causing food *allergies* that should be avoided:__________

If resident has **life threatening** allergies*, check appropriate box: ☐ **Ingestion** ☐ **Contact Inhalation**

*Residents with life threatening food allergies must have an emergency action plan in place

For any special diet, list food omitted and substitutions, you may list a Meal care plan below.

Foods To Be Omitted	***Recommended Substitutions***

Meal Care Plan:

____

____

____

____

____

____

____

Signature of Physician/Medical Authority	***Printed Name***
Contact Information	***Date of Health Assessment***

Part C: BGH Food Services Notes

(Completed by BGH Food Services Manager)

____

____

____

____

____

BGH Food Services Manager Signature: __________ ***Date:*** __________

Previous School Information Form

Student Name:____	**DOB:**____________

Previous School Name:____

Previous School's Information

Address:____

City:______________________________________State:__________Zip Code:________

Phone Number:____

FERPA CONSENT TO RELEASE STUDENT INFORMATION
To be completed by LEGAL GUARDIAN of minor student
LEGAL DOCUMENTATION OF GUARDIANSHIP REQUIRED TO ACCOMPANY THIS REQUEST

To: Thomas Academy 400 Flemington Drive, Lake Waccamaw, NC 28450

Please provide information from the educational records of_________________________________ to:
(Name of Student/DOB)

____

(Name of person to whom the educational records will be released, and the relationship to the student, such as: "Prospective Employer", "Attorney", or "Case Manager")

- The only type of information that is to be released under this consent is:

  __ Transcript
  __Disciplinary Records
  __Quarterly Grades
  __Parent Powerschool Access

- The information is to be released for the following purpose:

  __ Family Communications About School Experience
  __Employment
  __Admission to an Educational Institution
  __Other (Specify)____

I understand that the information may be released in the form of copies of written or electronic records or Powerschool Parent access, as preferred by the LEGAL GUARDIAN of minor student. LEGAL GUARDIAN has a right to inspect any written/electronic records released pursuant to this content.

LEGAL GUARDIAN understands that they may revoke this consent upon providing written notice to:

Dr. Cathy Gantz, Principal of Thomas Academy
cathy.gantz@thomasacademync.org

LEGAL GUARDIAN further understands that until this revocation is made, this consent shall remain in effect and aforementioned student's educational records will continue to be provided to Thomas Academy for the specific purpose described above.

LEGAL GUARDIAN NAME:____

Signature:____Date:_______________

Relation to student:____

(Note: This consent does not cover medical records held solely by the School Nurse or the Counseling Center - contact those offices for consent forms)

Student Emergency Card

Student Information

Name of Student:____
(Last) **(First)** **(Middle)**

911 Address:____

Home Phone:________________________________ Grade:____________

Parent/Guardian Information

Parent/Guardian Name:____

Home/Cell Phone:____________________ Work Phone:____________________

911 Address if different____

List two relatives or friends who you can designate to provide temporary care of your child, if you cannot be reached:

Person One:

Name:________________________________ Phone:____________

911 Address:____

Person Two:

Name:________________________________ Phone:____________

911 Address:____

Please list any person(s) that can pick your child up on the back of student emergency card along with phone numbers

Important Medical Information for Student

Please check any health problems your child has:

__Asthma (Date of last attack__________)
__Arthritis
__Bleeding Disorders
__Diabetes
__Hearing Problems
__Heart Problems
__Orthopedic Problems
__Seizures (Date of last seizure __________)
__Sickle Cell Disease
__Vision Problems

__Other____

Doctor:________________________________ Telephone:____________

List any medications taken daily OR medications needed in a medical emergency:

____

List any allergies your child has (drugs, vaccines, foods, insect bites, ect)

Allergy	**What kind of problem it causes**
____________________	____________________
____________________	____________________