Canyon Hills Treatment Facility

CHTF OFFERS QUALITY & PROFESSIONAL SUPPORT SERVICES

Two-Way Consent for Release of Information

Effective Date: _____ (valid for 1-year)

Consumer Name:	Contact Number:	SSN:	Date of Birth:
Address:	City:	State:	Zip:
Funding Source#:	Consumer Record Number:		

Signature & Initials on this form authorize **Canyon Hills Treatment Facility** to receive, release **and/or** discuss specific information concerning the above-named Consumer to the following individual and/or entity:

Consumer Name:	Contact Number:	SSN:	Date of Birth:
Address:	City:	State:	Zip:

Please "check" the appropriate action(s):

Information to be O Received O Released O Discussed

Consumer / Guardian must initial each category to be disclosed. Enter N/ A next to items not applicable

_ Admission/Screening ___ Inpatient Information ___ Service Notes/Progress
_ Medication Rx/Physicians Orders ___ Psychological Evaluation ___ PCP/Service Plan
_ Labs/Medical Information HIV Related Information Substance Abuse Information
_Attendance/Appointments School Other: _____

Reason: Continuity of Care_ Referral_ Legal_ Service Delivery Other:_____

Canyon Hills Treatment Facility

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CONSUMER CHOICE & ACKNOWLEDGEMENT FORM

Consumer ID#:_____

Name:
_____

SSN_____
D.O.B._____

Record #_____

Medicaid/ NC Health Choice#: ___ ___ ___ ___ _____ ___

- o Referred to provider by
- o Provider chosen by Client and/ or Guardian
- o Other: Please Specify _____

Client's Home County: _____

Client was given other provider choices that were listed on the LME Provider List and Chose:

CANYON HILLS TREATMENT FACILITY

Reason(s) Provider was Chosen:

- o Hours
- o Location
- o Specialties
- o Age Group Specialty
- o Payer Source
- o Special Accommodations
- o Language
- o Other

Requested Service:

- o Residential Treatment Level III
- o Day Treatment Intensive In-Home Services
- o Psychiatric Residential Treatment Facility (PRTF)

By signing below, I acknowledge that I was given a choice of provider. A discussion on location, available times, specialty, culture and linguistic preferences were held during the screening session with me. I have selected, Canyon Hills Treatment Facility as my provider for the above listed services.

_____ _____

Consumer and/or Guardian Signature **Date**

_____ _____

Canyon Hills Director and/or Authorized Staff Signature **Date**

Appointment Information

Canyon Hills Treatment Facility

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This consent shall be valid for one (1} year from the signature date of this form.

Master Consent Form

Consumer ID#:_____

Name:
_____ SSN_____

D.O.B._____

Record #_____Medicaid/ NC Health Choice#: _____Programs (s):_____ Effective Date: _____

Consumer/Guardian must initial each category. Enter N/A next to items not applicable

Consent for Travel

I, the undersigned Consumer, Parent, Guardian or Legal Custodian of the above referenced Consumer, give consent to Canyon Hills Treatment Facility to participate in trips away from their facilities and/or residential group home. Trips may exceed over SO miles from the facility and/or residential group home. I understand Canyon Hills will abide by all safety rules when said Consumer is transported in a vehicle by its staff. Canyon Hills will notify me each time that said Consumer is to participate in an activity that would involve transportation over SO miles from the facility and/or residential group home.

_____

(Consumer &/or Guardian Initials Here)

Consent for Visitors

The persons listed below are NOT authorized or permitted to visit the above name Consumer at the facility (if applicable) and/or group home:

_____ _____

_____ _____

_____ _____

_____ _____

_____

(Consumer &/or Guardian Initials Here)

Canyon Hills Treatment Facility

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*** Original to be kept in consumer record file, copy to be given to consumer and legal guardian {if applicable) ***

Revised 12/2015

Consumer Orientation Summary

Name: _____ SSN:_____Record#:_____

The consumer and legally responsible person should initial each item:

1. I have discussed and/or received the policies and procedure for:
a. The rules to follow, including possible penalties
b. My protection regarding confidential information and disclosure of such
c. How to receive a copy of my service plan and/or other pertinent information
d. Fees charged and collection of those fees for treatment provided
g. Grievance procedure to follow
f. Suspension and expulsion from services and/ or privileges
g. How to reinstate services and/ or privileges of which have been suspended and/or revoked
h. Search and Seizure of personal possessions policy & procedure
i. Policy on Seclusion & Restraint
2. I understand I can contact the

Disability Rights North Carolina:
Their street address is:
2626Glenwood Ave
Suite 550
Raleigh, NC
27_608
Phone number: 919-571-0852 or 877-235-4210
Website: www.disabilltvright snc.org

3. I understand the benefits, potential risks, and possible alternative methods for treatment.

4. I understand I have the 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 only viable option available at CHTF.
5. I understand I have the right to be free from harm, abuse, neglect and financial or other exploitation.
6. I have received a copy of the consumer handbook and related application material/information.

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

_____ _____

Consumer Signature / Date Legal Guardian Signature

Canyon Hills Treatment Facility

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Assurance of Client Rights

As a person, each consumer has specific human and legal rights as granted in the constitution of the United State, which will be followed and respected daily by all staff member of CHTF. The following is a brief outline. Further information and explanations can be found in the NC domiciliary Home Bill of Rights, and PSM 95-2 Clients Rights in the community MH/DD/SAS:

A. The Right to privacy:
B. The right to receive mail and make phone calls; (Residential Consumer may only receive mail from individual that's on client call list. Phone calls can only be made during call hours 6pm-8pm. Client can only use the phone for 20 mins at a time. All call must be made in the common area.
C. The rights to be treated as an individual with feeling, emotions, and preferences;
D. The right to be involved in decision which concerns you;
E. The right to productive work, include opportunities for training;
F. The right to maintain personal earning and possession and decide how to spend their money;
G. The right to be protected from abuse, neglect, financial or other exploitation, and any other unfair treatment.
H. The right to education and training to assist in acquiring skills;
I. The right to participate in all aspect of community life;
J. The right to live with other people their own age in a home environment;
K. The right to proper treatment, medical care, dental care, or other specialized medical/ health need;
L. The right to participate in their own religious beliefs.
M. The right to be protected from retaliation and humiliation.
N. The right to exercise all civil rights, including the right to dispose of property, execute instruments make purchases, enter into contractual relationships, register to and vote.

CHTF Staff are required to adhere to all consumer rights set forth in North Carolina Domiciliary Home Bill of Right, as it applies to the Program/Service.

By my Signature, I state that I have read and understand the summary of my rights as listed above.

_____

Consumer/Guardian Signature Date

_____

CHTF Director and/or Authorized Signature Date

Consumer Name: _____

Medicaid #:_____

D.O.B_____ Record Number:_____

Canyon Hills Treatment Facility

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Consumer Name: _____ Record #_____ Funding Source #:_____

This consent shall be valid for one (1) year from the signature date of this form.

Treatment including alleged benefits, potential risks and possible alternate methods
Use of planned interventions
Consent to seek emergency care

Consent for Treatment

Consumer and/or Guardian of above named Consumer give consent to Canyon Hills Treatment Facility to authorize any routine or emergency medical, surgical, psychiatric, or psychological treatment, which in the opinion of Canyon Hills Clinical Staff deemed to be necessary to consumer's well-being. Canyon Hills will inform the Consumer, Parent, Guardian or Legal Custodian of any pending treatment that is elected an obtains hi/her consent, except that it should be in the case of a life-threatening emergency at which time Canyon Hills will act upon the advice of the physician/licensed professional on hand. Notification will then be made as soon as possible to the guardian of the consumer.

I have read and understand the above statements and do hereby give my consent.

Copy Clause: I agree that a copy of this form may act as an original.

_____ _____

Consumer/Guardian Signature (if applicable) Date

_____ _____

Canyon Hills Director and/or Authorized Signature Date

Canyon Hills Treatment Facility

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Assurance of Confidentiality- Notification to Consumer

Consumer Name: _____ Record #_____ Funding Source #:_____

The information you provide during screening, admission, treatment, placement, and discharge is considered confidential by: CHTF, contractual providers, and any other services providers. This information, however may be shared when deemed necessary with each other in order in order to provide you with the highest quality of treatment and services available.

Under the following conditions, release of information outside of CHTF is permitted and/or required by law and stringent ethical standards when:

1. CHTF has received a signed authorization from you or your legal guardian/representative - consent for release of information on
2. There is a medical or psychiatric emergency involving your health or safety of or the safety of other.
3. CHTF is require by law to report incident or suspected or substantiated neglect or abuse.
4. Responding to a court order or in a commitment proceeding.
5. CHTF authorizes research for the purpose of program planning and/or evaluation however, every effort will be made to protect the identity of you as a Consumer receiving services from CHTF.

Each release of information will be documented in your service record. These will be authorized by the Consumer, Legal Guardian and/ or CHTF Director, whenever practical. All identifying information on is removed when computerized information is sent out regrading statistical,
Financial, and/ or medical information. It is your right to fully understand all regulations. Pertaining to confidentiality. It is important to CHTF that you feel safe while using our services if you need further clarification, please ask your primary care giver and/ Authorized CHTF representative.

I have received copies of the following forms, to include but not limited to and had each explained to me during my Orientation:

Assurance & Acknowledgement of My Rights and Rules
Provider Choice Form
Master choice Form
Consent for Release of Information
Consumer's Emergency Information

Consumer / Legal Guardian Date

CHTF Director Signature

CONSENT FOR RELEASE OF INFORMATION

Consumer:___ Record#:_____
ID#: _____

Toe signature below to release/request specific information concerning the above named consumer to/from authorizes _ _ _ _ _ _ _ _ _ _ _ _ (name of agency/facility).
Information to be released: Medical and/or psychiatric
Reason: To ensure proper medical and/or psychiatric treatment for the named consumer.

This consent shall be valid for one(l) year from the date of this form.

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 contract attached.

The doctrine of informed consent has been explained to me and I understand the contents to be released. I understand substance abuse records are covered under federal regulation (42 C Part. 2) and that there are statutes 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, testing for HIV/AIDS diagnosis only with my specified consent. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. 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.

_____ _____
Parent, guardian, legal custodian, consumer Date

_____ _____
Director Date

Canyon Hills Treatment Facility

CHTF OFFERS QUALITY & PROFESSIONAL SUPPORT SERVICES

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 authorization, 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 and therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. I understand substance abuse records are covered under Federal Regulations (42 CFR, Part 2) and that there are statutes 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 by submitting a short written, signed & dated request, except to the extent that action based on this consent has already been taken. I understand I may request a copy of this consent or any other pertinent information in regards to my consumer file by submitting a short written, signed and dated request. CHTF will respond to my written request(s) with 48 business hours of receipt.

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 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.

Copy Clause: I agree that a copy of this form may act as an original.

_____ _____

Consumer and/or Legal Guardian Signature Date

_____ _____

Canyon Hills Director and/or Authorized Signature Date

This consent shall be valid for one {1) year from the signature date of this form.

Canyon Hills Treatment Facility
769 Aberdeen Rd
Raeford, NC 28376
Office: (910) 878-1502
Fax: (910) 878-1503

Micheaux Hollingsworth
President, Owner

Cheryl A. Smith
Vice President

Julian McMillian
Assistant Vice President
of Consumer Affairs

Anthony Jenkins
Assistant Vice President
of Employee Affairs

New Consumer Check Personal Items Check List

Please see the following list of items allowed at Consumer Intake. During the weekday, all consumers wear Canyon Hills uniforms. Polo styled shirts are provided for the consumer to wear during the school period. After the education period, consumers are provided after school play and sleep wear. No profane or offensive language or images is permitted on any of the personal items.

1. 2 Pairs of Brown Khakis
2. Regular White Tube Socks
3. Plain White T-Shirts
4. 2 pairs of shoes- Tennis Shoes for outdoor activity; Shower Shoes
5. Underwear
6. 1 Light Jacket
7. Heavy Winter Coat
8. 2 Regular Outfits (i.e. one long sleeve shirt and short sleeve shirt, jeans, sweat pants, or short) Toboggan or Fitted Cap

Thank you,
Canyon Hills Administration

ACADEMY ADMISSION LETTER

Canyon Hills Treatment Facility
796 Aberdeen Rd
Raeford, NC 28376

Date:_____

Receiving School:
Attn: Registrar Office/Data Manager

Dear Registrar,
I am writing to inform you that_____D.O. B_____has been admitted into our Psychiatric Residential Treatment Facility program as of _____Below you will find a list of pertinent information we are requesting in order to provide appropriate services to this student. A release of information is included with this letter. Since this is a temporary placement, the cumulative records should continue to be maintained at the home school. In most cases, the student will return to your school upon discharge. Recommendations will be shared with you upon discharge.

Please send a copy of the students:

Most recent report card
Attendance records
Immunization record
Most recent standardized test scores
Discipline records and/or anecdotal records
504-Plan
State Mandated Test Data
FBA/BiP
Current IEP

If Applicable:

EC Referral
Invitation to conference
DEC 1
DEC 2 and evaluations/supporting documents
DEC5

Initial Evaluation
Invitation to conference
DEC 3 and appropriate worksheets
DEC S
DEC6
DEC4
DEC 4a (if applicable)

All Re-evaluations
Invitation to conference
DEC 7 and evaluations/ supporting documents
DEC2
DEC 3 and appropriate worksheets
DEC4
DEC 4a (if applicable)
DECS

Most current Annual Review
Invitation to conference
DEC4
DEC 4a (if applicable)
DECS

Thank you for your assistance in this matter. Please feel free to call with any questions of concern. Sincerely,
Stephanie McFayden, Education Specialist
Phone: (910) 878-1502 **Fax:** (910)878-1503

. **Confidential Request for Educational Records**

North Carolina General Statue l 22C-450.2 states that upon admission of a child to a Psychiatric Residential Treatment Facility (PRTF), the facility must request copies of a child's most current Individualized Education Plan (IEP) and any other available documents related to the provision of appropriate educational services from the local school administrative unit that last served the child and that to the extent practicable the local administrative unit will provide this information within three (3) business days of receiving this request.

The purpose of this request is to obtain educational records to ensure the delivery of educational services while the student resides in a Psychiatric Residential Treatment Facility (PRTF).

To: Date:

From: Canyon Hills PRTF Date of Admission:

Student's FullName: _____ Date of Birth:_____

I understand the purpose of the I understand Confidential Request for Educational Records that I can provide or revoke consent for the release of my child's educational record, in writing, at any time. I also understand that all records are confidential and my consent for the release of my child's educational records expires one year after the date for which consent is provided.

I give my consent for my child's educational records to be obtained from:

_____

(Name LEA, School or Facility)

_____

(Address)

_____

(Telephone) (Fax)

_____ _____

(Printed Parent/Guardian Name) (Date)

_____

(Printed Parent/Guardian Signature)

DI DO NOT give my consent for the release of my child's educational records. I understand this may have an adverse effect on the educational services provided to my child residing in PRTF.

_____ _____

(Printed Parent/Guardian Name) (Date)

_____ _____

(Printed Parent/Guardian Name) (Date)