SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

REFERRAL FOR SERVICES

Consumer Name: _____ Date of Referral: _____

Legal Guardian's County:_____County Consumer is Currently Residing_____

School & Grade: _____ Date of Birth: _____

Race: _____ Gender: _____ Social Security: _____

Medicaid#: _____ Insurance: _____

Referral Source Name: _____ Phone: _____

Referring Agency: _____

Legal Guardian Name: _____ Phone: _____

Legal Guardian Address: _____

Consumer's Current Address: _____

What services are currently being provided to this consumer?

_____

Check all that apply (this section may not be applicable to this consumer):

- ❑ Been hospitalized within last year
- ❑ Been in detention, prison, or jail within last year
- ❑ Police have been called out to the home on emergency due to client's behavior within last year
- ❑ Convicted of 2 or more serious misdemeanors within the last year
- ❑ DSS substantiated report within last year
- ❑ Currently in DSS custody

Services Requested/Recommended:

- ❑ Community Support
- ❑ Community Support Group
- ❑ Residential Treatment
- ❑ Diagnostic Assessment

Child is involved with:

- ❑ DSS
- ❑ Juvenile Justice
- ❑ DPI/Schools Systems
- ❑ Mental Health
- ❑ Health Department
- ❑ Community Organizations

Is the parent/legal guardian party aware of this referral: ___Yes ___No

Additional Problem Areas/Needs and or Comments: _____

_____

_____

Person Completing Form: _____

SUNLIGHT BEHAVIOR CENTER, INC.

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FACE SHEET

Admission Date _____ Client Number _____ SSC _____

Name _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Race _____ Sex _____ Spiritual Awareness _____

EMERGENCY CONTACT INFORMATION

Legal Guardian _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Next of Kin _____ Relationship _____

INSURANCE INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

PHYSICIAN INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

Diagnosis

_____

_____

_____

_____

Medication _____

_____

_____

_____

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Name: _____ **MR#:** _____ **Date:** __/__/__
Last **First** **M.I.**

MEDICAID I.D.#: _____

Social Security #: _____ Type Screening: ___ Face-to-Face
___ Telephone

Insurance/Medical Coverage: _____ ___ Other _____

Date of Birth:__/__/__ Age: ____ Sex: ___ Ethnic Group: _____ Marital Status: M ___W___D___S____

Guardian: _____Relationship: _____ Clinician: _____

Current Living Arrangements: _____County of Residence:_____

Housing Status: (Own, Rent, Housing Authority) _____

Address: _____ Phone#: _____
_____

Emergency Contact: _____ Phone#: _____

School: _____ Grade: _____

Employment Status: _____ If not employed, last date of employment: _____

FINANCIAL HISTORY:

_____ TANF	AMOUNT: _____
_____ SSI (Supplemental Security Income)	AMOUNT: _____
_____ CHILD SUPPORT	AMOUNT: _____
_____ SOCIAL SECURITY	AMOUNT: _____
_____ ANY OTHER INCOME	AMOUNT: _____

Referral Source: _____ Facility:
_____

CHIEF COMPLAINT / REASON FOR REFERRAL: (List succinct presenting problems as described by patient and/or collateral informant(s)

_____
_____
_____
_____

BRIEF HISTORY OF PRESENTING PROBLEMS: (Precipitating events, source of distress, onset, course, duration, signs, symptoms, effects of/on environment (family, job, friends), associated problems or symptoms and recent progressions)

_____
_____
_____
_____

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Name: _____ **MR#:** _____

Last, **First** **M.I.**

PREVIOUS PSYCHIATRIC HISTORY: (history of similar episodes, previous outpatient, habilitation, hospitalizations, and/or residential treatment to include date, duration, and treatment rendered.)

( ) Prior Psychiatric Hospitalization : _____

_____

( ) Residential Treatment Facility: _____

( ) Outpatient Mental Health Treatment: _____

_____

( ) Substance Abuse Treatment _____

_____

SIGNIFICANT SOCIAL/ FAMILY HISTORY: (Include educational, work history, current family relationships, childhood trauma, including physical, emotional, and sexual abuse)

Supportive Persons:

_____

Education: H.S. Grad: _____ GED: ____ Highest Grade Achieved: _____ Years in College: _____ Degree: ____

Academic Grades/Programs: _____

Academic Problems: _____

_____

Legal History/Current Status:

_____

_____

SUBSTANCE USE AND OR ABUSE HISTORY:

None _____ Non-Abusive Use _____

(Describe) _____

_____

Family History of Substance Abuse: No ____ Yes_____ (Describe)

_____

_____

(Required for SA related diagnosis for females): Is consumer pregnant? Yes ____ No ____

MEDICAL HISTORY:

Medical Issues:

_____

_____

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Name: _____ **MR#:** _____
Last, **First** **M.I.**

Current Medications: (list all medications, including psychotropic meds):

_____

_____

Prescribing Physician(s): _____

Childhood Nutritional Issues: None:_____ (briefly describe any issues)

_____

Allergies:

_____

_____

Significant Childhood Developmental Issues: (Required for Developmentally Disabled Clients) :
Unremarkable:

_____

_____

_____

Danger to Self: ___None
___Threats of Suicide
___Suicide Gesture
___Suicide attempts
___Other (Explain) _____
___Thoughts of Suicide
___Plan for Suicide
___Preoccupation with death
___Attempts to harm others

Danger to Others:
___None
___Plans to harm others
___Attempts to harm others
___Thoughts to harm others
___Felt like killing someone
___Has harmed others
___Other (Explain) _____

Antisocial Behaviors:
___None
___Stealing
___Arrests
___Running Away
___Destroying Property
___Frequent Lying
___Fire Setting
___Promiscuity
___Excessive Fighting
___Convictions
___Other (Explain)_____

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Name: _____ **MR#:** _____

Last, **First** **M.I.**

Depressive Like Behaviors:

___None
___Fatigue
___Loss of Interest
___Crying
___Feeling of worthlessness
___Sadness
___Hypoactive
___Withdrawn
___Guilty Feeling
___Poor Concentration

___Other (Explain) _____

Psychotic Like Behaviors:

___None
___Inability to care for self
___Obscene acts
___Wanders Off
___Talks to self
___Bizarre Behavior
___Delusions
___Unmanageable
___Irritability
___Withdrawn
___Poor personal hygiene
___Suspiciousness
___Hallucinations
___Other (Explain)

Biological Functions:

___None
___Sleep disturbance (Explain) _____
___Sleep (no change increased-decreased-restless_
___Appetite (no change increase-decrease)
___Weight (loss or gain)
___Constipation
___Diarrhea
___Other (Explain)

Attitude:

___Appropriate
___Aggressive
___Manipulative
___Resistive
___Reserved
___Negativistic
___Guarded
___Dependent
___Passive aggressive
___Cooperative
___Belligerent
___Reclusive
___Sarcastic
___Other (Explain)

Thought Process:

___None
___Rational
___Neologism
___Incoherent
___Slowness in thought association
___Echolalia
___Coherent
___Tangential thinking
___Circumstantial
___Other (Explain)

Thought Content:

___None
___Suicide
___Paranoid Trends
___Delusions
___Hallucinations (auditory-visual-tactile)
___Other (Explain) _____
___Normal
___Homicide
___Ideas of Reference
___Hypochondrias

CREDIBILITY • INTEGRITY • ACHIEVEMENT

Name: _____ **MR#:** _____ **Page 5**
Last, **First** **M.I.**

Description of Living Conditions:

_____
_____
_____

COMMENTS:

_____
_____
_____

PLEASE ATTACH A COPY OF THE MOST RECENT PSYCHOLOGICAL. IF A PSYCHOLOGICAL IS NOT AVAILABLE, PELASE NOTE IN THE ADDITIONAL COMMENTS SECTION.

Initial Treatment Plan:

___ Referred for Diagnostic Assessment
___ Community Support Services
___ Targeted Case Management
___ Residential Treatment: (What Level) _____

_____ **Date:** ____/____/____
Signature/ Position/ Credentials

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

ACKNOWLEDGEMENT OF PROVIDER CHOICE

Consumer's Name:_____ **MR No.**_____

I understand services provided by **Sunlight Behavior Center, Inc.** must be authorized by _____, and that Residential and/or Community Support Services is required to ensure that services provided are deemed medically necessary.

I have been informed of my right to choose a provider from a list of service providers within Cumberland County provider network. I have also been informed of my right to change providers at a later date in my treatment.

_____I am requesting services to be provided by: Sunlight Behavior Center Inc.

I, and I alone, have made this choice. My decision was not influenced by personnel from **Sunlight Behavior Center, Inc.**_____

My choice was denied and I understand that I can file a grievance with:

_____ Emergency choice: _____ (Date) _____

Explanation for denial of provider request / emergency choice:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Client/Guardian / Legal Representative Date

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

EMERGENCY MEDICAL INFORMATION

Client Name: _____

DOB: _____

MR NO: _____ Race: _____ Age: _____ Sex: _____

Address: _____

_____

Home Phone: _____

Emergency Contact Name: _____ Phone: _____

Preferred Physician: _____Phone: _____

Address: _____

_____

Insurance Name & No: _____

Medical Information

Chronic Illness/Diseases: _____

_____

Current Medications: _____

_____

Allergies/Sensitivities: _____

_____

I authorize Sunlight Behavior Center, Inc. and/or a representative of the above agency to act on my behalf in case of a major accident, injury or illness when immediate medical or dental care is required, provided the representative makes every effort to first notify guardian or next of kin of the situation and obtain my preferences. If such efforts to get in touch with guardian/next of kin of the situation are unsuccessful, I authorize representatives of this agency to take such action and give such consent on my behalf as his judgment dictates. I further acknowledge that I may revoke this consent at any time except to the extent that action based on the reliance of this consent has been taken.

Parent/Legal guardian: _____ Date: _____

Witness: _____ Date: _____

CREDIBILITY · INTEGRITY · ACHIEVEMENT

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT/MEDICAL RELEASE FORM

I, _____ being legal parent/guardian of _____(client) give consent for Sunlight Behavior Center Inc. to obtain treatment for _____(client) from a duly trained, Licensed Physician/Nurse/Emergency Personnel in the case of an accident of injury. I give full authorization Sunlight Behavior Center, Inc. personnel to authorize any and all measures to insure that _____(client) is protected and treated as swiftly as possible. I fully understand that in such situations it may be impossible to contact me or other appropriate persons, but Sunlight Behavior Center, Inc. will attempt to contact me as soon as possible.

This authorization for EMERGENCY MEDICAL TREATMENT/MEDICAL RELEASE FORM is valid from _____ to _____.

_____ _____

Parent/Guardian Signature Date

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY • INTEGRITY • ACHIEVEMENT

REQUEST FOR FIRST-AID, URGENT AND EMERGENCY CARE

Client: _____ Medical Record Number: _____

I, _____, legal guardian, request and consent that _____ receive usual and customary first-aid, urgent, and emergency care as deemed necessary by Sunlight Behavior Center Inc. staff.

_____ _____

Legal Guardian Date

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY • INTEGRITY • ACHIEVEMENT

Parent-Guardian-Agency Consent for Treatment

I _____, parent/guardian hereby agree to the following arrangement providing for the medical and personal care as well as education needs of _____.

SUNLIGHT BEHAVIOR CENTER AGREES:

1. To provide professional and Para-professional services for the resident as needed, based on a annual Interdisciplinary Team's evaluation of the resident by staff of SBC and the client's parent/guardian, case manager and/or probation officer.
2. To determine at initial team meeting the appropriateness of treatment based on the client's needs and available services.
3. To keep the Parent/Guardian informed of the client's program and/or changes in status.

PARENT/GUARDIAN AGREES:

1. To participate in scheduled team meetings and/or parent conferences as required developing and following through on the program designed to meet the needs of the consumer.
2. To permit Sunlight Behavior Center to take consumer on field trips or visits in the community or out of town trips as deemed necessary and appropriate when accompanied by Sunlight Behavior Center employees.
3. To cooperate with Area Mental Heath and/or any other funding agencies in maintaining the consumers eligibility for continued funding while in the care of Sunlight Behavior Center.
4. To hereby waive and release any rights, claims or demands that the parent/guardian may have now or in the future against Sunlight Behavior Center, for any injury sustained by consumer while consumer is in the care of Sunlight Behavior Center staff.

This Agreement will automatically expire upon satisfaction or the need for disclosure, or to renew after 365 days.

_____ _____

Signature of Parent/Guardian Date

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

TREATMENT CONSENT

CLIENT NAME: _____ MR#: _____

I am requesting evaluation/treatment at SBC. If the following the evaluation, it is determined that further treatment/habilitation is appropriate I hereby consent to treatment/habilitation as deemed necessary, which may include MH/DD/SAS Treatment, Community Support Services, Residential Treatment, and medications as ordered by the attending physician. I further understand that goals of treatment/habilitation will b e discussed with me and I may refuse/withdraw from services at any time. In case of accident or illness, I also give my consent for the center staff to provide and/or obtain emergency medical/dental treatment.

The Fee Schedule for SBC has been explained to me. I understand that my health insurance may cover a portion of treatment costs, and that I am responsible for charges not covered or reimbursed by my insurance company. In the event of non-payment, I agree to assume the cost of the interest, collection and legal action (if required). I have been informed and understand that if I refuse to allow SBC to file my insurance that will be required to the full charge for each session.

I authorize my insurance carrier, Medicare and/or Medicaid to release information regarding my coverage to SBC.

I authorize SBC to release information as requested by my insurance carrier, Medicare, Medicaid or other government sponsored program to support the filing of the claim and medical necessity for the services provided.

I acknowledge that my signature on this document authorizes SBC to submit claims for benefits of services rendered without obtaining my signature on each claim, and that I will be bound by this signature as though I had personally signed the claim. My rights to payment of all benefits filed are hereby assigned to SBC. This assignment covers any and all benefits under Medicare, other government sponsored programs, and private insurance and any other health plans. I the event that my insurance carrier does not accept Assignment of Benefits or if payments are made directly to my representative, or me I will insure such payment to SBC.

I understand that payment is expected at the time of each visit. I understand that if I am unable to pay the scheduled fee at each visit, a payment plan may be established for me. I agree to notify SBC at least 24 hours in advance if I am unable to keep an appointment in accordance with SBC. Normal hours of operation are 8am to 5pm, Monday-Friday.
I hereby authorize SBC to release diagnostic and treatment records when required to my insurance carrier, Medicaid, Medicare or any other third party payor. This authorization shall be valid until all claims have been processed not to exceed 1 year from date of discharge.
I have read or had explained to me by a member of SBC staff the above statements and fully understand my treatment and financial obligations.
I have been informed and received a copy of the Client's Bill of Rights for SBC.

I have been informed to the Notice of Privacy Practices for SBC and have received a copy of the Notice of Privacy Practices. I understand that the Notice of Privacy Practices discusses how my personal health care information may be used, and/or disclosed, my rights with respect to health information, and how and where I may file a privacy-related complaint. I understand I have a right to restrict disclosure of my health information and the right to request alternative ways of communication.

Preferred method for communication:
( ) Mail to home ( ) Home Telephone ( ) Answering Machine
( ) Work – Address: _____ Phone: _____
( ) Other – Address: _____ Phone: _____

I understand that the terms of this Notice may be changed in the future, ad these changes will be posted in the waiting room of the agency.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

_____ / _____ _____ / _____
Signature of Client/Guardian Date Signature of Client/Guardian Date

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

CONSENT TO ACT IN LOCO PARENTIS FOR EDUCATIONAL PLANNING

Client: _____ MR#: _____

I, _____, legal guardian, for _____, client, request that Sunlight Behavior Center Inc, Residential and Community Support Services Staff to act in Loco Parentis for the aforementioned client for educational planning. This includes alternative placement, home schooling, IEP meetings; meetings with school officials, teachers and guidance counselors.

_____ _____

Legal Guardian Date

TRANSPORTATION CONSENT

I, _____, legal guardian, give permission and consent for _____, to be transported by Sunlight Behavior Center Inc. Community Support Services Staff. Consent for transportation allows clients to participate in outings, events, appointments, school and other activities. I hereby release Sunlight Behavior Center Inc Community Support Services Staff or other agency staff from any liability, which may arise as a result of accident/injury and give my permission for transportation as needed.

I hereby acknowledge that this consent is truly voluntary. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will expire automatically upon client's discharge from Sunlight Behavior Center Inc.

_____ _____

Legal Guardian Date

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY • INTEGRITY • ACHIEVEMENT

ACITIVITY AUTHORIZATION

Client Name: _____ Record #: _____

I grant permission for, _____, to participate in extracurricular activities such as field trips, sports, employment, kinship, culturally diverse activities while at Sunlight Behavior Center Inc.

Guardian Signature: _____ Date: _____

Witness Signature: _____

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Activities Participation Release Form

Name: _____ **Record#:** _____

As part of treatment services at Sunlight Behavior Center, the client is encouraged to participate in scheduled activities as part of the treatment process. Many activities, at and away from the facility will be planned during the client's stay.

I do hereby give consent for my child to participate in the following activities while in treatment at Sunlight.

_____ Physical sports/activities
_____ Field Trips
_____ Educational Activities
_____ Swimming
_____ General Transportation
_____ School Activities
_____ Movies
_____ Yard Work
_____ Horse Back Riding
_____ Other

This consent will automatically expire one year from the date it is signed.

_____ _____
Client Signature Date

_____ _____
Legal Representative Date

CREDIBILITY · INTEGRITY · ACHIEVEMENT

CONSENT FOR USE OF RESTRICTIVE INTERVENTIONS

I have been informed of the reasons, use, and potential risks involved in the use of restrictive interventions. I understand these interventions will only be utilized when less restrictive measures have not been proven to be successful in de-escalation of client's behavior. Behavioral interventions will be employed by privileged staff in order to encourage appropriate behavior (decreased aggressiveness, increased self-control and compliance within milieu).

The following steps shall take place:

- Staff will make requests of the client in positive, non-threatening and non-authoritarian way and give the client an opportunity to respond appropriately.
- If this does not result in appropriate behavior, the staff will repeat the request with a warning that a secondary intervention will occur.
- Initial interventions will include individual counseling or a variety of psychoeducation services listed for High Risk Intervention and/or Resident Behavior Intervention Services.
- If after issuing the warning, AND initial interventions do not result in appropriate behavior, secondary interventions may occur. The safety of client, others and preservation of property will be considered when making the decision to employ a behavior intervention. The more restrictive behavioral interventions (tertiary interventions) are to be used if the client exhibits behaviors that are potentially dangerous to self, others or if the resident is destroying property. Interventions at all levels require individual counseling and notation of the outcome following the intervention(s).

I understand these interventions will only be used by qualified staffs who have received training in the use of restrictive interventions.

I consent to the use of appropriate restrictive interventions, including the use of Therapeutic Holds as may be required and outlined in the Behavior Plan which is a part of the Service Plan, and as ordered by PhD Psychologist or the Psychiatrist.

I hereby release Sunlight Behavior Center Inc, and any staff representing Sunlight Behavior Center Inc from any liability, which may arise as a result of injuries sustained during the intervention process.

_____ _____

Client / Parent / Legal Guardian Date

CREDIBILITY • INTEGRITY • ACHIEVEMENT

Resident's Funds

Client: _____ Medical Record Number: _____

I give Sunlight Behavior Center, Inc. consent to handle my child's _____ funds. A receipt must be kept in consumer's file, of all consumers' spending of personal funds.

This consent is good from _____ to _____.

_____ _____

Legal Guardian Date

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Unauthorized Leave - AWOL

Name: _____ **Record#:** _____

I have been informed and acknowledge that if my child leaves Sunlight Behavior Center without staff permission, the Sheriff's Department and the parent/guardian of client will be notified immediately. With my signature, I hereby release Sunlight from all liability should an accident / injury occur while my child is AWOL.

_____ _____

Client Signature Date

_____ _____

Legal Representative Date

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Behavioral Management Plan

Name: _____ **Record#:** _____

The Behavioral Management Plan is as follows and is to be incorporated into the Comprehensive Treatment Goal Plan.

Level I:

Staff will make requests of the consumer in appositive non-threatening, non authoritarian way and give the client an opportunity to respond appropriately. If this does not result in appropriate behavior, staff will repeat the requests with a warning that Level II intervention will occur. Level I intervention will also include individual counseling or a variety of psychoeductional service. If after issuing the warning, Level I interventions do not result in appropriate behavior, Level II interventions will occur.

Level II:

May include one or more of the following:

1. Loss of privileges
2. Designated area (if applicable)
3. Early bedtime
4. Activity time out

Note: If Level I and II interventions exceed 12 hours, Level III Interventions is applicable. If Level II does not result in appropriate behavior, Level III is applicable.

Level III:

These interventions are also to be used if the consumer exhibits behaviors that are potentially dangerous to self, others or if the client is destroying property or is in an emotional state of mind that pose a threat to his or others lives or safety, i.e. during runaway, going on home visitations, etc.

1. NCI technique up to 15 minute intervals.
2. Time out for 15 minute periods in consumer's room.
3. Subsequent 15 minute periods of time out only to be approved by QP or responsible professional.
4. Intrusive interventions include: visual constant, due to sever behavioral deficits during personal hygiene, sleep, social isolation, time out and runaway, delayed gratification, visitation and telephone privileges, unplanned interventions may occur if situation/behaviors are life threatening to self or others.
5. Notification of law enforcement with approval of Director.
6. Hospitalization if deemed medically necessary by psychiatrist, if applicable.

Note: a facility employee privileged to administer an emergency intervention may do so for up to 15 minutes without further authorization.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Behavioral Management Plan (continued)

Continued use must be authorized only by the responsible professional or another QP who is privileged as per experience and training.

Professional or QP shall meet with and conduct on-site assessment of client and write a continuation as soon as possible, after the intervention. If unavailable to do on-site, but concurs after discussion with employee that the intervention is justified, may authorize telephonically until on-site assessment can be made, up to 24 hours. A verbal authorization shall not exceed 24 hours after initial employment of intervention.

When a restrictive intervention is used for more that 24 hours, there must be written approval by the designee of the governing body (Client's Rights Committee).

_____ _____

Client Signature Date

_____ _____

Legal Representative Date

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Drug Therapy Use Authorization

Client: _____ Medical Record Number: _____

I am aware that my child is/are on the following medications prescribed by a licensed physician/psychiatrist.

List Medication and Dosage:

_____ _____

_____ _____

_____ _____

_____ _____

I understand that these medications have certain side effects. I give Sunlight authority to administer these medications to my child.

This consent is good from _____to _____.

_____ _____

Legal Guardian Date

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Mail Authorization

Client: _____ Medical Record Number: _____

Every client has the right to send and receive mail, at their expense, free from interference by the facility staff otherwise stated by guardian. However when the consumer's treatment team determines that monitoring of mail is clinically necessary, the staff will provide the monitoring.

This consent is good from _____ to _____.

_____ _____

Legal Guardian Date

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Photographic/Film Release

Client: _____ Medical Record Number: _____

I do agree to release to Sunlight Behavior Center, Inc. the right to photograph/film myself or my child during any activities deemed appropriate by the staff. I understand that these photographs/films will be used in an integral part of the frequent training sessions for staff member, as well as a method of observing client behavior, or if any event is taking place by Sunlight where photographs are being taken.

Sunlight agrees not to release the photograph/films publicly. They will be viewed within the respect field(s) by professionals and trainees.

This consent is good from _____ to _____.

_____ _____

Legal Guardian Date

_____ _____

Client Date

SUNLIGHT BEHAVIOR CENTER, INC.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Consent to Attend Religious Services

Name: _____ **Record#:** _____

I do hereby give permission for my child, to attend religious services, and otherwise participate in religious activities.

In case of an accident or illness while enrolled to religious services/activities, I also give my consent for Sunlight Behavior Center to provide transportation to these activities. I fully understand the above statement that has been read and explained to me by a staff person at Sunlight.

This consent will automatically expire one year from the date it is signed.

_____ _____

Client Signature Date

_____ _____

Legal Representative Date

CREDIBILITY • INTEGRITY • ACHIEVEMENT

RESIDENTIAL SERVICES

INTAKE PACKET

CREDIBILITY · INTEGRITY · ACHIEVEMENT

MANAGEMENT AUTHORITY

Sunlight Behavior Center Inc. is owned and operated by Rashad ,Virginia and Rachell Rahmaan. They are the designated operators of the agency and are responsible for the management of the agency.

Sunlight Behavior Center Inc. is a for profit private provider agency that offers residential, community based services (both professional and paraprofessional), and case management. The primary objective of Sunlight Behavior Center Inc. is to provide quality services to consumers with mental illness, mild mental retardation and/or developmental disabilities while promoting a high level of independence.

Sunlight Behavior Center staff secure facility for children or adolescents is a freestanding residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. Sunlight Behavior Center shall not be the primary residence of an individual who is not a client of the facility. Staff secures means staff are required to be awake during the clients sleep hours and supervision shall be continuous. Sunlight Behavior Center will not focus on sex offenders or substance abuse consumers.

Hours of Operation: Sunlight Behavior Center is open Monday through Friday 9am to 5pm except holidays. QMHP can be reached by cell phone 24 hours ad day/7 days a week.

MISSION STATEMENT

Sunlight Behavior Center Incorporated is committed to helping individuals and families affected by mental illness and substance abuse, to achieve their full potential, to live, work and grow in their community and have a higher quality of life.

***** Sunlight Behavior Center Inc. does not discriminate based on age, gender, race, sexual orientation, religion or diagnosis. Sunlight Behavior Center reserves the right to request drug testing when the care of a consumer is at risk.**

CREDIBILITY · INTEGRITY · ACHIEVEMENT

Residential Level III Services

Residential Treatment Level III service is responsive to the need for intensive, active therapeutic intervention, which requires a staff secure treatment setting in order to be successfully implemented. This setting has a higher level of consultative and direct service from psychologists, psychiatrists, medical professionals, etc.

Individualized, intensive, and constant supervision and structure of daily living designed to minimize the occurrence of behaviors related to functional deficits, to ensure safety and contain out-of-control behaviors including intensive and frequent crisis management with or without physical restraint or to maintain optimum level of functioning.

Includes active efforts to contain and actively confront inappropriate behaviors and assist consumers in unlearning maladaptive behaviors. Includes relationship support to assist the consumer in managing the stress and discomfort associated with the process of change and maintenance of gains achieved earlier and specifically planned and implemented therapeutically focused interactions designed to assist the consumer in correcting various patterns of grossly inappropriate interpersonal behavior, as needed. Additionally, providers require significant skill in maintaining positive relationship in interpersonal dynamics, which typically provoke rejection, hostility, anger, and avoidance.

CREDIBILITY · INTEGRITY · ACHIEVEMENT

CLIENT RIGHTS

1. Exercise his/ her rights as a client and citizen.
2. Be fully informed of his/her rights and responsibilities and the rules and regulations governing conduct and responsibilities.
3. To be treated with respect, consideration dignity and full recognition of his/her individuality and the right to privacy.
4. To receive care and services which are adequate, appropriate and in compliance with relevant Federal and State laws and regulations;
5. To receive upon admission and during his/her stay a written statement of the services provided by the facility;
6. Voice grievances and recommend changes in policies and service through facility staff and/or through outside representatives and to do so without restraint interference, coercion, discrimination or reprisal;
7. To be free of mental and physical abuse, neglect and exploitation;
8. Privacy for visits by his/ her family if no other mandates are involved.
9. Except in emergencies, to be free from chemical and physical restraint unless authorized for specified period of time, by a physician according to clear and concise medical needs;
10. Receive or refuse visitors at any reasonable hour.
11. Make scheduled trips into to the community;
12. Participate in recreation, physical exercise and outdoor activities on a regular basis.
13. Wear keep and use his/ her clothing personal hygiene items and personal possessions
14. To have his/her personal and medical records kept confidential and revealed only with his / her written consent or as required by state or federal law or regulation.
15. Be free from the loss of any meal or a portion of a meal as a disciplinary action
16. Have access to all living areas, recreational areas and habilitative supplies and equipment of **SUNLIGHT BEHAVIOR CENTER, INC.**
17. Communicate and meet with persons of his/her own choice upon mutual consent and under appropriate supervision;
18. Live and work in an unlocked environment during waking hours;
19. Have access to individual lockable storage space for his/her private use;
20. Be free from mistreatment, abuse, neglect or exploitation in any form;
21. Be paid for work performed that is not part of his/her habilitation plan;
22. To receive a reasonable or excessive compensation for damage resulting from his/her behavior;
23. Be free from unreasonable or excessive compensation for damage resulting from his/ her behavior;
24. Obtain and/or retain a driver's license, unless prohibited;
25. Receive written notice and rationale if transferred within **SUNLIGHT BEHAVIOR CENTER, INC.,** or to another facility;
26. Have no unauthorized publicity on use of or discussion of his/her care, treatment or records unless informed consent is given;
27. Be assured that no information shall be released from his/ her record unless written informed consent is given;
28. Be involved in research only upon giving informed voluntary consent;

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29. Be free from treatment involving aversive conditioning experimental drugs or procedures and non-emergency surgery unless informed voluntary consent or written consent of the guardian is given;
30. Be free from physical and chemical restraint unless informed consent is given and when authorized in writing by a physician for use during behavior modification sessions;
31. Exercise all civil rights;
32. Communicate and consult with the individual or agency having legal custody
33. Communicate and consult with legal counsel of his/her guardian's choice at his/her expense;
34. Have access to adequate private facilities for daily hygiene and grooming purposes;
35. Access to barber or beautician services;
36. Participate in religious worship of his/her choice;
37. Keep and spend a reasonable sum of his/her own money;
38. To have access at any reasonable hour to a telephone where he/she may speak privately;
39. To send and receive mail promptly and unopened unless the resident requests that someone open and read mail and to have access at his/her expense to writing instruments, stationary and postage.
40. To be encouraged to exercise his/her rights as a resident and citizen and to be permitted to make complaints and suggestions without fear of coercion or retaliation.
41. To have use of his/her own possessions where reasonable and have accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the residents and the program director.
42. To manage his/her personal needs funds unless such authority had been delegated to another. If authority to manage personal needs funds has been delegated to the facility the resident has the right to examine the account at any time.
43. To be notified when the facility issues a provisional license by the North Carolina Department of Human Resources and the basis on which the provisional license was issued. The resident's responsible family member or guardian shall also be notified.
44. To have freedom to participate by choice in accessible community activities and in social, political, medical and religious resources and to have freedom to refuse such participation.
45. To receive upon admission to the facility a copy of this section.

* If you have any complaints that facility has not handled you may contact the Governor's Advocacy Council.

Write to: Governor's Advocacy Council

1314 Mail Service Center

Raleigh, NC 27699

(919) 733-9250

1-877-235-4210

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HOUSE RULES

These rules, along with others, are to be followed at all times. Specific inappropriate behaviors not listed will be dealt with on an individual basis.

1. No yelling, running, touching, horseplay, or boxing in the house.
2. No lending and borrowing of any and all items, property, clothing, or giving of gifts between residents.
3. Feet off furniture
4. No profane language
5. Must have permission before hanging pictures. Pictures with sexual connotations, alcohol, violence, drugs, gang paraphernalia are not allowed
6. No verbal aggression
7. No contraband or weapons allowed, i.e. items that can be utilized for harm
8. Must follow level system
9. Must maintain good hygiene at all times
10. Residents will have access to items such as nail clippers, shaving razors, scissors, pins, needles, etc. but will be supervised by staff and these items will be secured when finished
11. No room visitation to include standing in hallway talking into another room
12. No smoking or use of tobacco products, narcotics will not be permitted in the house or on the premises
13. No sagging
14. No physical aggression including damage or misuse of property. No fighting. Threats of physical aggression will not be tolerated. When the resident is malicious or irresponsible with Sunlight's property, Sunlight may bill the parents/guardians for replacement or repair of the items involved
15. The resident may not make or receive long distance phone calls that are billed to the facility. Should the consumer bill long distance phone calls or collect calls to the facility, the consumer/parent or guardian will be responsible for the charges incurred
16. Sunlight is not responsible for lost or stolen items
17. Each individual is responsible for cleaning up after themselves and for completing their assigned chores in a timely manner
18. Residents will not be permitted in the office without staff permission
19. Each resident's right to privacy, possessions, and physical safety will be respected at all times, with exception of posing threats to self or other's safety
20. No personal electronics, i.e. radios, computers, and hand held games, etc. without the permission from Sunlight
21. Residents may bring no more than 10 outfits and 5 pair of shoes unless otherwise specified

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FEE ASSESSMENT

Sunlight is endorsed and contracted with the Local Area Mental Health Center to provide RESIDENTIAL. These services are reimbursed through the billing of Medicaid. To be eligible for the service, you/your child must be a Medicaid recipient and have a current Medicaid Card.

There are some situations where RESIDENTIAL are provided through a different funding source, but the reimbursement rate remains the same Medicaid set rate.

PROGRAM GUIDELINES

Improving Client Care

Sunlight Behavior Center Inc. shall design programs to provide opportunities for positive learning experiences and to meet the needs of individuals, children and families.

The following strategies will be implemented for improving and monitoring client care:

- Client Activities
  - The activities program will be organized and staffed to meet the needs of clients
    - A member of the staff will be assigned responsibility for developing, documenting, and maintaining the activities program
    - A sufficient number of support persons will be available to meet the activity needs of the clients
    - The facility will provide adequate and suitable activity areas in accordance with federal, state, and local laws, rules and regulations
    - A variety of supplies and equipment will be available to satisfy the activities and interest of clients
      - The supplies and equipment will be:
        - Maintained in safe and functional order, and
        - Easily accessible to clients where feasible
- Activities designed to address individual needs
  - The activities program will provide services that are suite to the needs, abilities, and interest of clients
    - Activities will be provided in individual and group setting
    - The activities program will include a variety of activities, both inside and outside the facility, that will include but not be limited to, the following:
      - Exercise classes
      - Recreational and social activities

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- Literary and educational activities
- Community activities
- Spiritual activities
- Creative activities
- Intellectually stimulating activities, and

- Other activities that allow clients to maintain their lifestyle
- Clients will be encouraged, but not obligated, to participate in planned activities
- Activities will be posted and/or published and will be made available to all clients, staff and visitors

- Monitoring activities
  - The quality and appropriateness of activities will be monitored as an integral part of the overall Quality Assurance Program

- Medical services
  - The health care of every client will be supervised by a qualified licensed physician
  - Clients will visit the physician in accordance with his/her needs and at least once during the first 30 days following admission
  - After first visit, the attending physician will establish an appropriate visiting schedule which will comply with state and federal regulations

Search & Seizure:

Searches and/or seizures may take place only when there exists good cause or the reasonable indication of possession of stolen property, substances or items which may be health-threatening or dangerous and are not allowed by the component program rules.

SUSPENSION AND EXPULSION POLICY

Each client shall be free from threat or fear of unwarranted suspension or expulsion from SUNLIGHT BEHAVIOR CENTER

No client shall be suspended from SUNLIGHT BEHAVIOR CENTER facility/component program without a meeting first taking place with the following client rights advocates present:

- Qualified Professional responsible for supervising case
- Client and/or Legal Guardian.
- Treatment Team

Expulsion/Discharge:

You/your child may be expelled from our services for the following reasons:

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- Change in client residence
- Client incarceration
- Extreme acting out/assaultive behavior
- Area program treatment team recommendation
- No longer meets eligibility requirements (loss of Medicaid/other funding)

Discharge Planning:

Discharge planning is a function of the client's treatment team.

Suspended or expelled clients (or their families) have access to the clinic grievances procedures.

Grievances:

It is the policy of Sunlight Behavior Center that the Qualified Professional will ensure that the clients are adequately informed of their rights to express concerns about the services rendered. If the client becomes dissatisfied with services through the RESIDENTIAL program:

- First, speak directly with the Qualified Professional. If this does not resolve the problem, the client should then contact the Director.
- Arrangements will be made for the client to discuss concerns/grievances with the Director within 24hours, or the next working day. The consumer will receive feedback within 2 business days.
- The supervisor will let you know either verbally or in writing what was done to solve the problem.

If the client is still dissatisfied, they should file a grievance with their Home County Area Program and/or contact the Governor's Advocacy Council for Persons with Disabilities

CLIENT GRIEVANCE/COMPLAINT POLICY

Sunlight Behavior Center's clients/legally responsible parties have the right to voice concerns, complaints and grievances with respect to the treatment and care that is provided or not provided.

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PURPOSE: This policy is set forth to assure that quality services are provided on a consistent basis to each client and to allow for the resolution of grievances as presented by clients in a fair and timely fashion.

PROCEDURE:

1. Upon admission, each client will be provided with the following address and telephone numbers to be used for reporting concerns, complaints and/or grievances about services provided.

SUNLIGHT BEHAVIOR CENTER
2030 Hoke Loop
Fayetteville, NC 28314
Phone/Fax (910) 864-2443

1. Any report, complaint or expressed concern about services, care provided or not provided, visit scheduling, billing, supplies, staff behavior or performance of duty should be reported to the County Director of Sunlight Behavior Center INC. on the appropriate concern/complaint form (See Appendix E). The client is responsible for notifying the agency of any dissatisfaction with services. Employees and referral sources may also notify the agency of any concerns about provision of services provided to a particular client.
2. If the problem is not solved, the client/guardian should talk with the Clinical Services Director, who shall investigate the situation and document the results.
3. If these two steps do not resolve the client's grievances, client/guardian should request a meeting with the Chairman of the Board or his designee. This meeting should also be documented on the Client Grievance Form.
4. If these three steps do not achieve the desired results for the client, the client/guardian may submit a letter to the Sunlight Behavior Center Inc. Board of Directors requesting a review of the complaint. The Board will review the complaint and document its findings. If not resolved, the client has the right to submit a complaint to the Governor's Advocacy Council.
    - Sunlight Behavior Center INC. will review and aggregate client grievances at least quarterly as part of the ongoing quality improvement program.

Confidentiality

Sunlight Behavior Center ensures that confidential information regarding consumers will not be released until Consent for Release formal has been obtained. Sunlight Behavior Center ensures that confidential information regarding consumers will be protected from disclosure without consent. The dignity and privacy of all consumers are protected by vigilant oversight of confidential records and information. All records are maintained in accordance with the APSM 45-1.

HIPPA NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

Note: If you have questions about this notice, please contact **Sunlight Behavior Center at (910) 864-2443 or at the above address**.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the privacy practices of {**Sunlight Behavior Center**}. All of our staff may have access to information in your chart for treatment, payment and health care operations, which are described below, and may use and disclose information as described in this Notice. This Notice also applies to any volunteer or trainee we allow to help you while seeking services from us.

OUR PLEDGE REGARDING THE PRIVACY OF YOUR MEDICAL INFORMATION:

Your medical information includes information about your physical and mental health. We understand that information about your physical and mental health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from us. We need his record to provide you with quality care and services and to comply with certain legal requirements. This notice applies to any and all of the records of your care generated by us.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. We will post a copy of our current notice in our offices in a prominent place and will post the notice on our website.

OUR OBLIGATIONS TO YOU:

We are required by law to:

- make sure that medical information that identifies you is kept private except as otherwise provided by state or federal law;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not

every use or disclosure in a category will be listed. This notice covers treatment, payment, and what are called health care operations, as discussed below. It also covers other uses and disclosures for which a consent or authorization are not necessary. Where {**North Carolina**} law is more protective of your medical information, we will follow state law, as explained below.

For Treatment: We may use medical information about you to provide you with medical treatment or services without consent or authorization unless otherwise required by applicable state law. We may disclose medical information about you to doctors, pharmacists, laboratories, or other health care providers or case managers or case coordinators or other service providers who are involved in taking care of you whether or not they are affiliated with us. For example, we may disclose medical information concerning you to the local hospital, or physicians or counselors who care for you as well as to any other entity that has provided or will provide care to you.

We will disclose any mental health information, including psychotherapy notes, AIDS or HIV-related information, or drug treatment information, that we may have about you only with written authorization as required by {**North Carolina**} law, HIPAA and other federal regulations.

During the course of your treatment, we may refer you to other health care providers with which you may not have direct contact. These providers are called "indirect treatment providers." "Indirect treatment providers" are required to comply with the privacy requirements of state and federal law and keep your medical information confidential. These providers will be bound by the HIPAA privacy rule.

For Payment: We may use and disclose medical information about you without consent or authorization so that the treatment and services you receive from us may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment received so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan or insurance company about a treatment you are going to receive to obtain prior approval or to determine whether it will cover the treatment. We may also provide your information to case coordinators or case managers for payment purposes as well.

For Health Care Operations: We may use and disclose medical information about you without consent or authorization for "health care operations." These uses and disclosures are necessary to operate {**Sunlight**} and make sure that all individuals receive quality care. For example, we may use medical information or mental health treatment information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose your protected health information to doctors or staff or consultants for review and learning purposes. We may also use your protected health information in preparing for litigation.

Appointment Reminders: We may use and disclose medical information to contact you by mail or phone to remind you that you have an appointment for treatment, unless you tell us otherwise in writing.

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Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. However, we will not use or disclose medical information to market other products and services, either ours or those of third parties, without your authorization.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information, including mental health information, about you to a family member who is involved in your medical care without consent or authorization. We may also give medical information, including prescription information or information concerning your appointments to other individuals who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If {**North Carolina**} law requires specific authorization for such disclosures, we will obtain an authorization from you prior to such disclosures.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law without your consent or authorization.

To Avert a Serious Threat to Health or Safety: We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Business Associates: {**Sunlight**} from time to time will hire consultants called "business associates," who render services to us. We may disclose your medical information to such business associates without your consent or authorization. Business associates are required to maintain and comply with the privacy requirements of state and federal law and keep your medical information confidential. Examples of "business associates" are accounting firms that we hire to perform audits of billing and payment information, and computer software vendors who assist us in maintaining and processing medical information.

Public Health Risks: We may disclose medical information about you for public health activities without your consent or authorization. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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Health Oversight Activities: We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Administrative Proceedings: If you are involved in a lawsuit or dispute as a party, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. Similarly we may disclose medical information about you in proceedings where you are not a party, but only if efforts have been made to tell you or your attorney about the request or to obtain an order protecting the information requested. In addition, we may disclose medical information, including mental health treatment information, to the opposing party in any lawsuit or administrative proceeding where you have put your physical or mental condition at issue if you have signed a valid release.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at {**Sunlight**}; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. If you wish to be provided a copy of medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at {**Sunlight**}. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing and or other supplies associated with your request.

We may deny your request to inspect and/or obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at {**Sunlight**}. In addition, you must provide a reason that supports your request.

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We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make that amendment;
- Is not part of the medical information kept by us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of some of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at {**Sunlight**}. Your request must state a time period which may not be longer than six years starting with {**October 1, 2006**}.Your request will be provided to you on paper. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. However, you will need to make alternative arrangements for payment if you restrict access of individuals responsible for the payment of your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer at {**Sunlight**}. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer at {**Sunlight**}. We will not ask the reason for your

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request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint in writing to the Privacy Officer at {**Sunlight**}. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission as set out in an authorization signed by you. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I read and understand the information contained in this packet. I have received a copy of this packet.

This packet contains the following information:

- Introduction to Management
- Mission Statement
- Description of Services
- Client Rights
- House Rules
- Fee Assessment
- Program Guidelines
- Search & Seizure
- Suspension & Expulsion
- Discharge
- Grievances/Complaints
- HIPPA/Confidentiality

_____ _____

Parent/Guardian Signature, Date Client/Date