THE UNIQUE
CARING
FOUNDATION
"BUILDING BRIDGES TO THE COMMUNITY"
www.uniquecaringfoundation.com

Medical Records #: _____

PLACEMENT AGREEMENT

I hereby consent to the placement of _____ with THE UNIQUE CARING FOUNDATION, INC. This child is in the custody of _____. As the Placing Authority my relationship to this child is: ☐ mother; ☐ father; ☐ guardian; ☐ legal custodian; ☐ other (specify) _____. It is understood that the Placing Authority may remove the child at anytime from THE UNIQUE CARING FOUNDATION, INC. It is understood that THE UNIQUE CARING FOUNDATION, INC. may request that the child be removed from their program at anytime. However, unless there is an emergency situation both parties agree to a 72-hour notification.

This child will be placed in a ☐ Family Foster Home or a ☐ Therapeutic Foster Home or a ☐ Residential Child Care Facility licensed by the North Carolina Division of Social Services under the auspices of THE UNIQUE CARING FOUNDATION, INC

Date of Placement:_____ Time of Placement:_____ .

FEE SCHEDULE

Foster Parents are paid monthly based upon the amount agreed upon in the Agency's Foster Parent Agreement. The fees are to cover: room, board, foster care services, transportation, etc. The Unique Caring Foundation Foster Parent pay period outlined the date services billed for are paid.

When the foster child is not in the foster home by midnight (ex: visiting with family, hospitalized, etc.), the foster parent is not paid the daily rate for that (those) day(s).

All of the foster child's expenses are to be covered by the monthly stipend. If the county allows for a clothing allowance, the agency will sign over that total check amount to the foster parent: however, this is a far less frequent occurrence than happened in the past. The legal guardian/custodian understands that The Unique Caring Foundation, Inc. will be the guardian of finances if foster child is the recipient of monthly Social Security Insurance Stipend. _____ (Initials). It is the law that the monies follow the child.

GENERAL INFORMATION

Child's Full Name:_____ Date of Birth:_____

Home Address:_____

Legal Custodian:_____ Phone #:_____

Address:_____ City/State/Zip_____

Last School Attended:_____ Grade:_____

Medical Doctor:_____ Phone #:_____

Dentist:_____ Phone #:_____

Revised 8/20/2009 revised 11/23/10 rev. 10/16/2012 Rev. 4/2014

Medical Records #: _____

MEDICAL INSURANCE INFORMATION

Name of Policy:_____ Policy Number:_____

Policy Holder:_____

Contact Person for Medical Insurance:_____ Phone #:_____

OTHER PROVISIONS:

I, the legal guardian/custodian has received a program handbook which includes information on client rights, the grievance process, confidentiality, inclusion in service planning, policies on religious participation, searches and seizures of property, and policies regarding family visits, mail, money and telephone use. _____ (Initials)

I, the legal guardian/custodian understand that THE UNIQUE CARING FOUNDATION, INC. does not permit foster parents to use corporal punishment. _____ (Initials)

I, the legal guardian/custodian understand that THE UNIQUE CARING FOUNDATION, INC.. is responsible for involving the child and their parents or other family members in the service planning process as well as working with them towards reunification when this is the permanent plan for the child. _____ (Initials)

I, the legal guardian/custodian understand that THE UNIQUE CARING FOUNDATION, INC. will adhere to the visitation and family contact schedule developed for the child. _____ (Initials)

I, the legal guardian/custodian understand that the above mentioned child is scheduled for discharge from THE UNIQUE CARING FOUNDATION, INC. on or about _____ based upon the completion of the Service/Treatment Plan. I further understand that the child's treatment team will routinely review the projected discharge date and criteria (at least quarterly) and I will be advised of these reviews. _____ (Initials)

List any other special provisions or circumstances you feel need to be covered in the Placement Agreement.

SIGNATURES

I certify that the information contained herein is accurate and properly represented.

_____ _____

Placing Authority (Signature) Date

_____ _____

Agency Representative (Signature and Title) Date

Revised 8/20/2009 revised 11/23/10 rev. 10/16/2012 Rev. 4/2014

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PERSON SERVED EMERGENCY INFORMATION

CONSUMER NAME: _____ **Med. Record #:**_____

PERSONAL INFORMATION:

SS#:	DOB:	Medicaid#
Sex:	Race:	Height:
Weight:	Eye Color:	Hair Color:
Identifying Marks or Scars:		
Address (foster home):		Telephone #:

DSS/GUARDIAN INFORMATION:

Full Name:		
Address:		
Telephone Contact Information:		

CASE MANAGER INFORMATION (if applicable)

Full Name:		
Address:		
Telephone Contact Information:		

MEDICAL AGENCY:

Name:		Phone #:
Address:		
Medical Alerts: ( ) No ( ) Yes Explain:		
Allergies: ( ) No ( ) Yes Explain:		
Seizures: ( ) No ( ) Yes Type:	Diabetes: ( ) No ( ) Yes	Hep. B: ( ) No ( ) Yes
Medications:		
Special Diet: ( ) No ( ) Yes Explain:		

Med. Record #_____

THERAPIST INFORMATION:

Name:	Phone #:
Address:	
Medical Alerts: ( ) No ( ) Yes Explain:	
Allergies: ( ) No ( ) Yes Explain:	
Medications:	

Please Check All that apply:

CATEGORY	YES	NO	CATEGORY	YES	NO
Physical Aggression			Property Destruction		
Verbal Aggression			Cruelty to Animals		
Substance Abuse			Psychotic		
Fire Setting			Suicidal		
BEH			Behaviors of Concern		

Explain: _____

Communication Level: _____ Communication Method: _____

Vision: _____ Hearing: _____ Respond to Own Name: ( ) Yes ( ) No

Explain: _____

Signature of Person Completing Form: _____

Print Name: _____ Date: _____

Relationship to Person Served: _____

Consumer ID#: _____

Admission Profile Assessment Application for Services

Name of Consumer: _____ Intake Date: _____

Social Security #: _____ Medicaid #: _____ LME billed: _____

DOB: _____ Gender Id: _____ Gender Expression: _____ Ethnicity: _____

Sexual Orientation: _____

Address: _____
Street Address City State Zip Code

_____
Social Worker Name Agency Contact #

Parent/Guardian Info:

Name: _____ Relationship: _____

Address: _____ Phone: _____
Street City State Zip Code

Proposed Date Service Begins: _____

Updated PCP [ ] Updated Service Order [ ] Diagnostic Assess./CCA [ ]

I. **Presenting Problem** (Consumer statement, Referral/Collateral Statement, Nature of Problem, Rationale for Service):

_____

_____

II. **Problem History** (Onset, Frequency, Duration, Previous treatment received, previous psychiatric hospitalizations, suicide risk and what helps, history of abuse/neglect/violence. This information may be obtained by reviewing written documents such as current social history, hospital summary, etc. If these are not available, interview consumer, family member, collateral, etc.)

_____

_____

_____

III. **The consumer has a current Service Plan:** ___ Yes ___ No

If no, state reason: _____

_____

IV. **The team agrees that this service is appropriate at this time:** ___ Yes ___ No
If no, state reason: _____

_____

V. **Family and Individual History** (Parents, siblings, present relationship with family, sexual history, Behavior of Concern, Fire setting, Cruelty to animals and risk taking behaviors):

_____

_____

_____

VI. **Developmental History** (developmental stage factors, motor development and functioning)

_____

_____

_____

VII. **Parental/Guardian Custodial Status:** _____

VIII. **Parent's/guardian's ability/willingness to participate in services:**

_____

_____

_____

IX. **Social Supports** (friends, religious affiliations, hobbies/activities, availability of social supports)

_____

_____

_____

X. **School History** (highest grade, difficulties, achievements, behavioral difficulties, learning ability/disability):

_____

_____

_____

XI. **Medical History** (current physician, hospitalizations [medical/psychiatric], family medical problems, childhood/adolescent illnesses, immunization history):

_____

_____

_____

_____

XII. **Allergies:**
None at this time [ ] Allergic to: _____

XIII. **Speech / Hearing / Vision Functioning:**

_____

_____

_____

XIV. **Drug and Alcohol Information** (Family use/addiction, past and present, age of first use, longest period of time without alcohol/drugs in past year, frequency of usage in past year, amount consumed per episode, treatment history)

_____

_____

_____

Consumer ID#: _____

XV. Interpretive Summary:

_____

_____

_____

XVI. Diagnosis (may use most recent psychological)

Axis I: _____ Axis II: _____

Axis III: _____ Axis IV: _____

Axis V: _____

XVII. Immediate Needs:

_____

_____

XVIII. Planned Follow up/Recommendations

_____

_____

XIX. Efficacy of Medication: _____

XX. Have proceedings been initiated to terminate parental rights for this child's:
Mother? Yes [ ] No [ ] **Father?** Yes [ ] No [ ]

XXI. Any other legal issues/court dates for pending issues: Yes [ ] No [ ]

XXII. Check if there is any [ ] physical, [ ] medical, [ ] developmental, [ ] psychological, [ ] suicidal problem which will require special attention in caring for this child. **Attach a description of each problem checked.**

_____ _____
Printed Name of Person Completing Assessment **Title**

To be Completed by Unique Caring Foundation:

[ ] Eligible **[ ] Ineligible:** _____

_____ _____
Signature of Qualified Professional **Date**

Consumer ID#: _____

APPLICATION FOR SERVICE /ADMISSION

TO (Name of Agency): **THE UNIQUE CARING FOUNDATION, INC**

Application For: Name of Consumer: _____

☐ Therapeutic Foster Care ☐ Family Foster Care ☐ Residential Child Care

FROM: (PRINT name of person making application): _____

Title: _____ Agency/LME: _____

This complete application, with supporting documentation, provides the information necessary to complete the admit process of the child. As a part of the admit process, the documents relating specifically to admission will be required. If additional space is needed for any question, add an extra sheet or write on the back of the application.

FAMILY INFORMATION FOR CHILD

Child's Full Name:_____ Prefers to be called: _____

Date of Birth:_____ Verified? ☐ Yes ☐ No

Social Security Number:_____ Sex Orientation: ☐ Male ☐ Female

Gender ID: _____ Gender Expression: _____ Race:_____

Place of Birth (city):_____ (county):_____ (state or Country): _____

Currently Living With: ☐ Biological Parents ☐ Relative ☐ Foster Family

☐ Other (Specify): _____

Have proceedings been initiated to terminate parental rights for this child's:

Mother: ☐ Yes ☐ No Father: ☐ Yes ☐ No

If yes, give the date of the final order terminating parental rights:

of the mother: _____ of the father: _____

Has this child been adopted? ☐ Yes ☐ No If yes, date(s) of the final adoption order(s): _____

Does Child Receive Social Security Insurance Benefits? _____ Yes _____ No

(Note that by law the SSI stipend must follow the child)

Type of Health Insurance: [ ] Health Choice [ ] Partners [ ] Other: _____

Give the name/role of other volunteers/professionals assigned to this child (Guardian ad Litem, Child Advocate, Court Counselor, etc.) : _____

_____

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Consumer ID#: _____

CURRENT PARENTAL RELATIONSHIPS: (The persons, if other than biological parents, who will be working in a parental capacity with child while in care):

Full Name: _____ Date of Birth: _____

Relationship to Child: ☐ Step ☐ Adoptive ☐ Other (Specify): _____

Address: _____

Phone Number: _____

Full Name: _____ Date of Birth: _____

Relationship to Child: ☐ Step ☐ Adoptive ☐ Other (Specify): _____

Address: _____

Phone Number: _____

CHILD'S SIBLING INFORMATION: (Include all half siblings, step siblings, adoptive siblings)

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Relationship: _____

Presently Living With: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Relationship: _____

Presently Living With: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Relationship: _____

Presently Living With: _____

SURROGATE PARENT

Name of Person: Phone #:

Address:

Consumer ID#: _____

PRESCRIPTION MEDICATIONS: medications child is taking and for what condition(s):		
NAME OF MEDICATION	DOSAGE	WHAT CONDITION

Any history of Adjustment/Response to previous medications/Efficacy of Meds? Yes ( )

No ( ) If 'Yes', explain: _____

MEDICAL INFORMATION FOR CHILD	
NAME OF PHYSICIAN:	Phone #:
Address:	
NAME OF DENTIST:	Phone #:
Address:	
NAME OF THERAPIST:	Phone #:
Address:	
NAME OF PSYCH.:	Phone #
Address:	

LATEST EVALUATION INFORMATION

Achievement Evaluation: (ex: Woodcock Johnson, etc)

Assessment/Test:_____ Date: _____

Results: _____

_____

Psychological Evaluation; (ex: WISC-III, etc.)

Assessment/Test: _____ Date: _____

Results: _____

_____

Consumer ID#: _____

EDUCATIONAL INFORMATION: If this form is completed between school terms, please give the information pertaining to the previous school year. If assistance is needed in completing the form, please consult the child's school.

Assigned School Grade: _____ In which grade(s) has the child been retained? _____

Attach copy of the child's report card for the latest reporting period

School performance this year is: ( )better than ( )equal to, or ( )poorer than pervious year

Education Setting: ( ) Regular Class ( ) Special Education ( ) Other (specify): _____

Has child been classified as special needs? ( ) Yes ( ) No If "yes" specify classification:

_____

Name of school currently/last attended: _____

Phone#: _____ Address: _____

School Transcript attached: ( ) Yes ( ) No Promised by date: _____

Attendance record for school year: # days in attendance: _____ # excused absences: _____

Number unexcused absences (suspension, expulsion, truancy, etc): _____

Explain: _____

Academic strengths:

Academic Weakness:

School behavioral strengths:

School behavioral weakness:

Recommended school information pertinent to this application: _____

_____

Recommended educational plan/program (IEP, etc):

Other special needs/talents, including extra-curricular activities and interests:

Additional school information pertinent to this application:

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Consumer ID#: _____

WHAT MAKES THIS CHILD:	WHO MAKES THIS CHILD:
Glad:	Glad:
Sad:	Sad:
Mad:	Mad:
Fight:	Fight:
Run:	Run:

From what agencies/professionals has the family sought or been given help? Specify services and the results.

AGENCY	SERVICES	RESULTS

OUT OF HOME PLACEMENTS

Name:_____ **Phone#:** _____ **Date of Care:** _____

Address: _____

Name:_____ **Phone#:** _____ **Date of Care:** _____

Address: _____

Name:_____ **Phone#:** _____ **Date of Care:** _____

Address: _____

Name:_____ **Phone#:** _____ **Date of Care:** _____

Address: _____

Consumer ID#: _____

Is there a history of delinquent behavior? ( ) Yes ( ) No If "yes" attach description including history of court involvement and a copy of any court order currently in effect.

Is this child suicidal? ( ) Yes ( ) No. If yes, attach history with description of attempts.

PLANNING : This section requires equal attention to the family and the child in answering the questions. If the child is in DSS custody attach a current copy of the out-of-home family services agreement
What is the Permanent Plan for this child?
Is there a current need to revise the Permanent Plan? ( ) Yes ( ) No If 'yes" explain: _____
State the goals toward which the family and child are working to achieve the permanent plan: See PCP
How will the requested services help the family and child achieve their permanent plan? See PCP

Identify in the order of your priority all agencies to which this application is being made:

1. _____ 2. _____

3. _____ 4. _____

Consumer ID#: _____

VII. SIGNATURE(S)

I (we), the undersigned, hereby apply to the (Name of agency) for services named above on behalf of the named child for whom I (we) hold legal custody and/or placement authority. I (we) certify that the information contained in this application and the attachments is true and accurate to the best of my (our) knowledge. I (we) agree to share additional information pertinent to this application as requested by the agency. I (we) also agree to cooperate with the agency and to support the plan of service to which we mutually agree.

_____ Date:_____
Print Name of ☐ Parent(s), ☐ Guardian, or ☐ Legal Custodian

_____ Date:_____
Signature of ☐ Parent(s), ☐ Guardian, or ☐ Legal Custodian

Voluntary Placement Agreement:

Name of Agency holding Voluntary Placement Agreement:_____

_____ Date:_____
Print Name of Representative of Agency holding Voluntary Placement Agreement

_____ Date:_____
Signature of Representative of Agency holding Voluntary Placement Agreement

CARS Agreement:

Name of Agency with whom CARS Agreement was signed:_____

_____ Date:_____
Print Name

_____ Date:_____
Signature

_____ Date:_____
Print Name of Representative of Agency with whom CARS Agreement was signed

_____ Date:_____
Signature of Representative of Agency with whom CARS Agreement was signed

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AUTHORIZATION TO OBTAIN ROUTINE AND EMERGENCY MEDICAL CARE

EMERGENCY CONTACT INFORMATION

Client Name: _____ Med. Record #_____

Social Security Number: _____ Date of Birth: _____

EMERGENCY CONTACT PERSON:

Name: _____ Relationship: _____

Primary Phone #: _____ Work Phone: _____

Other #: _____

Address: _____
Street City State Zip

PREFERRED LICENSED MEDICAL PROVIDER/ PRIMARY CARE PHYSICIAN:

Facility Name: _____ Phone #: _____

Address: _____
Street City State Zip

PREFERRED LICENSED HOSPITAL/MEDICAL PROVIDER:

Hospital Name: _____ Phone #: _____

Address: _____
Street City State Zip

ROUTINE MEDICAL CARE: I hereby give permission to the staff of THE UNIQUE CARING FOUNDATION, INC. to seek routine medical care on behalf of the above named client should the need arise.

EMERGENCY MEDICAL CARE: In case of sudden illness/accident/emergency, I hereby give permission to the staff of THE UNIQUE CARING FOUNDATION, INC. to seek emergency treatment on behalf of the above named client should the need arise. It is understood that a qualified medical professional, physician, and/or hospital emergency room personnel will provide this treatment. In addition, a copy of current medications and known medical conditions and allergies may be released. Efforts will be made to contact a person named below prior to treatment, should this be possible.

The above consent has been read by me or to me, and explained to me by an employee of THE UNIQUE CARING FOUNDATION, INC.. I agree with the above consents as evidenced by the signature below.

_____ _____
Consumer/Guardian/Legally Responsible Person Signature Date

_____ _____
Agency Representative Signature Date

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AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

This form **MUST** be returned to Unique Caring even if Person Served is **not** authorizing us to administer NON-prescription medications

PERSON SERVED: _____ Medical Record #: _____

( ) **NO**, I do not want Unique Caring Foundation service provider to give non-prescription medications to : _____ (name of person served)

_____ _____

Signature of Parent, Guardian, or Custodian Date Signed

* * * * *

As the physician/parent/guardian/custodian of _____ I agree to allow the staff and foster parents of **UNIQUE CARING FOUNDATION** to administer the following non-prescription medications only as needed for periodic treatment of condition as described below:
NOTE: Signature of physician is required if the client is currently taking prescription medication

EXTERNAL

Please **"X"** below the medications you consent to Unique Caring Foundation service provider administering.

Medication	For Treatment of
1. Neosporin or antibiotic ointment	Minor burns, cuts, abrasions
2. Calamine lotion (with or without Phenol)	Allergic rashes (poison ivy, poison oak, etc.)
3. Rubbing alcohol	Insect bites
4. Betadine scrubs or soap and water	Cleaning area of minor injury
5. Other: _____	For: _____

INTERNAL

Please **"X"** below the medications you consent to Unique Caring Foundation service provider administering.

1. Acetaminophen tablets (Tylenol, Datril, Panadol, etc.)	Headache or minor pain
2. Pepto Bismol liquid	Upset stomach
3. Kaopectate liquid	Diarrhea
4. Chlortrimeton tablets Chlorpheninamine (antihistamine)	Common cold or minor allergic Reaction to insect bites
5. Dextromethorphan (lozenge and spray form)	Cough
6. Cepacol or chloraceptic lozenge	Sore throat
7. Mineral oil	Constipation
8. Milk of Magnesia	Constipation
9. Benedryl capsules	Allergic reaction (bee stings)
10. Ipecac syrup	Induce vomiting (clear with doctor and/or emergency room before administering)
11. Other: _____	For: _____

_____ _____

Signature of Parent, Guardian, or Custodian Date Signed

_____ _____

Signature of Physician Date Signed

(signature of Physician is required if the client is currently taking prescription medication)

Non-prescription medicines are to be administered according to package directions and only for symptoms listed on the package labeling. If symptoms persist, the client's physician will be consulted.

Revised 8-21-09 revised 11/22/10

Copy given to_____, caregiver, on ____/____/____by_____

CHILD PHYSICAL EXAMINATION

(Please print all information)

Child's Name _____ Medical Record #: _____
Date of Birth _____ Sex: ( ) Male ( ) Female Race/Eth._____
County DSS _____ Name of Social Worker _____
Person Accompanying Child _____
Name of Examining Physician _____
Address_____ Telephone: _____

PHYSICAL EXAMINATION FINDINGS

Temp _____ Pulse _____ Respirations _____ Blood Pressure _____/_____
Height _____ (Percentile) ____ Weight _____ (Percentile) _____ Head Circum. _____ (Percentile) _____

Screening Vision (Circle One) HOTV SNELLEN PICTURE Hearing (Circle One) Belltone Hear Kit
R _____ L _____ OU _____ R _____ L _____ OU _____ With glasses? Yes ___ No ___

Development (Circle One): SCREEN DDST II PDQ NOT TESTED
Results: Untestable _____ Normal _____ Questionable _____ Abnormal _____
Comments:_____
Lab: Hgb/Hct (If indicated): Normal _ Abnormal_; TB Skin Test (If Indicated): Normal _ Abnormal _
Physical exam (0=normal, X=abnormal)
Head _____ Eyes ____ Ears _____ Nose ____ Mouth _____ Teeth _____ Throat _____
Breasts ____ Lungs ____ Heart _____ Abdomen ____ Genitalia ____ Extremities ____
Neurological ____ Skin/Nodes ____
Positive findings of any medical/dental conditions needing attention: _____
_____

Communicable Diseases: Tests (As Indicated)
_ VDRL Results:_____ _ HIV/AIDS Results:_____
_ HEPATITIS B Results:_____ _ OTHER Results:_____
Does child have signs or symptoms of any communicable disease(s) that would pose a significant risk of transmission in a household setting? ( ) Yes ( ) No ( ) Unknown_____
If yes, specify disease _____

Recommendations:
Additional tests:_____
Follow-up treatment:_____
Medications:_____
Immunizations provided:_____
Limitations on physical activity:_____
Other:_____
_____

Signature Examining Physician: _____ Date: _____

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CLIENT RIGHTS POLICY

1. Each individual who is admitted to a Unique Caring Foundation service will be informed of his/her rights as stipulated in 122C Article 3. A written summary will be given each participant and his/her legally responsible person.
2. All staff, care providers and volunteers are informed of the rights of the participants. Documentation of this training is signed by each staff member, care provider, contractor and volunteers and maintained by the program.
3. The Unique Caring Foundation Client Rights Committee will conduct an annual review of the Client Rights Policy, rights training and agency compliance with the Client Rights Policy.
4. Information provided to the participant will be consistent with their level of comprehension and will include: Protection regarding disclosure of confidential information; the governing body policies for fee assessment; grievance procedure; service suspension or expulsion; search and seizure procedure; and program rules with potential penalties.
5. Participants/legally responsible persons will be informed in terms they can understand about the potential risks and benefits of services, and will give consent to receive these services except in emergency situations or otherwise specified by laws.
6. Each voluntarily admitted individual has the right to refuse any treatment and or service.
7. If treatment is refused, the qualified professional will determine if another type of treatment is possible. If all appropriate modalities are refused, a voluntarily admitted consumer can be discharged. Refusal of consent should not be used as the sole grounds for termination unless the procedure is the only viable treatment/habilitation method available at the agency.
8. Documentation of informed consent will be placed in the individual's record.
9. Each individual will be encouraged to participate in appropriate, generally accepted social interactions and activities with other members of the community.
10. Special procedures and safeguards will be developed and implemented according to sound medical practice when a medication that is known to present serious risk to an individual is prescribed.
11. Care providers and staff will make every reasonable effort to protect each participant's personal clothing and possessions from theft, damage, destruction, loss or misplacement.
12. Each participant is assured the right to dignity, privacy and human treatment in the provision of personal health, hygiene and grooming care. Such rights include but are not limited to an opportunity for a shower or tub bath daily, the opportunity to shave daily, the opportunity to obtain individual personal hygiene articles which include but not limited to toothpaste, toothbrush, sanitary napkins, shaving cream and utensils.
13. Bath tubs or showers and toilets that ensure individual privacy will be available. Adequate toilet, lavatory, and bath facilities for use by an individual with mobility impairment may be available.

14. Each consumer will be provided a quiet atmosphere for uninterrupted sleep during scheduled sleeping yours and accessible areas for personal privacy for at least limited periods of time as clinically appropriate.
15. Each participant will maintain communication rights. Adult participants will have access to a telephone in a private area.
16. Individuals will be free from unwarranted invasion of his/her privacy. Searches of the individual or their property is warranted only when there is a reason to believe that they have possession of materials that are prohibited by the program's admission policy (including House Rules) or our agreement with the individual. All searches will be conducted according to the Unique Caring Foundation policy.
17. Each participant will be free from the threat or fear of unwarranted suspension or expulsion from the program. Any suspension or termination of services will comply with The Unique caring Foundation Suspension/Termination Policy.
18. Care providers and staff will not subject any participant to any sort of neglect or indignity or inflict abuse upon anyone. Care providers and staff will ensure to prevent the neglect or abuse of any participant in their care by others.
19. Care providers and staff are prohibited from engaging in ay acts that constitute a sexual offense, sexual molestation, sexual harassment or sexual abuse.
20. All instances of alleged or suspected abuse, neglect or exploitation of consumers will be reported to the appropriate county Department of Social services, Division of Facility Services and the Healthcare Registry. Persons reporting instances of abuse, neglect or exploitation will be protected from harassment or threats.
21. The goal of the agency is to provide services using the least restrictive, most appropriate and effective positive modality.
22. Each participant will be free from unnecessary or excessive medication.
23. The following restrictive interventions are <u>not used at all</u>: Seclusion, physical restraint, isolated time out (see policy).
24. The following types of procedures are <u>prohibited</u>: Interventions prohibited by statute, corporal punishment, painful body contact, substance administered to induce painful bodily reactions, unpleasant tasting foodstuffs, noxious situations or substances, noise, bad smells, splashing with water, potentially physically painful procedures, electric shock, and insulin shock.
25. Use of protective devices will not be permitted unless the following conditions are met: The device has been assessed, it is the least restrictive appropriate measure, the individual is monitored at all times and the devices are cleaned at regular intervals.
26. The Unique Caring Foundation and our care providers reserve the right to establish rules regarding acceptable behaviors and medical records requirements. Violation of these rules may cause a service disruption and replacement or suspension/termination. Service suspensions or terminations will comply with The Unique Caring Foundation policies and the Grievance Procedure.
27. Participants/legally responsible persons may recommend changes in program policies and procedures or agency governance.
28. Each participant maintains all civil rights unless adjudicated incompetent.

29. Participants have the right to contact the Governor Advocacy for persons with Disabilities and will be given assistance by the program staff if necessary. The telephone number for the council is 1-704-433-2067.
30. The Grievance Policy and procedure is distributed to all participants and/or family members upon admission to the program. This policy allows consumers, family members, significant others, care providers and staff to express concerns about services and what response they may expect. The procedures include how to concern/complaint is to be expressed, to whom the concern/complaint should be addressed, a time frame for a response, and subsequent levels of management to contact if the response is unsatisfactory.

Referral to the Advocate may be made at any point in the grievance process. Referrals to the appropriate Governor's Advocacy Council staff may be made at any point in the process. Each complaint will be evaluated and may be referred to the Client Rights Committee for investigation at any point.

_____ _____

Employee/Contractor/Provider Legally Responsible Person Signature Date

_____ _____

Witness Signature Date

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NOTIFICATION OF RECEIPT OF CLIENT RIGHTS INFORMATION

I have received and read a copy of the client rights policies and procedures, which is a written summary of 122C, Article 3. I understand it is regarding client rights and responsibilities. My questions that I had regarding client rights have been answered.

I also understand that specific programs may have additional policies and procedures pertaining to client rights and that those will be explained to me upon initiation with those programs.

I have received the following information:

1. Rules and responsibilities that I am expected to follow regarding client rights and that I accept the penalties for any violation of the rules.
2. Protections regarding disclosure of confidential information
3. Policies addressing fee assessment and collection practices
4. Grievance policy and procedure and name of contact person.
5. Search and Seizure policies & procedures
6. Notification of provisions regarding emergency use of restrictive interventions

I understand that failure to comply with these regulations could result in dismissal from employment with The Unique Caring and may result in legal consequences.

_____ _____

Signature Legally Responsible Individual Date

_____ _____

Signature Witness Date

THE UNIQUE
CARING
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"BUILDING BRIDGES TO THE COMMUNITY"
www.uniquecaringfoundation.com

CONFIDENTIALITY AGREEMENT FORM

I, _____, a

[ ] Legally Responsible Individual [ ] Provider/Contractor

[ ] Staff [ ] Other: _____

of The Unique Caring Foundation, Inc. acknowledge that policies related to confidentiality have been provided and explained to me. I understand that information about foster children and their families will be shared for the purpose of providing foster care services. I also understand that this information is shared with others only when there is a need to know and when there is a written working agreement between agencies, or a specific signed release for information has been executed. I also understand that this information cannot be shared with individuals and/or agencies that have no direct need for the information. I further understand that my affiliation / relationship with The Unique Caring Foundation, Inc. can be terminated if I violate the agency's confidentiality policy. I understand and I am willing to comply with these confidentiality requirements.

_____ _____

Print Name: Legally Responsible Individual/Contractor/Provider / Staff Date

_____ _____

Signature: Legally Responsible Individual/Contractor/Provider/Staff Date

_____ _____

Signature: Social Worker/Supervisor or Designee Date

Confidentiality agreement/cliviamilburn

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Name of Consumer: _____ Medical Record #: _____

CONSENT FOR ROUTINE AND OVERNIGHT TRAVEL

During the course of placement, the client may require ROUTINE AND OVERNIGHT travel and transportation to appointments, school, various activities, community outings, and trips both in and out of the State of North Carolina.

The parent/guardian/legally responsible individual: _____ gives permission for **THE UNIQUE CARING FOUNDATION** staff and foster parents to transport : _____ by use of personal or agency vehicle. This consent is valid until discharge from the program or by written termination of permission by parent/guardian/legally responsible individual.

Emergency Contact Person:	Address: Street/City/State	
Home telephone #	Work telephone #	Cellular telephone #

I have read this consent or it has been read and explained to me. I agree with the above consent as evidenced by my signature below.

_____ _____
Parent/Guardian/Legally Responsible Individual Signature Date

_____ _____
Witness Signature Date

Unique Caring Foundation, 5500 Executive Center Drive, Suite 118, Charlotte, North Carolina 28212

THE UNIQUE CARING FOUNDATION
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CONSENT FOR SERVICES FORM

PERSON SERVED: RECORD #:

1. I request admission for evaluation, treatment or habilitation. Should staff determine that admission for services is appropriate, I consent for treatment as deemed necessary. I understand that I may withdraw from services at any time unless ordered by a court of law to attend.
2. I authorize The Unique Caring Foundation staff to seek emergency medical or dental care in the event that I become ill or have an accident while participating in services. This shall include emergency first aid by authorized personnel for the agency. I further understand that I will assume financial responsibility for any necessary medical care, including payment of physician, emergency room and rescue unit charges.
3. I understand that certain information from my record may be continued in a computerized record system for reimbursement, statistical and program planning purposes.
4. I understand that as a Person Served of services from a contract affiliate agency of the Area Mental Health/Developmental Disabilities/Substance Abuse Services and/or Youth and Family Services, I shall receive appropriate treatment and continuity of care. In order to accomplish this, information may be shared between treating agencies for quality care without consent in accordance with G.S. 122C-52 through 122C-56.
5. Person Served records relating to substance abuse are protected by Federal Confidentiality rules (42CFR Part 2). The Federal Rules prohibit this agency or its staff from making any disclosure regarding the person to medical or other information IS NOT sufficient for this purpose.
6. If I participate in a supervised program activity which involves transportation, I consent to be transported and hold The Unique Caring Foundation and its staff harmless in case of accident or injury.
7. I have received a copy of The Unique Caring Foundation Person Served Rights and Responsibilities Handbook, which contains a summary of my rights as a Person Served as defined in F.S. 122C, Article 3. The contents of the Handbook were explained to me, especially rules I am expected to follow, how to obtain a copy of my treatment plan, and how to file a consumer grievance. I was informed how to contact the Governor's Advocacy Council for Persons with Disabilities and local advocacy groups. I understand this information as explained to me.

The doctrine of informed consent for release of information has been explained to me, and I understand the contents to be released/exchanged, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. 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.

This Consent is VALID for 1 year from date of Signature:

_____ _____

Signature of Person Served OR Guardian/Legally Responsible Person Date

_____

Print Name of Person Signing Above

_____ _____

Signature of Witness Date

THE UNIQUE CARING FOUNDATION

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CONSENT FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

NAME: _____ **RECORD #:** _____

I, _____ , hereby authorize Unique Caring Foundation, Inc. and
(Person receiving service or Legal Representative)

_____ to release, exchange, and/or communicate with one
Agency or Person to whom the requested use or disclosure will be made

another the protected information that is listed below

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

_____ Psychological Evaluation of _____
_____ Psychiatric Evaluation of _____
_____ Progress Notes from _____ to _____
_____ Intake Assessment
_____ Diagnosis
_____ Service Plan
_____ Screening/Contact Assessment Form
_____ Other/Disclosures made regarding: _____

_____ HIV/AIDS
_____ Alcohol/Drug Treatment*
_____ STD
_____ Hepatitis
_____ Tuberculosis
_____ Medication Information
_____ Financial/Reimbursement

The purpose of the disclosure is for:

Service Delivery ☐ Continuity of Care ☐ Referral ☐ Other ☐ _____
(At the Request of the Individual)

I understand that this authorization will expire on the following date, event, or condition: _____

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

RE-DISCLOSURE: Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient for re-disclosing it. Other laws, however, may prohibit re-disclosure. When Unique Caring Foundation disclose mental health and developmental disabilities information protected by state law (NCGS 122C) or substance abuse treatment information protected by federal law (42CFR 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 is permitted or required by these two laws.

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

_____ _____
Signature of Person Receiving Supports ***Date***

_____ _____
Signature of Personal Representative/Legal Guardian or Parent of a Minor Child, (If Required) ***Date***

_____ _____
(Witness, only if Person receiving services signs with a mark) *Date*

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

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_____ Hepatitis
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Service Delivery ☐ Continuity of Care ☐ Referral ☐ Other ☐ _____
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Rev. 6/18/11

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(Person receiving service or Legal Representative)

_____ to release, exchange, and/or communicate with one
Agency or Person to whom the requested use or disclosure will be made

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

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The purpose of the disclosure is for:

Service Delivery ☐ Continuity of Care ☐ Referral ☐ Other ☐ _____
(At the Request of the Individual)

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THE UNIQUE
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VIDEOTAPING AND PHOTOGRAPHING CONSENT FORM

Client Name: _____ Medical Record #: _____

I, (Name of Consumer/Parent/Guardian/Legally Responsible Person), _____
hereby authorize THE UNIQUE CARING FOUNDATION, INC. to MAKE and USE the following:

Check all boxes consumer authorizes by this consent

- ☐ Audio-Visual recordings
- ☐ Photograph of my image

The Unique Caring Foundation, Inc. will use these recordings for the purpose of identification, promotional and public awareness.

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

_____ _____
Client Signature (required if age 12 or older) Date

_____ _____
Parent/Guardian/ Legally Responsible Person Signature Date

OR

I decline authorization of audio-visual recordings and photographic imaging of :

Client Name: _____ .

_____ _____
Client Signature (required if age 12 or older) Date

_____ _____
Parent/Guardian/ Legally Responsible Person Signature Date

THE UNIQUE CARING FOUNDATION

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PERSON SERVED EMERGENCY INFORMATION

CONSUMER NAME: _____ **Med. Record #**_____

PERSONAL INFORMATION:

SS#:	DOB:	Medicaid#
Sex:	Race:	Height:
Weight:	Eye Color:	Hair Color:
Identifying Marks or Scars:		
Address (foster home):		Telephone #:

DSS/GUARDIAN INFORMATION:

Full Name:		
Address:		
Telephone Contact Information:		

CASE MANAGER INFORMATION (if applicable)

Full Name:		
Address:		
Telephone Contact Information:		

MEDICAL AGENCY:

Name:		Phone #:
Address:		
Medical Alerts: ( ) No ( ) Yes Explain:		
Allergies: ( ) No ( ) Yes Explain:		
Seizures: ( ) No ( ) Yes Type:	Diabetes: ( ) No ( ) Yes	Hep. B: ( ) No ( ) Yes
Medications:		
Special Diet: ( ) No ( ) Yes Explain:		

Med. Record #_____

THERAPIST INFORMATION:

Name:	Phone #:
Address:	
Medical Alerts: ( ) No ( ) Yes Explain:	
Allergies: ( ) No ( ) Yes Explain:	
Medications:	

Please Check All that apply:

CATEGORY	YES	NO	CATEGORY	YES	NO
Physical Aggression			Property Destruction		
Verbal Aggression			Other Behavior(s)		
Substance Abuse			Psychotic		
BEH			Suicidal		

Explain: _____

Communication Level: _____ Communication Method: _____

Vision: _____ Hearing: _____ Respond to Own Name: ( ) Yes ( ) No

Explain: _____

Signature of Person Completing Form: _____

Print Name: _____ Date: _____

Relationship to Person Served: _____

THE UNIQUE
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PERSON SERVED GRIEVANCE POLICY & PROCEDURE FORM

PERSON SERVED:_____ **MEDICAL REC.#:**_____

Providers of The Unique Caring Foundation, Inc. will at all times respect the rights of clients as individuals. If at any time a client wishes to express dissatisfaction with services or feels that his/her rights or the rights of another have been violated, he/she shall have access to a process through which the grievance will be fairly considered, investigated and appropriately acted upon. The Unique Caring Foundation, Inc. shall give high priority to being responsive to appropriate requests for help.

PROCEDURE:

A. Clients have the right to make a grievance about any aspect of The Unique Caring Foundation, Inc. services or operation.

B. Clients will be informed of the grievance procedure at first face to face contact and anytime upon client's request. Where a client may be incapable of making or pursuing a grievance because of mental disability, mental retardation, or as an effect of treatment, staff shall act on the client's behalf in accordance with this policy. At the time a complaint is initiated, the client will receive a new copy of the detailed grievance procedure.

C. The manner of dealing with the grievance serves as a vital source of information for assessing and improving the quality of service therefore, The Unique Caring Foundation, Inc. has established a mandatory reporting requirement. Any employee or other staff, who is the recipient of, is witness to, or who otherwise becomes aware of a complaint is required to facilitate the reporting of it in writing according to procedures defined under this policy. Where clients or others may have difficulty registering a complaint, employees of The Unique Caring Foundation, Inc. are required to help them.

D. There shall be no penalty, or retaliation direct or indirect, for any action reasonably taken by any employee or other staff acting in compliance with this policy.

E. Review and response to client grievances shall be investigated through established administrative channels as follows:
    a. Client shall present complaint to any staff or provider and/or to the Executive Director. The person receiving the complaint must forward it to Human Resources within 1 – 2 working days. Human Resources will respond to the complaint and to the consumer within 1 to 2 working days of receipt, or sooner if clinically indicated. Response may include one or all of the following: letter, meeting, or specific action as documented on the client complaint form.

F. Upon its completion of "Step E", the Grievance and Complaint Report must be received by the Executive Director who shall take one of the following actions within 2 to 5 days of receiving the complaint:

1. Determine that there is *no reasonable cause for complaint.* If the Executive Director determines the complaint was unfounded and documents this in writing, by checking the appropriate line on the bottom of the complaint form. The complainant must sign the complaint form again indicating that they have been informed of this determination.
2. If the Executive Director is *able to offer a resolution that is acceptable to the complainant,* this resolution will be documented on the complaint form. The complainant must check the appropriate line on the complaint form and sign the bottom of the complaint form indicating that they agree that the proposed resolution is acceptable.
3. *Attempt to resolve the complaint, but finds that his/her proposed resolution is not satisfactory to the complainant.* If the Executive Director is unable to resolve the complaint, this will be indicated on the complaint form and forwarded to the Quality Assurance/Quality Improvement Committee.

If it is determined that an investigation is required or that the matter cannot be resolved no later than five (5) days. If a lengthy investigation is anticipated, the Quality Assurance/Quality Improvement Committee should document on the complaint form the expected length and scope of the investigation.

G. A summary of all complaint reports and their resolutions shall be submitted to the Quality Improvement Committee at the first meeting of this body after report is received by the Executive Director.

H. Right of Appeal: The complainant or other party involved in the complaint may appeal the decision which will be processed through the Executive Director and Quality Improvement Committee. All parties will receive notification of results of appeals.

I. This procedure does not preclude or prohibit the client from contacting advocates who are outside of the agency. At any point during the client's care, he will be afforded the opportunity to contact officials from the Department of Social Services, Disability Rights North Carolina, formerly (the Governor's Advocacy Council for Persons with Disabilities Council) – Voice 919-856-2195, Toll Free Voice 877-235-4210, TTY 888-268-5535 or Email: Info@disabilityrightsnc.org, an attorney and/or Guardian Ad Litem.

J. A file of complaints shall be maintained by the owner and shall remain on file until the end of the second calendar year after the one in which complaint was filed.

_____ _____

Signature of Person Served/Guardian/Legally Responsible Person Date

_____ _____

Signature of Witness Date

CONFIDENTIALITY / HIPPA

This policy is to ensure that a basic understanding of general information regarding confidentiality rules, laws, and regulations have been identified to inform The Unique Caring Foundation, Inc. staff and others as deemed appropriate as cited in GS 122C51-56.

All client records are the property of The Unique Caring Foundation, Inc. Any information received from other agencies or individuals regarding a client will be placed in the client's record at The Unique Caring Foundation, Inc. Any release of client information, whether generated by The Unique Caring Foundation, Inc. or obtained from other agencies/individuals requires a valid consent for release. All records, including those which contain confidential information that are generated in connection with the performance of any function of an area or state facility, are the property of the facility.

Safeguards are in place to ensure that any confidential information, including financial and employee/provider/contractor/board of directors records and/or records stored in an electronic system will be protected. Secure passwords are needed by authorized staff to access any data in the computer database. All staff/contractor/provider/board of director will sign off any computer screen when not in use. When staff is no longer employed by The Unique Caring Foundation, Inc., access will be denied by removing the password from the system. The Unique Caring Foundation, Inc. shall develop written policies and procedures regarding the provision of safeguards to ensure controlled access to automated data processing system.

Confidential information regarding substance abusers shall be released or disclosed in accordance with the federal regulations 42 CFR Part 2, Confidentiality of alcohol and Drug Abuse Patient Records, which are adopted by reference pursuant to G.S. 150B-14©, unless the rules in this Subchapter are more restrictive in which case the rules in this Subchapter shall be followed..

Assurance of Confidentiality
Client information is confidential. The Unique Caring Foundation Inc. shall develop written policies and procedures in accordance with the rules of Federal and State statutes The Unique Caring Foundation, Inc. shall provide training to all individuals with access to confidential information, All employees, students, volunteers, auditors and others with access hall indicate an understanding of the requirement governing client confidentiality by signing the confidentiality agreement which indicates an understanding of the requirements governing confidentiality by signing a statement of understanding and compliance. Employees shall sign such statement upon employment and again whenever revisions are made to the policy. The form will include the date and signature of the individual and his/her title; facility name (The Unique Caring Foundation, Inc.); statement of understanding; agreement to hold information confidential and acknowledgment of civil penalties and disciplinary action for improper release or disclosure. The Executive Director or designee is responsible for providing confidentiality training and for ensuring that each new employee signs the confidentiality agreement form at the time of orientation. All confidentiality agreement forms will be maintained in the personnel office.

The Executive Director or designee is responsible for:

- Providing basic confidentiality training to new employees within one working day of starting work. The confidentiality agreement form is signed by each employee and forwarded to the Executive Director or designee.
- Providing confidentiality reviews during the annual employee evaluation.
- Notifying all employees of changes/revisions in the law and procedures at staff meeting and by memo.

AND

- Obtaining the confidentiality agreement from persons having access to confidential information within their possession, including, but not limited to, students, interns, researchers, auditors, volunteers, non Unique Caring Foundation treating professionals, etc. The forms are to be forwarded to the personnel office.
- The disclosure and/or release of confidential information but may delegate the authority for disclosure and/or release to other persons under his/her supervision. In the absence of the Executive Director, the assistant Executive Director has the authority to disclose confidential information.

Liability of Persons with Access to Client Information

Failure to comply with state regulations constitutes a misdemeanor. Individuals employed by The Unique Caring Foundation, Inc. are subject to possible suspension, dismissal or other disciplinary actions for failure to comply with rules on confidentiality. This is punishable by a fine not to exceed ($500.00). Violation of federal regulation is a crime punishable by a fine of not more than ($500.00). Individuals, other than employees but Foundation including students and volunteers, who are agents of the Department of Health and Human Services who have access to confidential information at the facility who fail to comply with the rules in this Subchapter shall be denied access to confidential information by the facility.

Security of Records

Measures to safeguard all confidential information shall be made by The Unique Caring Foundation, Inc. and all staff. The Executive Director shall ensure that only authorized staff shall have access to the client records. Client records must be maintained in a secured location with controlled access. Location of records must be secured at all times. The Executive Director shall develop written policies and procedures regarding controlled access to those records. The Executive Director shall develop written policies and procedures regarding controlled access to those records. The employee to whom the record is signed out is responsible for the records. All the records must be returned to the client record area at the end of the day.

The original client record may not be taken from the premises except under the following conditions:

- In response to a subpoena and/or court order.
- Transfer of facilities within the program.
- Audit purposes within the program.
- For emergency purposes (life threatening) the record may be securely transported to a local health care provider in custody of a delegated employee.
  In accordance with a subpoena to produce document or object or other order of the court or when client records are needed for district court hearings held in accordance with Article 5 of Chapter 122C of the N.C. General statutes; whenever client records are needed for treatment/habilitation or audit purposes, records may be transported within an area facility or between state facilities; in situations where the facility determines it is not feasible or practical to copy the client record or portions thereof, client records may be securely transported to a local health care provider, provided the record remains in the custody of a delegated employee; whenever a client expires at The Unique Caring Foundation, Inc. and an autopsy is to be conducted, the client record may be transported to the agency wherein the autopsy will be performed.
  Provided the agency complies with Rule .0108 of this Subchapter.

- In situations when it is not feasible or practical to copy the record the client record may be securely transported to a local health care provider, provided the record remains in the custody of the employee.
- Whenever a client expires and an autopsy is to be conducted, the record may be transported to the agency wherein the autopsy will be performed.

Notice to Client

The client shall be notified on admission (or as soon as possible), of the conditions surrounding the release and/or disclosure of client confidential information. The Unique Caring Foundation Inc. shall give written notice to client and/or legally responsible person at the time of admission that disclosure written notice to client and/or legally responsible person at the time of admission that disclosure may be made of pertinent information without his/her expressed consent in accordance with GS 122C-52 through 122C-56. This notice shall be explained to the client and/or legally responsible person as soon as possible. This information is incorporated in The Unique Caring Foundation, Inc. consent for services form. This document is required to be signed by the client legally responsible person, witnessed and dated on admission and placed in the client record (or as soon as possible).

Client Access

A client and/or legally responsible person may request access to information in his/her client record. Whether to allow access to the client record will be determined by the Executive Director. If the Executive Director believes access would be injurious to the phys8cal or mental well being of the client, he shall consult with the client and/or legally responsible person to determine whether to grant access. The qualified professional shall determine whether to grant access and shall document reasons for either the release or denial of information.

If the client and/or legally responsible person are denied access to the record, the client may request that copies be sent to a physician or psychologist. In this event, the information shall be released. The client must sign an authorization to release the client's records.

If the client and/or legally responsible person are granted access to review his record, he may also receive copies. The Executive Director and/or designee determine if the client receives copies of their record with or without a clinician present. A cost may be incurred by the client according to the fees for reproduction of the client record. The Executive Director shall ensure that a clinical staff member is present in order to explain and protect the record when a client or a client's legally responsible person comes to the facility to review the client record. A delegated employee shall document such review in the client's record.

Information shall be provided to the next of kin or other family member who has a legitimate role in the therapeutic services offered or other person designated the client or legally responsible person in accordance with GS 122C-55.

Fee for Reproduction

- Reproduction of the consumer records will be a uniform feel of five dollars ($5.00) for up to three pages and fifteen cents ($0.15) for each additional page, postage and handling shall also be charged.
- There shall be no charge in the following situations:
    1. Professional courtesy when records are requested by physicians, psychologist, hospital or other health care providers.
    2. Third party payers when The Unique Caring Foundation Inc. will derive direct financial benefits.
    3. Providers of support services as defined in G.S. 122C-3.
    4. Attorney's representing the Attorney General's office and Special Counsel.

5. Other situations determined by The Unique Caring Foundation, Inc. to be for a good cause.
6. When indigent consumers request pertinent portions of their consumer records necessary for the purpose of establishing eligibility for SSI.

Access of Record by Non-Custodial Parent
While a court may award custody to one parent, the order may reserve certain rights including the right to participate in decisions regarding health, education, and welfare of the child to the non-custodial parent. Therefore, a copy of the recent custody order should always be filed, maintained, and referred to in the child's client record.

Regardless of the court order, the only exception for both custodial and non-custodial parent not having access to the child's record is when that information would be injurious to the client's physical or mental well being as determined by the attending physician or, if there is none, the Executive Director. If access is granted to the non-custodial parent, always contact the custodial parent prior to the non-custodial parent's review of the record.

Access of Record by the Guardian Ad Litem
In every case where a child is alleged to be a victim of child abuse or neglect, the court appoints a Guardian Ad Litem (GAL) to speak for the child, and to represent the child through litigation. The Guardian ad Litem, a citizen and trained volunteer, advocates for the child as an investigator, protector and spokesman.

GS 7A-586 states that GAL, if granted in a court order, has the authority "to demand any information or reports whether or not confidential, that may in the GAL's opinion be relevant to the case. "In other words, the agency is required to disclose any information the GAL deems relevant to the child's case upon proper and valid request. The order contains similar wording. There are two exceptions:

- The judge may limit the order regarding agencies, persons, or kinds of information that the GAL may obtain under #1 of the court order of appointment.
- This order does not apply to substance abuse clients which come under the Drug and Alcohol Abuse Regulation, 42 CFR Part 2.

Before releasing client information to the GAL, always:

- Obtain a copy of "Order to Appoint a GAL and Attorney Advocate" and "Order to Release Records".
- Refer the request and order to the Executive Director.
- Determine if the order is valid, limited, and if the substance abuse regulations apply to the Unique Caring Foundation. client.
- Verify the identity of the GAL by requesting to see picture ID.
- If there are concerns regarding the confines of the GAL, make inquiries to the Clerk of Court.
- If there are concerns regarding the confines of the GAL appointment or right to continue to receive client information, verify appointment with attorney and document verification on back of GAL order.
- When the order and identity of the GAL is validated, proceed with agency procedure for release of information.

Access of Record in a Worker's Compensation Case
Once an employee reports and files their case as a "Worker's Compensation Case", with the NC Industrial Commission, and IC file number is assigned to the case and shall be provided on all written requests before client information can be released. NC GS 97-27 states that a medical

examination required by the employer is not privileged and can be disclosed without client consent. This law is currently interpreted too broadly and attorneys, insurance companies, etc, usually request more client information that the law allows.

Before releasing client information:

- All requests for client information pertaining to a Worker's Compensation Case require a valid authorization by the client and/or legally responsible person information is released. Exception: the medical examination will be disclosed if the IC file number is provided.
- Release copies of records free of charge, based on the NC IC 994 minutes.

Access of Record by Department of Social Services

Gs 7a-544 authorizes the Executive Director of county social services or the Executive Director's representative, when carrying out his/her investigative duties in response to a report of child abuse, neglect, dependency or death by maltreatment, to make a written demand for any information of reports that the Executive Director or designer believes to be relevant to the protective servicers case. The Unique Caring Foundation, Inc. must provide access to and copies of the requested information, whether or not the information is confidential, unless the information is protected by the attorney-client privilege or its disclosure is prohibited by federal law (42 CFR Part 2). Effective October 1, 1995, GS 7A-544 was amended to clarify that the statutes applies not only to information relevant to the investigation of a report but also to information relevant to the "provision of Protective services" after the substantiation of a report. DSS will have access to all client records in accordance with rule GS 122C-25.

Observation, Audio Video Taped and Photographing of Clients

Just as client information contained in the client record is private, so to are observations and tapings, including photographs made of clients. The client's right to privacy extends to include the consenting to and the release of observation, taping and photographs

Consent for Release

The Unique Caring Foundation, Inc. may not release any confidential information until an Authorization for Release of Information form has been obtained. Disclosure without authorization shall be in accordance with GS 122C.

When consent for release of information is obtained by The Unique Caring Foundation, Inc. an Authorization to Release form containing the information below shall be utilized. The form shall contain:

- Client's name.
- Name of facility releasing the information.
- Name of individual(s), agency to which information is being released.
- Information to be released.
- Purpose of release.
- Length of time consent is valid.
- A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent.
- Signature of individual witnessing consent.
- Unless revoked sooner by the client or legally responsible person, a consent for release of information shall be valid for a period not to exceed one year except under the following conditions:
    - A consent to continue established financial benefits shall be considered valid until cessation of benefits.

OR

- A consent for release of information to the Division, the Department of Motor Vehicles, the court and the Department of Correction for information needed in order to reinstate a client's driving privilege shall be considered valid until reinstatement of the client's driving privilege.

Consent for release of information received from an individual or agency not covered by the rules does not have to be on the form utilized by The Unique Caring Foundation, Inc. however, the receiving facility shall determine that the content of the consent form substantially conforms to the requirements.

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

Confidential information relative to a client with HIV infection, AIDS or AIDS related conditions shall only be released in accordance with GS 130A-143. Whenever authorization is required for the release of this information, the consent shall specify that the information to release includes the information relative HIV infection, AIDS or AIDS related conditions. Documentation shall include the consent form, the date the information was released and signature of the person who will be releasing information.

Verification of Authorization in Cases of Doubt
Whenever the validity of an authorization is in question The Unique Caring Foundation, Inc. shall contact the client and./or legally responsible person to confirm that the consent is valid. Such determination of validity of the consent shall be documented in client record.

Informed Consent
Prior to obtaining consent for release of confidential information, the delegated employee shall inform the client and/or legally responsible person that the provision of services is not contingent upon such consent and of the need for such release. The client or legally responsible person shall give consent voluntarily.

Documentation of Release
Whenever confidential information is released with consent, the Executive Director shall ensure that documentation of the release is place in the client record. Such documentation shall include the consent form and the date the information was released and signature of the Executive Director who has released the information.

Information of Disclosure
The Executive Director shall ensure that documentation of the disclosure is recorded in the client record containing the following:

- Name of recipient.
- Extent of information disclosed.
- Specific reasons for disclosure.
- Date
- Full and legible signature of the individual who disclosed the information and title.

Whenever The Unique Caring Foundation, Inc. makes repeated disclosures to a provider of support services concerning the same client, the disclosing facility may document such disclosures one time in the client record. Whenever confidential information is disclosed in accordance with GS 122C-55(e), the reason written consent could not be obtained shall be documented in the client's record. Whenever confidential information is released with consent, the Executive Director shall ensure that

documentation of the release is placed in the client record. Such documentation shall include the consent form, the date the information was released and signature of the Executive Director who has released the information.

Prohibitation against Re -Disclosure
The Unique Caring Foundation, Inc. shall inform the client and/or legally responsible person that re-disclosure of confidential information is prohibited without client and/or legally responsible person's consent. A stamp may be used to fulfill this requirement.

Persons Who May Sign Consent for Release
The following person may sign consent for release of confidential information:

- The competent adult client.
- The client's legally responsible person if an incompetent adult or minor.
- Minor clients under the following conditions:
  - When seeking services for venereal disease and other diseases' reportable under GS 130A, pregnancy, abuse of controlled substances or alcohol, or emotional disturbances under (GS 90-21.5).
  - When married or divorced.
  - When emancipated by a decree issued by a court of competent jurisdiction.
  - When a member of the armed forces.
  - Personal representative of a deceased client if the estate is being settled or next of kin of a deceased client if the estate is not being settled.

The Unique Caring Foundation, Inc. shall give written notice to the client of the legally responsible person at the time of admission that disclosure may be made of pertinent information without his expressed consent in accordance with G.S. 122C-52 through 122C-56. This notice shall be explained to the client or legally responsible person as soon as possible. The giving of notice to the client or legally responsible person shall be documented in the client record.

Persons Designated to Release and/or Disclose Confidential Information
The Executive Director shall be responsible for the release and/or disclosure of confidential information but may delegate the authority for release and/or disclosure to other persons under his/her supervision. The delegation shall be in writing.

Release to Client Rights Committee Member and Area Board Members
Client Rights Committee members may have access to confidential information only upon written consent of the client or legal guardian. The Executive Director shall release confidential information upon written consent to the Client Rights Committee members only when such members are engaged in fulfilling their functions as set forth in
10 NCAC 26/B.0207 and when involved in or being consulted in connection with the training or treatment of the client. Client Rights Committee members may have access to non-identifying client information.

Area Board Members may have access to confidential information only upon written consent of the client and/or legally responsible person. Area Board Members may have access to non-identifying client information. Internal client advocates may disclose confidential information obtained while fulfilling monitoring and advocacy functions.

Review of Decisions
Clients, clients' legally responsible persons or employees may request a review of any decisions made under the rules in this Subchapter by the Executive Director or if elsewhere within the Division, by the Division Executive Director.

NOTIFICATION OF RECEIPT OF CONFIDENTIALITY/HIPAA INFORMATION

The Unique Caring Foundation, Inc. shall give written notice to the client of the legally responsible person at the time of admission that disclosure may be made of pertinent information without his expressed consent in accordance with G.S. 122C-52 through 122C-56. This notice shall be explained to the client or legally responsible person as soon as possible. The giving of notice to the client or legally responsible person shall be documented in the client record.

I have received and read a copy of the confidentiality/HIPAA policy and procedure I understand it and my questions that I had regarding confidentiality/HIPAA have been answered.

_____ _____

Signature of Guardian / Legally Responsible Individual or Client (18yrs or older) Date

_____ _____

Signature Witness/Staff Date

The Unique Caring Foundation, Inc., 5500 Executive Center Drive, #118, Charlotte, NC 28212 704-569-8654 (o)

PHYSICIAN INFORMATION FORM

Consumer Name:_____ **DOB**_____ **Medical Record #:** _____

SPECIALTY	PHYSICIAN NAME / PERSON NAME	ADDRESS	PHONE NUMBER	DATE OF LAST VISIT
PRIMARY CARE				
DENTIST				
THERAPIST				
PSYCHIATRIST / PSYCHOLOGIST				
MEDICATION EVALUATION				
EYE DOCTOR				
PROBATION OFFICER				
MEDICATIONS:	1.	2.	3.	
4.	5.	6.	7.	

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www.uniquecaringfoundation.com

PHYSICIAN'S ORDERS FORM

NAME OF PERSON SERVED: _____

D.O.B: _____ **MEDICAL RECORD #:** _____

INSTRUCTIONS:

- A signed order is required for each visit in which there is a medication change (new or discontinue).
- Orders for administering medications must include the dosage and schedule for administration.
- Orders must be renewed every 6 months.
- A Medication Information form is required for prescription medications. If the resident has a legal guardian, an Authorization to Administer a Medication form is required for psychotropic and over-the-counter medications.

Date: _____ **Type of Service:** Foster Care

Diagnosis (Optional): _____

Orders for Treatment: _____

Medication Name	Strength	Dosage	Frequency	Discontinue Date If Any	Initial if PRN	Authorization to self -administer

OVER-THE-COUNTER PRN MEDICATIONS

The medications initialed below may be given as directed:

( ) Acetaminophen: (Tylenol) 2 tablets (350/500 mg. ea.) every 4 hours, (max 10 per day) as needed for pain or fever.
( ) Ibuprofen: (Advil) 1-2 tablets (200 mg. ea.) every 4 hours, (max 10 per day), as needed for pain.
( ) Pepto Bismol: 2 tablespoons per hour (max 8 tbsp/day) as needed for nausea.
( ) Loperamide HCl: (Imodium AD) 2 tablets (2 mg. ea.), then 1 tablet every 4 hours (max 4 per day), as needed for diarrhea.
( ) Methylcellulose: (Metamucil) 1 heaping tablespoon in 1 cup of juice 3 times per day, as needed for constipation.
( ) Casanthranol & Docusate Sodium: (PeriColace) 2 capsules at bedtime (max 2 days), as needed for constipation.
( ) Guaifensin & Destromethorpan: (Robitussin DM) 2 teaspoons every 4 hours, as Needed for persistent cough with cold or flu.
( ) Tolnaftate (spray or ointment): (Tinactin) apply topically to feet twice daily for up to 7 days for fungal infection.
( ) Other O-T-C PRN medications (please specify dosage and frequency). _____

_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** ____/____/____

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PROVIDER CHOICE FORM

Consumer Name: _____ Med. Rec. #: _____

Parent/Guardian/Legally Responsible Person: _____

This is to confirm that _____,
(Consumer/ Parent/ Guardian/ Legally Responsible Person)
has chosen to receive Foster Care services from The Unique Caring Foundation, Inc. I have been made aware of other contracting agencies that provide Foster Care services. After being made aware of these agency choices in the Foster Care services network, I would like my services to be provided by The Unique Caring Foundation, Inc.

_____ _____
Consumer's Signature Date

_____ _____
Parent/Guardian/Legally Responsible Person Signature Date

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POLICY NAME: SEARCH AND SEIZURE	EFFECTIVE DATE: 04/01/04
ANNUAL REVIEWS: 01/01/05, 01/01/06, 01/01/07, 01/01/08, 01/01/09, 01/01/10, UPDATE REVISIONS: 08/25/10, 11/23/10, 11/24/10, 02/04/11, 04/03/11	

POLICY:

When receiving services through THE UNIQUE CARING FOUNDATION, INC. person served shall be free from any unwarranted search of their person or property as well as invasion of privacy. Person served shall be afforded the same rights as any citizen regarding searches with following exceptions:

1. Staff and foster parents may be authorized to conduct the two types of searches allowed at THE UNIQUE CARING FOUNDATION, INC.; (a) at the time of admission to establish a record of their personal property and (b) to control what is brought into the foster home.

2. A facility or foster home approved search may be conducted when there is reason to believe that dangerous or illegal substances, contraband or weapons have been brought into the facility, AFL provider home or foster home. The Unique Caring Foundation staff shall obtain authorization for a search from the supervising Qualified Professional, Quality Assurance Manager, Program Manager or Executive Director if the search disrupts services to person served or could be considered an invasion of person served privacy.

PROCEDURES:

1. Prior to any search taking place, the staff member, AFL provider or foster parent contacts the supervising Qualified Professional, Quality Assurance Manager, Program Manager or Executive Director for prior approval. If, in the judgment of the staff member or foster parent, a search needs to take place immediately, the search may be conducted, and a follow up call to the supervising Qualified Professional, Quality Assurance Manager or Program Manager immediately after the search.

2. THE UNIQUE CARING FOUNDATION, INC. authorizes two types of searches:

   A. **Search of Person:** The person served personally empties their pockets inside out and turns shoes upside down. No patted frisk searches by staff member, AFL provider or foster parents are authorized.

   B. **Search of Foster Home:** The home is searched for hidden items. The search is supervised by a staff member, AFL provider or foster parent. At any time a search is warranted and the person served refuses to be searched, a debriefing is held between the staff member and/or foster parent, and the supervising Qualified Professional, Quality Assurance Manager or Program Manager. A decision is made whether the police should be called to conduct the search. If it is determined that the person served has any illegal substances, contraband or a weapon, the supervising Qualified Professional, Quality Assurance Manager or Program Manager will authorize the police to be dispatched to conduct a search and help promote the safety of everyone involved. The foster parent or AFL provider has the power to decide and contact the police to perform a search. If such a decision is made, the incident must be documented on an incident report for Unique Caring record.

Reasons for a Search and Seizure Incident:

If the foster parent, beyond a reasonable doubt, knows that the foster child is:

- Distributing an illegal substances
- In possession of illegal substances
- In possession or a firearm or illegal weapon,
- In possession of expensive equipment in boxes that do not belong to them.
- In possession of expensive jewelry that is not theirs

The legal guardian will be made aware of the Unique Caring Foundation, Inc. policy during admission. Documents will be signed stating acceptance and authorization to the search and seizure policy that THE UNIQUE CARING FOUNDATION, INC. has in place. In the event that items' not belonging to the person served are confiscated during the search, the supervising Qualified Professional, Quality Assurance Manager or Program Manager will take possession of those items. A determination will be made regarding the disposition of item(s). Every effort will be made to return the item(s) to the rightful owner. If the confiscated items are illegal drugs, contraband and/or a weapon, the Director or Supervisor will turn the items over to the local police department. In both cases, the legal guardian will be contacted, within 24 hours in writing, or immediately if safety is an issue, by the supervising Qualified Professional of what has taken place.

Informing Legal Guardian or Legally Responsible Individual:

1. The legal custodian/legally responsible person is informed as soon as possible but within 48 hours after the search is conducted.

2. A Search and Seizure Report Form is completed and placed in the person served record by the Supervising Qualified Professional. The legal guardian will also receive a copy within 48 hours of completion of this report. Please note, the police department report will determine the delivery of this report.

Documentation:

Every Search and Seizure that required the presence of Law Enforcement must have a police report and number attached to the report. Every Search and Seizure shall be documented. The documentation shall include:

1. Action taken by foster parent
2. Reason for Search
3. Procedures followed in the search
4. A description of any property seized and
5. An account of the disposal of seized property.
6. Date & time of the search
7. Action taken by the agency
8. Name of the foster parent informing the agency
9. Date & time parent/guardian was notified by agency
10. Date & time the agency was informed

_____ _____

Parent/Guardian/Legally Responsible Person Signature Date

_____ _____

Witness Signature Date