2011

Admission Packet

Resident Name: _____

Date of Birth: _____

Date of Admission: _____

TABLE OF CONTENTS

DOCUMENTS NEEDED FOR ADMISSION

1. Bio-psychosocial report and CBHA, if applicable.
2. Psychological testing reports within 6-8 months and past psychological reports, if applicable.
3. Proof of recent physical exam, including sexually transmitted disease and tuberculosis testing.
4. Medical and immunization (current yellow & blue forms) records.
5. Current documentation of medications and name & phone no. of consulting psychiatrist.
6. 30 day supply of medications, if any, along with prescriptions for renewal.
7. Court orders for foster placement and other documents verifying legal custody.
8. Academic information to include grades, attendance, discipline, referrals and special education placement. (Copy of IEP, if applicable).
9. Notify school of withdrawal and transfer.
10. Birth certificate – original.
11. Social security card – original
12. Medicaid card – original
13. Placement agreement notarized (done on premises).
14. PDS/R Pre Disposition Study/Report.
15. Guardian ad litem names and addresses.
16. List of any agencies involved with child.
17. Authorized contact list
18. Child Resource Record (CRR)
19. DCM contact info (email & office/cell/fax #'s) and supervisor's email and phone no.

ADMISSION INTERVIEW

Name: _____

DOB: _____

Medicaid #: _____

On _____, youth _____ was interviewed by the Chief Operating Officer/Clinical Director to determine eligibility for BHOS services. A face to face interview was conducted and youth meets/does not meet eligibility. Upon admission to The Haven a Certification of Eligibility for Behavioral Health Overlay Services will be completed and placed in the clinical file.

_____ Meets BHOS Eligibility

_____ Does Not Meet BHOS Eligibility

_____

Chief Operating Officer

PARENTAL AUTHORIZATION AND RELEASE

In the interest of: _____

_____

I/We _____

being the _____ of the above child and having legal custody, do hereby voluntarily and of my own free will, grant The Haven, Inc., 21441 Boca Rio Rd, Boca Raton, Florida 33433 temporary care, custody and control of said child with said The Haven, Inc., having all rights to act as parent in all legal and medical matters pertaining to said child.

I/We do agree the above aforesaid shall be in effect and binding until:

1. An order is entered by the appropriate Court having jurisdiction granting such authority to some other person(s).

2. The child is discharged from The Haven in cooperation with the parent/legal guardian.

3. The child otherwise leaves The Haven as set forth in the Placement agreement.

I/We further hereby agree that in consideration of The Haven, taking said custody, I/we do hereby release and discharge The Haven from all liability, claims, causes of action or demands whatsoever, in connection with said care, custody and control which I/we ever had, now have, or hereafter may have.

_____ _____
Parent or Legal Guardian Signature Date

STATE OF FLORIDA
COUNTY OF _____

Subscribed and sworn to before me by _____

This _____ day of _____, _____.
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_____
Notary Public
My commission expires _____

PLACEMENT AGREEMENT

The purpose of the Agreement is to outline the responsibilities of The Haven, Inc., acting in the interest of the minor child while a resident at The Haven and the responsibilities of the Legal Guardian during said placement. _____, a minor child,
(Resident's Name)
is placed for treatment at The Haven by: _____
(Parent, Legal Guardian, or Sponsoring Agency)

The Haven shall:

1. Determine the types, frequency and intensity of therapy required and provide such as needed.
2. Provide routine care while the child is in residence, including regular meals, soap, towels, toothpaste, toothbrushes, shampoo, deodorant and allowance.
3. Be responsible for, and provide for the child's educational needs and/or determine placement in public school.
4. Regulate visiting, phone calls and letters as indicated, based upon the best interests of the child in the treatment program. Information regarding a child's participation, progress and development in the program shall be shared during family therapy or upon request.
5. Secure necessary and routine medical and dental care, including emergency medical and psychiatric hospitalization if needed. (Payment for such services will be covered by Medicaid through the sponsoring public agency).
6. Determine the readiness for, preparation and time of discharge from The Haven Residential Treatment Program in cooperation with the parent(s) and/or sponsoring agency. An appropriate aftercare plan will be determined at this time.
7. The Haven will contact the parent in the event a child becomes ill, is hospitalized or injured runs away, dies or leaves The Haven premises for some other reason for a significant period of time. Contact with the parent will be made within 24 hours of the occurrence of the incident.
8. Services are funded through the Department of Children and Families and Medicaid Behavioral Health Overlay Services.

The Haven shall work with parent(s), sponsoring agency, department or person(s) to assure the best possible course of treatment for the above-named child. The resident's assigned therapist or the clinical director is responsible for working with these individuals.

Should the above-named child be removed from this program by the parent against the recommendations of the Haven, then The Haven shall be released and absolved of all responsibility for said child's custody, control, mental health and well-being, from the time that the child is removed by the parent.

The Parent(s), Legal Guardian, or Sponsoring Agency or Person(s) shall:

1. Agree to permit The Haven to act in all respects as parent to the child, including but not limited to, supervising the child's behavior, permitting or restricting the child's activities or taking any necessary actions to safeguard the life, limb, health and property of the child, other residents or others, including contacting appropriate law enforcement or emergency medical personal in a manner deemed by the staff The Haven to be in the best interest of the child.
2. Supply required information about the child and prepare him/her for the initial placement at The Haven, in cooperation with The Haven staff.
3. Establish contacts with the child at a frequency determined by The Haven to best fit the needs of the child, and comply with visiting regulations.
4. Pay the agreed upon per diem rate plus assessed charges that include, but are not limited to, clothing, medical, optical and dental care, both routine and emergency.
5. Maintain regularly scheduled conferences with The Haven social work therapist to review the child's service plan on at least a quarterly basis. The parent or sponsoring agency will participate in the development of the service plan. Family members will participate in family therapy on a regular basis. Failure to comply may jeopardize the child's placement or return to the home.
6. Plan with the social work therapist for the child's return or foster or group placement, as well as to participate in aftercare services.
7. Inform The Haven of family circumstances such as changes in economic and marital status, address, as well as assist The Haven in evaluating service delivery through participation in proposed follow-up studies. The social work therapist will provide aftercare services when appropriate.
8. Consent to the observation of the child by visiting students, professionals or consultants understanding that confidentiality will not be violated in such instances.
9. It is understood that possession or usage of any unauthorized chemical substance by a resident may be deemed a decision to terminate treatment without refund of money. The legal guardian below agrees to chemical testing of the residents as may be required to substantiate the use of an unauthorized chemical substance , and agrees to permit the staff of The Haven, Inc. to search that person, his or her residence and personal belongings as they might see necessary. Searches and testing for unauthorized chemical abuse, include, but are not limited to, urinalysis. The Haven does not provide drug or alcohol treatment to residents. If it is deemed necessary for a child to receive substance abuse services, they will be referred to treatment outside of our facility. All costs will be incurred by the client and/or client's guardian.
10. The parent noted below agrees that the resident must comply with all rules and regulations of The Haven as they may be promulgated from time to time. It is understood that all such rules are made for the good of the resident, the other residents as well as for The Haven. It is further understood that violations of the rules may result in sanctions, including dismissal and discharge to determine appropriate actions. The program rules emphasize discipline rather than punishment. Discipline involves teaching and guiding, drawing on a child's own internal controls and accepting responsibility for one's own behavior.

11. All costs of collection of charges and expenses due The Haven, including reasonable attorney's fees at all trial and appellate levels, in the event of litigation, shall be paid by the parent. Venue for all provisions of this Agreement shall lie in Palm Beach County, Florida. This agreement shall be construed in accordance with and governed by the laws of the Sate of Florida.

Miscellaneous Information to be provided to the Parent/Legal Guardian upon admission to the program:

1. DCM's must visit the residents at least once a month and be available to Haven Staff members for planned meetings regarding the care of the resident.
2. A summary of the child's progress will be given to the case worker monthly.
3. Parents/Guardians may contact The Haven's therapists at any time to discuss the progress and needs of the resident in care.
4. A treatment plan will be developed in the first 30 days and be effective at all times and reviewed within the first 90-120 days and every 6 months thereafter. Parents/ Guardians may work with The Haven therapists to develop this plan and provide feedback for modifications when needed.
5. Planned terminations will begin at least 45 days prior to the discharge date.
6. Reasons for immediate discharge from the program include:
    a. Arrests resulting in imprisonment or detention center
    b. Excessive physical aggression
    c. Repeated running away
    d. Possession of an illegal weapon, drugs or alcohol

This Agreement shall be binding on and inure to the benefit of the parties hereto and their respective heirs, personal representative, legal representatives, successors and assigns.

We hereby agree to the above:

_____ _____

Signature of Resident Date

_____ _____

Signature of Parent, Legal Guardian, or Authorized Representative of Sponsoring Agency Date

_____ _____

Signature of Authorized Haven Representative Date

RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize The Haven, Inc.
(Guardian's Name)

21441 Boca Rio Rd., Boca Raton, FL 33433 to release the information listed below to:

_____

for the purpose of _____

I understand that the specific reports shall include: _____

_____

I understand that this consent is revocable upon written notice to the requesting party, except to the extent that action by the requesting party has been taken in reliance on this authorization, and that this authorization shall remain in force for a period of 90 days or _____(date) in order to effect the purpose for which it is given. Alcohol or drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part II) prohibit making any further disclosure of it without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

MEDICAL RELEASE

TO WHOM IT MAY CONCERN:

I hereby give permission to any hospital located in the State of Florida and all physicians and surgeons as may be designated by my agent, the Executive Director or other authorized representative of The Haven, 21441 Boca Rio Road, Boca Raton, Florida 33433, to give medical care and treatment and to perform any operation they deem advisable and administer anesthetics on or to my minor child, _____ age _____ years.

_____
Parent or Legal Guardian Signature

_____
Date

STATE OF FLORIDA

COUNTY OF _____

Subscribed and sworn to before me by _____

This_____ day of _____, _____

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_____
Notary Public
My commission expires _____.

MEDICAL HISTORY

Resident Name: _____ Date: _____

Medicaid #_____ Case# _____

Sex: _____ Race: _____ Weight: _____ lbs. Height: _____

General Health (circle one): Good Fair Poor Left or Right handed: _____

Primary Care Physician: _____ Telephone #: _____

Date of last physical exam: ___/___/___ Tetanus Booster: ___/___/___

TB Skin Test: ___/___/___

Hospitalizations (any major surgery). List dates, Physician and reasons:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Systems Review

List any medications you use routinely (name of medication, dosage and time(s) taken):

_____

_____

Infectious Diseases: (Check if yes, and explain)

___ Measles, mumps, chicken pox _____

___ Whooping cough, diphtheria, smallpox _____

___ Thyroid fever, malaria, hepatitis _____

___ Scarlet fever, rheumatic fever, strep throat _____

___ Tonsillitis, chronic ear infections, sinusitis _____

___ Influenza, pleurisy, pneumonia, tuberculosis, or bronchitis _____

___ Venereal diseases (gonorrhea, syphilis, etc.) _____

___ HIV _____

When last treated: _____

Medical (Have you had any problem in the past five (5) years? Check, if applicable):

___ Skin rashes, easy bruising, hair changes, nail changes, skin cancer

___ Lymph nodes swelling, lumps under arms, lumps in groin or neck

___ Fractures (broken bones), muscle cramps or weakness, arthritis, gout

___ Blood problems such as anemia or leukemia

___ Chronic headaches, dizziness, history of head injury, seizures
___ Wear glasses (date last exam ____/____/____)
___ Vision loss, blurriness, double vision, glaucoma, cataracts
___ Deafness; ringing in ears
___ Nosebleeds, sore mouth, sore throat
___ Speech difficulties, difficulty swallowing, hoarseness
___ Chronic cough, night sweats, wheezing
___ Heart murmur, irregular heart rate, rapid heart rate
___ History of heart attack, chest pains with normal exercise
___ High blood pressure, history of heart failure
___ Varicose veins, phlebitis, calf pains when walking
___ Appetite changes, abdominal pain, nausea and/or vomiting
___ History of ulcers, gallbladder problems
___ Bloody stools, vomiting blood
___ Liver trouble, jaundice, cancer
___ Marked weight loss in the past year
___ Chronic bladder or kidney problems (infections, stones, blood in urine)
___ Herpes or any other STD's
___ Testicular problems, prostate problems
___ Endocrine problems (diabetes, thyroid)
___ Food allergies, hay fever, allergic skin reactions, asthma
___ Hallucinations, disturbances of vision, taste, smell or hearing
___ Numbness, muscle weakness, paralysis, tremors

Behavioral (Have you had any problem in the past five (5) years? Check, if applicable):
___ Nervousness, irritability
___ Anxiety, depression, mood changes
___ Phobias (fears)
___ Inability to cope, memory loss
___ Sexual disturbances
___ Tobacco, alcohol, or drug use
___ Nightmares
___ Enuresis (bedwetting) or encopresis (soiling)
___ Fainting spells
___ Insomnia (cannot sleep)
___ Aggressive behavior
___ Fire setting
___ Stealing
___ Drug/Alcohol use
___ Sleep-walking
___ Poor personal hygiene
___ Extreme possessiveness (hoarding)
___ Obsessions/Compulsions

Staff Completing Form (print): _____

FAMILY HISTORY

Mother: (Full Name) _____

Present Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Income: _____ Religion: _____

Birth date: _____ Place of Birth: _____ Present Marital Status: _____

Visitation/Contact Permission (please be specific): _____ TPR (circle): Yes/No

Father: (Full Name) _____

Present Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Income: _____ Religion: _____

Birth date: _____ Place of Birth: _____ Present Marital Status: _____

Visitation/Contact Permission (please be specific): _____ TPR (circle): Yes/No

Does either parent (or both) have any special problems such as ill health, drug addiction, alcoholism, other?

If yes, explain: _____

If the child has a stepfather or stepmother, give the following information:

Full Name: _____

Present Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Visitation/Contact Permission (please be specific): _____

Does either parent (or both) have any special problems such as ill health, drug addiction, alcoholism, other?

If yes, explain: _____

Legal Guardian of Child:

Name: _____

Address: _____

Relationship to child: _____ Office Phone: _____

Cell Phone: _____ Fax Number: _____

Email Address: _____

Supervisor's Name: _____ Phone: _____ Email: _____

Brothers/Sisters of the child (list below):

Full Name	Birth Date	School/ Grade	Where, if not with both Parents

Do any of the brothers or sisters above have any special problems, ill health, difficulty in school, etc.? Yes/No

If yes, which child and please explain: _____

_____

BACKGROUND INFORMATION

List all out-of-home placements; include treatment centers, group homes, etc.

Dates	Name of Family/Residence	Reason

List all schools the child has attended:

Dates	Name and Address of School	Grades

What special services have the child received: speech therapy, physical therapy, etc.

Dates	Name and Address	Reason

The Haven
Home... To Our Boys

VISITATION/CONTACT PERMISSION

I, ________________________, here by give my permission for the following person(s) to be
(Parent or Legal Guardian)
allowed visitation/contact with ________________________ as stated below.
(Resident's Name)

Name: ______________________________ Relationship to Resident: ____________________
Address: ____ Home #: _____________
Cell #: _____________ City: ____________________________ State: ______ Zip: ________
Please circle (as appropriate): Supervised ~ Unsupervised
Please circle (as appropriate): On Campus Only ~ Telephone Only ~ Overnights Allowed

Name: ______________________________ Relationship to Resident: ____________________
Address: ____ Home #: _____________
Cell #: _____________ City: ____________________________ State: ______ Zip: ________
Please circle (as appropriate): Supervised ~ Unsupervised
Please circle (as appropriate): On Campus Only ~ Telephone Only ~ Overnights Allowed

Name: ______________________________ Relationship to Resident: ____________________
Address: ____ Home #: _____________
Cell #: _____________ City: ____________________________ State: ______ Zip: ________
Please circle (as appropriate): Supervised ~ Unsupervised
Please circle (as appropriate): On Campus Only ~ Telephone Only ~ Overnights Allowed

This contact shall continue in force for ____ days from the date shown below or until revoked by me in writing.

Guardian Signature: ______________________________________ Date: _________

Witness Signature: ______________________________________ Date: _________

MENTOR PROGRAM PERMISSION

I, _____ (parent/guardian) give my consent for

_____ to participate in The Haven Mentor Program.

(Resident's Name)

I understand that the mentor has been appropriately screened and is aware of the guidelines regarding confidentiality. The resident's assigned mentor(s) has my permission to transport resident.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ILLEGAL SUBSTANCE USE POLICIES

Purpose:
To maintain a drug-free campus and reduce the risk of substance abuse.

Random Drug Testing Policy:

1. All Haven residents will comply with random drug testing while residing at the Haven.
2. Residents may be randomly selected each month for a urine screen analysis. They may also be tested using a saliva test, hair sample, and/or breath-alcohol testing.
3. A resident will be notified of the policy during the orientation process but will not receive any notification warning prior to testing.
4. A youth care worker will accompany the residents to the testing site and will remain with the resident throughout the testing process.
5. Under certain circumstances that suggest possible use, i.e. but not limited to elopement, excessive sleeping, aggressive or persistently non-compliant behavior or at Clinical Director's, Youth Services Director's or Counselor in Charge's discretion, a resident may be required to undergo a drug screening.

Substance Abuse Policy:

1. When a resident tests positive the first time for substance use, the offense will be processed in individual therapy, appropriate consequences will be assessed, and the resident's DCM/Child Advocate will be notified.
2. When a resident tests positive for substance use the second time, policy 1 will be followed and a staffing may be held with the resident's treatment team and the resident may be asked to complete a substance abuse assessment at a substance abuse program.
3. If a substance abuse assessment is requested, the resident must comply with all recommendations including residential substance abuse treatment, intensive outpatient, intensive outpatient treatment or a prevention/intervention program.
4. The resident may continue to reside at the Haven while participating in an outpatient substance abuse program.
5. If a resident continues to tests positive for substance use, the resident may be placed on 30-day notification and discharge from the program may occur.

I, _____, understand the policies stated above and agree to follow
(Resident's Name)
them as they are prescribed by The Haven.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

BEHAVIOR MANAGEMENT POLICY

The Haven **DOES NOT** use corporal punishment, mechanical or chemical interventions. The Haven uses a positive management system (rewards and incentives) in order to encourage residents to positively interact with their peers and staff. In case's where a resident is exhibiting dangerous behavior a diffusion technique will be used first. If the diffusion technique is unsuccessful and if the resident continues to be a danger to himself, others, or property a certified staff member will utilize HWC (Handle With Care). The proper notification chain will be followed in the event that HWC is utilized on a resident.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

RUNAWAY POLICY

It is the policy of The Haven that any runaway from The Haven, including leaving the premises for any unauthorized reason, will be handled as follows:

1. The Sheriff's Department will be immediately notified of the client's elopement/AWOL status. An incident report will be filled out.

2. The legal guardian or case manager/child advocate of the resident, and the resident's parents, if appropriate, will also be notified.

3. A clinical meeting with the Chief Operating Officer/Clinical Director, Youth Services Director, Counselor in Charge, and assigned Primary Therapist will be held to evaluate whether the resident should return to The Haven and the consequences to be taken.

I have read the above statement and agree to its terms for placement at The Haven.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

STATE OF FLORIDA

COUNTY OF _____

Subscribed and sworn to before me by _____

This _____ day of _____, _____

S
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_____

Notary Public

My commission expires _____

RESIDENTS' GRIEVANCE POLICY

If the client has a grievance against The Haven staff, they should complete a Grievance Form and submit it to the Chief Operating Officer/Clinical Director or the supervisor of the person whom the grievance is directed toward. All grievances will be brought to the attention of the COO/CD for follow-up and conclusion. It should be stated that a grievance is a very serious matter and should only be used for abuse accusations, as very serious consequences will occur when a grievance is deemed valid. Complaints are a disagreement over procedure actions, policy rules of The Haven, or Haven staff. Complaints will be addressed initially with the cottage's Counselor in Charge (CIC). If unresolved, it will follow the chain of control to the Executive Director. The COO/CD will arrange a meeting with the resident and relevant staff, and will attempt to resolve the issue.

PARENTS AND LEGAL GUARDIANS COMPLAINTS

All complaints from parents, legal guardians, or the sponsoring agency are to be referred to the Chief Operating Officer/Clinical Director. Parents may call the COO/CD at any time to arrange a conference to discuss the complaint. Any staff member receiving a complaint about any aspect of the program must inform the COO/CD within 24 hours of receiving the complaint. If the problem cannot be resolved by the COO/CD, the matter will be turned over to the Executive Director.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

CELL PHONE POLICY

Resident's Name: _____ Cell Phone: _____

A resident may own a cell phone if:

1. The resident is over the age of 14.
2. The resident has a source of income outside of their monthly allowance that exceeds the monthly cell phone charges, or has a parent, family member or other adult who takes written responsibility for any charges incurred.

Responsibilities:

1. Resident or designee will be responsible for all payments.
2. Lost, stolen, or damaged phones will NOT be the responsibility of the Haven.
3. Resident must provide staff with the cell phone number and must answer calls from staff.
4. If at any time the phone number changes, the resident must provide the new number to staff within 24 hours.
5. Phones may not be used during school, work essentials, or study hour/tutoring.
6. Phones may not be used during individual, group, or family therapy.
7. Phones may not be used after 10:00 pm on school nights without staff permission.
8. Phone can not be shared with any resident who is on restriction, has supervised phone contact privileges, and/or is under the age of 14.
9. Resident is responsible for notifying the Chief Operating Office/Clinical Director and/or Youth Services Director of the purchase, gift, or possession of a cell phone. Any phones not registered within 24 hours will be immediately confiscated.
10. All phones must be programmed to contain specified Haven phone numbers such as cottage phone number, Counselor in Charge phone number, Youth Care Worker phone number, etc.

Failure to comply with any of the rules/responsibilities stated above will result in loss of cell phone privileges. The resident's cell phone may be confiscated for up to 7 days.

Residents who violate Haven rules (i.e. – including, but not limited to, running away, substance use, school suspension, damaging property, and/or fighting) may result in loss of cell phone privileges. The resident's cell phone may be confiscated for up to 7 days.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

RESIDENTS' RIGHTS AND RESPONSIBILITIES

The Haven is committed to the provision of a safe, stable and caring environment for children. The program offers supportive counseling, case management, recreational activities and educational tutoring and support 24 hours a day. The administrative office is open 8am-5pm Monday - Friday. The Haven does not discriminate in the manner in which services are provided. The program is a residential group living facility and services are available seven days per week.

Your Rights as a Resident:

- Residents have the right to 3 balanced, healthy meals per day. At no time should one of these 3meals be withheld as a consequence.
- Residents have the right to safe, healthy, and clean housing.
- Residents have the right to a wardrobe of clothes that are in good repair, meet seasonal needs and maintain a supply of several days that would insure time to wash or mend clothing without deprivation.
- Residents have the right to live in an environment that is free of verbal or physical abuse or threat of abuse from staff and other clients.
- Residents have the right to proper, adequate, and timely medical care.
- Residents have the right to contact with their legal guardian, case manager, or Guardian ad Litem.
- Residents have the right not to have their private lives, events, and other information given out.
- Residents have the right to be involved in community activities and services. These will be scheduled and made available on a monthly basis.
- Residents have the right to be supervised in a 1:6 (staff to resident) ratio.
- Residents have the right to fully participate in the assessment and treatment planning process.
- Residents have the right to receive quality services and care from professional staff.
- Residents have the right to receive a referral to another therapist if you feel that the relationship is not productive to you.
- Residents have the right to speak with the Director for assistance in resolving any problems that may arise with the service residents receive.
- Residents have the right to refuse our services, unless those services are mandated by law or a court order.
- Residents have the right as a minor to have your legal guardian request to review your file on your behalf.
- Residents have the right to place a written statement in your file concerning the problem that brought you to our program or about the services you received.
- Residents have the right to receive services in a non-forceful or coercive manner and to fully participate in all decisions regarding the services you receive.
- Residents have the right to have the consequences of your refusal of services, medication or treatment discussed with you in an age appropriate manner.

Information that you share with our staff concerning yourself or your situation will be held in the strictest confidence. The information will not be shared with anyone outside of this program without your written consent or as required by law or contract. Under specific circumstances, we are required to release information about you or your family, for example:

- If you or a family member are threatening suicide or are involved in a medical emergency.

- If you or any member of your family are threatening to harm or abuse someone else.
- If you or any member of your family are involved in the commission of a felony; if we are court mandated to do so.
- If we are directed by the State or County Attorney to do so based upon legal determination.
- For the purposes of contract or quality improvement audit.

If any of these rights are violated, residents have the right to contact the proper authorities in the following order: Chief Operating Officer/Clinical Director, Executive Director, and Legal Guardian or Ombudsman.

Your Responsibilities as a Resident:
We ask that you discuss your concerns and problems as openly as you can with our staff during your assessment and service planning. The assessment is used to help our staff determine the type of needs that Are unique to your situation and to identify the most appropriate service goals to help improve your situation. You will be asked and are expected to assume certain age appropriate responsibilities to help improve your situation.

You may be asked:

1. To complete assignments, chores, and/or homework
2. To attend study hour and/or tutoring and/or read books
3. To attend and participate in life skills classes
4. To attend and participate in individual, group, and/or family therapy sessions
5. To meet with your Dependency Case Manager/Child Advocate

Failure to participate in the development or achievement of service plan goals will reduce the quality of the help you receive from the program and may result in our request for another placement. Abusive or violent behavior, drug usage or criminal activity during services may also result in our request for your immediate discharge or removal from the program.

Abuse Reporting Procedures
Florida law requires that any information regarding abuse of a child, disabled adult or aged person be reported to the State Abuse Hotline, which is responsible for ensuring the timely investigation of all abuse allegations. Haven employees are mandated reporters and are required by law to report any suspected abuse, even if it is obtained from another source. Suspected or know abuse or neglect, must be reported to the 24-hour Toll Free Abuse Registry Hotline at 1-800-96-ABUSE.

You will be asked to sign and date a copy of this document upon intake to the program that indicates that you have been made aware of your rights and responsibilities. Your signature also releases the Haven for all liability connected with the disclosure of confidential information.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

HIPPA BROCHURE RECEIPT

I, _____, have received a copy of the HIPPA Notice of
(Resident's Name)

Privacy Rights brochure and the contents of this brochure have been reviewed by me. Questions on reviewing personal health information, requests to view or change specific health information and complaints regarding the use of my PHI are to be directed to the Chief Operating Officer/Clinical Director. Copies of this brochure, requests to view or change health information, and complaint forms are available through the Chief Operating Officer/Clinical Director.

Resident Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____