Nevada Homes For Youth File Checklist
Inpatient

Client Name: _____ Date of Entry:_____

Intake:

___ Referral Form

___ Placement Letter

___ Court Paperwork

___ Residential Client Information

___ Informed Consent and Client Rights

___ Confidentiality of Alcohol and Drug Abuse Patient Records

___ Abstinence Agreement

___ Patient Rights

___ Grievance Procedure

___ Release of Information (CJJS)

___ Permission to Tape Record Sessions

___ Emergency Medical Permit

___ Nevada Homes for Youth Residential Agreement

Assessment:

___ Initial Comprehensive Evaluation

___ Initial Review

___ Initial Treatment Plan

___ DSM Worksheet

___ Master Problem List

___ Residential Release Form

___ Destruction of Consent Documents

___ Surveillance Cameras Release

___ Personal Information Form

___ Release of Information

___ Permission Slip for TB Testing

___ Planned Activities Permission Slip

___ Acknowledgment of Consumer Information

___ Client Searches Consent

___ Parent Agreement

___ Client Statement

___ Physical Education Log

___ Rules/Policies of Computer Usage

___ Therapy and Counseling Services

___ Client Treatment Acknowledgement

___ Personal Items Waiver

___ Confidentiality of Alcohol and Drug Abuse Patient Records

___ Consent for Online and Technology Based Counseling Services

I have reviewed with the above client the enclosed Inpatient forms to sign and initial his/her understanding of each of the above items.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Client Information *(Please fill out this packet completely)*

Name: *(Last)*_____ *(First)*_____ *(MI)*_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) - ____ - _____ Alt. Phone: (____) - ____ - _____ Marital Status: _____

Age: _____ Date of Birth: _____/_____/_____ Gender: ❑ Male. ❑ Female

Race: ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Decline to Disclose

Ethnicity: ❑ Puerto Rican ❑ Mexican ❑ Cuban ❑ Other ❑ Decline to Disclose

Religious Affiliation: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Mormon ❑ Other ❑ None ❑ Active ❑ Not active

Social Security Number: ____ - ____ - _____ Veteran: ❑ Yes ❑ No

Employer: _____ Job Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Hourly Wage/Salary: _____ Per: *(check one)* ❑ Week ❑ Month ❑ Year

Who referred you to us? _____

Responsible Party Information *(Parents, Legal Guardian)* IF YOU ARE OVER 18, YOU ARE RESPONSIBLE FOR YOURSELF- PLEASE PRINT YOUR NAME.

(#1) Name:_____ Relationship to Client:_____

Address: _____ City: _____ State: _____ Zip: _____

Hourly Wage/Salary: _____ Per: *(check one)* ❑ Week ❑ Month ❑ Year

Employer: _____ Job Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Hourly Wage/Salary: _____ Per: *(check one)* ❑ Week ❑ Month ❑ Year

(#2) Name: _____ Relationship to Client: _____

Address: _____ City: _____ State: _____ Zip: _____

Hourly Wage/Salary: _____ Per: *(check one)* ❑ Week ❑ Month ❑ Year

Employer: _____ Job Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Hourly Wage/Salary: _____ Per: *(check one)* ❑ Week ❑ Month ❑ Year

Client Signature: _____ Date: _____

NEVADA HOMES FOR YOUTH
RESIDENTIAL

Photo of Client

PERSONAL INFORMATION

Full Name: _____ Date of Birth: _____

Any Alias (nicknames, former names, gang names, etc.): _____

Age: _____ Race: _____ Social Security Number: ____-____-_____

Weight: _____ Height: _____ Hair Color: _____ Eye Color: _____

Probation Officer (P.O.) Name: _____ Phone #: (____) - ____ - _____

P.O. Cellular #: (____) - ____ - _____ P.O. Fax #: (____) - ____ - _____

Parent/Guardian Name: _____ Phone #: (____) - ____ - _____

Parent/Guardian Address: _____ City: _____ State: ____ Zip: _____

Parent/Guardian Cellular #: (____) - ____ - _____

Tattoos and/or other distinguishing marks (i.e. birthmarks):

_____

_____

Current Prescribed Medication: ❑ Yes ❑ No If **yes**, please explain: _____

_____

Any allergies to medication: ❑ Yes ❑ No If **yes**, please explain: _____

_____

Any allergies to food: ❑ Yes ❑ No If **yes**, please explain: _____

_____

Nevada Homes for Youth

Informed Consent and Client Rights

My signature confirms I consent to treatment and understand the rights listed below:

1. I have the right to refuse any or all treatment, and to leave treatment at any time, unless I am under a Court Order.

2. I will be actively involved in the planning of my treatment, and I will understand the potential consequences of treatment and/or be actively involved in the planning of my child's treatment.
3. I will be continually informed with the type of treatment I will be receiving. I will receive appropriate referrals if/when there are concerns about any medical, academic, genetic, or other conditions that may be present and need evaluation or services.
4. I understand that my counseling, or that of my child, is confidential and protected under state and federal law. There are three instances that confidentiality is mandated by law to be broken:

a. Where there is immediate concern that I am imminently in danger to harm myself or another person, and emergency measures must be taken for protection.

b. When there is significant reasonable suspicion that child or elder abuse or neglect is occurring.

c. When there is a direct order requiring a release of information through a judicial subpoena.

5. If I am participating in couples or family counseling sessions, I understand that all information shared in a joint session is open to all participants. Any information shared in an individual session is kept confidential and separate from joint sessions. This separate information is not open to any other member of the couple/family through the counselor or case documentation in the chart.

6. I understand that in accordance with the standard policies of Nevada Homes for Youth; all cases are staffed under clinical and administrative supervision with qualified supervisors in order to ensure the best client care possible. The content of staffing is held confidential.
7. With the exception of emergency situations, I agree to notify my counselor of a cancellation 24-hours prior to a scheduled session. I understand that there may be a fee charged for a cancellation or a no-show to a scheduled session.

_____

Client/Parent-Guardian Date

_____

Client/Parent-Guardian Date

_____

Therapist/Witness Date

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

1. The patient consents in writing;

2. The disclosure is allowed by a court order or;

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ce-3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

_____

Signature to acknowledge receipt of this document Date

_____

Parent/Guardian Signature Date

ABSTINENCE AGREEMENT

I agree to abstain from the use of any alcohol and/or drugs; this includes misuse of prescription medication during treatment at Nevada Homes for Youth. If abstinence is broken at any time during treatment, I understand it is my responsibility to inform my counselor/therapist of any and all use of alcohol and/or drugs, to include prescription medication, immediately. I further understand that any substance use may be grounds for discharge and/or referral to a higher level of care.

I also agree voluntarily to obtain a random drug-screening test whenever requested during treatment. I understand that drug-screening tests are a necessary and required part of the treatment program. I further understand that the costs of these tests is an additional expense ($15.00 for urine tests are not included in the program cost) and that I will be financially responsible for the costs of these tests.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

_____

Witness Date

NEVADA HOMES FOR YOUTH SUBSTANCE ABUSE TREATMENT PROGRAM CLIENT RIGHTS

As the patient of a program for treatment of abuse or dependency upon alcohol and/or other drugs, your rights include but are not limited to the following:

1. If the program receives funds from SAPTA, you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you and your family.

2. You have the right to be provided treatment appropriate to your needs.

3. If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.

4. You have the right to have your clinical records forwarded to the receiving program, if you are transferred to another treatment program.
5. You have the right to be informed of all program services, which may be of benefit to your treatment.
6. You have the right to be informed of your diagnosis, treatment plan, and prognosis.

7. You have the right to be given sufficient information for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimate of the costs of treatment, and a description of the alternatives to treatment.

8. Waiver of any civil or other rights protected by law cannot be required as a condition of program services.
9. You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, including the right to refuse participation in such experiments.

10. You have the right to examine your bill for treatment and to receive an explanation of your bill.

11. You have the right to be informed of the program's rules for y our conduct at the facility.

12. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.

13. You have the right to receive respectful and considerate care.

14. You have the right to receive continuo us care: To be informed of your appointment for treatment, the name of program staff available for treatment, and of any need for continuing care.

15. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.

16. You have the right to safe, healthy, and comfortable accommodations.

17. You have the right to confidential treatment. In other words, other than exceptions defined by law— such as those in which public safety takes priority without your explicit consent to do so— the program may release no information about you, including confirmation or denial that you are a patient.

18. Waiver of any civil or other rights protected by law cannot be required as a condition of program services.

19. You have the right to freedom from emotional, physical, intellectual, and/or sexual harassment or abuse.
20. You have the right to attend religious activities of your choice, including visitation from a spiritual counselor, to the extent that such activities do not conflict with program activities. The program shall make a reasonable accommodation to your chosen religious activities. Attendance and participation in any religious activity is to be only on a voluntary basis.
21. You have the right to grieve any actions and decisions of facility staff, which you believe are inappropriate, including but not limited to actions and decisions, which you believe violate your rights as a patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retribution or other adverse consequences as the product of filing a grievance.
22. You have the right to a file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution of other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to: Substance Abuse Prevention and Treatment Agency, ATTN: Statewide Program Coordinator; 4126 Technology Way, Second Floor; Carson City, Nevada 89706; Phone: (775) 684 -4190.

23. You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where they are immediately available to you and you are to be informed of these rights and given a listing of them as soon as it is practically possible upon your beginning treatment.

Patient Acknowledgement

I have read, understood, and been provided a copy of the above Patient's Rights

Date: _____ Patient Signature: _____

_____ _____

(Signature of person signing form, if not the patient) (Describe authority to sign on behalf of patient)

Date: _____ Witness Signature: _____

GRIEVANCE PROCEDURE

Clients have the right to register grievances about his/her therapeutic treatment, the administration of rules, regulations, disciplinary measures, sanctions, and modifications of rights to the Executive Director.

The Executive Director will investigate the grievance and will try to resolve the issue within 10 days of the complaint. If the issue cannot be resolved at the time, the Executive Director must inform the president of the board. The president will then appoint a grievance committee, who will consider the issue and make recommendations to the Executive Director within 15 days of receipt of the complaint. Each step of transfer will be officially dated and documented by each recipient to substantiate continuity in guaranteeing the rights of the client. If the client still does not feel that his/her grievance has been resolved, he/she has the right to present his/her case to the Substance Abuse Prevention and Treatment Agency.

_____

Client or Parent/Guardian of Minor Client Date

_____

Minor Client Signature Date

_____

Witness Signature Date

Nevada Homes for Youth

Adolescent Release for Information

I authorize Nevada Homes for Youth to contact the agency/person listed below for the purpose of obtaining and/or disclosing the information specified below regarding the following minor client:

Minor Client Name: _____ Date of Birth: _____

Agency/Person for disclosure:

Name: Yoga – Carmita Lorador Phone #: (____) - ____ - _____ Fax #: (____) - ____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose of disclosure:

Initials _____ Release information/documentation regarding assessment, treatment planning, interventions, and discharge status.

Initials _____ Obtain information/documentation regarding assessment, treatment planning, interventions, and discharge status.

Initials _____ Provide ongoing communication for case management, planning, and community transition.

Initials _____ Provide post-treatment follow-up with community referral.

I understand that my child's alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA"), 45 C.F.R. Pts. 60 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Upon revocation of consent, further release of information is to cease immediately. If not previously revoked, this consent will terminate at discharge of the case or, if post-treatment follow-up is consented for, it will automatically terminate six (6) months after discharge of the case. A fax copy is to be considered as an original.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. I will be provided a copy of this form upon request.

_____

Client Signature/Parent or Guardian Signature of Minor Client Date

_____

Minor Client Signature Date

Nevada Homes for Youth

Adolescent Release for Information

I authorize Nevada Homes for Youth to contact the agency/person listed below for the purpose of obtaining and/or disclosing the information specified below regarding the following minor client:

Minor Client Name: _____ Date of Birth: _____

Agency/Person for disclosure:

Name: Karen Bacher, SA Counselor Phone #: (____) - ____ - _____ Fax #: (____) - ____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose of disclosure:

Initials _____ Release information/documentation regarding assessment, treatment planning, interventions, and discharge status.

Initials _____ Obtain information/documentation regarding assessment, treatment planning, interventions, and discharge status.

Initials _____ Provide ongoing communication for case management, planning, and community transition.

Initials _____ Provide post-treatment follow-up with community referral.

I understand that my child's alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA"), 45 C.F.R. Pts. 60 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Upon revocation of consent, further release of information is to cease immediately. If not previously revoked, this consent will terminate at discharge of the case or, if post-treatment follow-up is consented for, it will automatically terminate six (6) months after discharge of the case. A fax copy is to be considered as an original.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. I will be provided a copy of this form upon request.

_____

Client Signature/Parent or Guardian Signature of Minor Client Date

_____

Minor Client Signature Date

Nevada Homes for Youth

Adolescent Release for Information

I authorize Nevada Homes for Youth to contact the agency/person listed below for the purpose of obtaining and/or disclosing the information specified below regarding the following minor client:

Minor Client Name: _____ Date of Birth: _____

Agency/Person for disclosure:

Name: _____C.C.J.J.S._____ Phone #: (____) - ____ - _____ Fax #: (____) - ____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose of disclosure:

Initials _____ Release information/documentation regarding assessment, treatment planning, interventions, and discharge status.

Initials _____ Obtain information/documentation regarding assessment, treatment planning, interventions, and discharge status.

Initials _____ Provide ongoing communication for case management, planning, and community transition.

Initials _____ Provide post-treatment follow-up with community referral.

I understand that my child's alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA"), 45 C.F.R. Pts. 60 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Upon revocation of consent, further release of information is to cease immediately. If not previously revoked, this consent will terminate at discharge of the case or, if post-treatment follow-up is consented for, it will automatically terminate six (6) months after discharge of the case. A fax copy is to be considered as an original.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. I will be provided a copy of this form upon request.

_____

Client Signature/Parent or Guardian Signature of Minor Client Date

_____

Minor Client Signature Date

Informed Consent

Permission to Tape or Record Sessions

The Purpose of Recording Counseling Sessions

In an effort to promote quality client care and to continually improve the service provided at Nevada Homes for Youth, counselors receive ongoing supervision and training. As part of this standard supervision and training, we are required to randomly record audio or video sessions for review by qualified supervisors and trainers.

Confidentiality of Audio/Video Tapes

When counseling sessions are recorded, all reasonable measures are taken to protect the client's confidentiality. For example, if videotaping a session, the camera is pointed only at the counselor, so the client's image is not recorded. Client names and identifying information are not written on the audio or video tapes. Audio and video tapes will be securely stored, and properly maintained and transferred. Tapes will be erased or destroyed after required review.

Client Consent:

I acknowledge that I have read and understand this information. My signature confirms that I am voluntarily allowing my counseling sessions to be audio taped and/or videotaped for the purposes described above. I understand that I can withdraw this consent at any time by notifying my counselor. I understand that if I refuse to have sessions recorded an intern supervisor will be required to observe a session in person.

Client Signature Date

Parent/Guardian Signature Date

Counselor/Witness Signature Date

Nevada Homes for Youth

Substance Abuse Residential

EMERGENCY MEDICAL PERMIT

It is understood and agreed that in the event _____
(Name of Client)

is in need of medical treatment, I hereby give permission to Nevada Homes for Youth staff or their designated representative, to initiate any emergency procedures necessary for the health and safety of my child. This includes the signing of operative permits and the granting of permission to use anesthesia.

I understand that Nevada Homes for Youth, or their designated representative, does not assume responsibility or financial obligation for any medical ser vices or treatment rendered to my child.

Legal Guardian Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____ - _____ Work Phone: (____) ____ - _____

Other Phone: (____) ____ - _____ Work Phone: (____) ____ - _____

Insurance Company: _____

Policy #: _____

Family Physician or Pediatrician: _____

Allergies to any medications: □ No □ Yes □ Unknown

If so, please specify:

_____

_____

_____

Nevada Homes for Youth
Substance Abuse Program
Residential Release Form

Child or Children's Names	Date of Birth	Age

Parent/Guardian Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Work phone: (_____) _____ - _____

Cellular Phone: (_____) _____ - _____

Please initial on the line provided, for each section below:

_____ I give permission to the child or children mentioned above to participate in the NHY Residential Program. I recognize that risks are associated with his/her behavior and agree to hold harmless those cities and agencies involved with the NHY Program. I certify that those municipalities and agencies are not responsible for any future actions of my child/children.

_____ I hereby authorize the NHY Program to release or obtain information from the school district, law enforcement, social services, juvenile justice, and any entity or agency involved with the NHY Program, as it may deem appropriate.

_____ I, the parent, guardian, and/or legal custodian of the above child/children understand that if counseling and/or life coaching is recommended or required, that a Certificate of Completion will not be issued until requirement is met.

I hereby consent to the above release and agree to all terms as stated above.

_____

Parent/Guardian Signature Date

_____

Witness Signature Date

_____

Probation Officer Signature Date

Nevada Homes for Youth
Substance Abuse Residential Program

AGREEMENT TO HOLD NEVADA HOMES FOR YOUTH HARMLESS AND TO INDEMINFY

AGREEMENT, made this _____ day of _____, 20____, by and between Nevada Homes for Youth

(hereinafter called the "AGENCY"), and _____.

Name(s) of Legal Guardians/Parents

WITNESSETH:

Whereas, the AGENCY is agreeable to place in its residential program, _____(hereinafter called the "CLIENT") and
Whereas, _____, as the parent or legal guardian of said child believes that the PROVIDER should be held harmless and indemnified against any and all damages caused by said CLIENT.

NOW, THEREFORE, IS IT AGREED AS FOLLOWS:
1. In consideration of the AGENCY'S taking the CLIENT into its program, the undersigned shall indemnify and hold the AGENCY harmless at all times against and in respect of (a) all damages of any nature caused by the CLIENT, to any person or entity, or to the property of any person or entity: and (b) all actions, suits, proceedings, demands, assessments, judgments, costs, and expenses incident to the foregoing. The Legal Guardian or Parents shall reimburse the AGENCY, or demand, for any payment made by the AGENCY at any time in respect of any liability or claim to which the foregoing indemnity and hold harmless relates.

This Agreement shall be binding upon and shall insure to the benefit of the parties, their legal representatives, heirs, assigns, and successors.

IN WITNESS WHEREOF, the parties have signed this Agreement with the date and year first above written.

NEVADA HOMES FOR YOUTH

BY: _____

PARENTS OR GUARDIAN:

_____
Parents

_____
Client

_____
Juvenile Justice Service
Probation Officer

Nevada Homes for Youth

Residential

Surveillance Cameras Release

Child's Name: _____

Last First Middle

I, _____, Parent/Guardian of _____, have been advised

that the residential facility, Nevada Homes for Youth, which is located at 525 So. 13th Street, Las Vegas, Nevada 89101 is equipped with surveillance cameras.

By signing this release, I agree to have my son or daughter placed at this facility.

_____

Parent/Guardian Signature Time Date

Staff: _____

Date: _____

Nevada Homes for Youth

525 South 13th Street

Las Vegas, Nevada 89101

(702) 380-2889 • Fax: (702) 380-2893

Permission Slip for TB Testing

Date: _____

To whom it may concern:

I, _____, am giving Nevada Homes
Parent Name

for Youth permission for my son/daughter, _____,
Client Name

to conduct a **TB Test (Tuberculosis Testing) at The Vaccine Center.**

Witness:

_____ _____
Staff Signature Date

Prior to Admission/Annual TB Symptoms Check

Date of Screening: ____ / ____ / ____

Name of person being screened (Please Print): _____

Your history indicates that you are a tuberculin skin test reactor. People with latent TB infection may develop active TB disease in their lifetime. Please answer the following questions honestly to help determine if you have symptoms of active TB, which may require treatment.

Do you have or have you been experiencing the following?

1. A cough that lasts longer than 3 weeks □ Yes □ No
   If yes, when did it start? _____
2. A productive cough □ Yes □ No
   If yes, when did it start? _____
3. Blood in sputum □ Yes □ No
   If yes, when did it start? _____
4. Fever (not associated with cold, flu, or other apparent illness) □ Yes □ No
   If yes, when did it start? _____
5. Sweating at night □ Yes □ No
   If yes, how long have you been experiencing this? _____
6. Unexplained weight loss □ Yes □ No
   If yes, how much weight have you lost? _____
7. Been in close contact with a person who has active tuberculosis □ Yes □ No

Have you consulted a medical professional for any of these symptoms? □ Yes □ No

If yes, please indicate the name of the medical professional: _____

The Medical Professional's telephone number (____) ____ - _____

What medications are you currently taking?

_____ _____

_____ _____

If it is determined that you answered yes to question number 1, any other yes answers to questions 2-7, and the person being screened has not consulted a medical professional, then a medical professional must be consulted. If the person conducting the screening is a medical professional, then the medical professional should make a determination concerning the disposition of the person being screened.

Name of the Screener (Please Print): _____

Signature of the Screener: _____Title: _____

Nevada Homes for Youth

525 South 13th Street

Las Vegas, Nevada

(702) 380-2889 • Fax: (702) 380-2893

I, _____, give permission for my son or daughter, _____, to participate in all activities that are planned for the inpatient residents of Nevada Homes for Youth. I understand that the activities may include 12-Step meetings, community service, trips to local parks and recreation areas, and to area restaurants. Additional activities may be planned as deemed appropriate by the Nevada Homes for Youth staff. I also understand that all planned activities will be supervised by Nevada Homes for Youth staff. The parent or guardian signature affixed below absolves Nevada Homes for Youth of any liability during planned activities.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

Substance Abuse Prevention and Treatment Services

Acknowledgement of Consumer Information

I, _____, acknowledge receiving a copy of the MEDICAL RECORD RETENTION POLICY. In accordance with the provisions of the 20098 session, healthcare records of a consumer, who is less than 25 years of age, may not be destroyed. Records may be destroyed if retained for at least 6 years after the person has reached 23 years of age.

_____ _____

Consumer/Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Staff Signature Date

Nevada Homes for Youth Substance Abuse

Residential Program CLIENT SEARCHES

Client Name: _____ Date: _____ Time: _____

Staff Conducting Search: _____

It is understood and agreed, that in the event that my child, _____,
(Name of Client)
leaves the facility, a search by the Staff of Nevada Homes for Youth will be conducted upon return and on a random basis when necessary.

I hereby give permission to Nevada Homes for Youth's Staff or their designated representative, to initiate a body search, which consists of either a client pat - down or full body search with the removal of all clothing.

I have read and understood the above procedure and by signing this agreement, I give Nevada Homes for Youth, authorization to conduct their search procedures.

Client Signature: _____

Parent/Legal Guardian Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) - ____ - _____ Work Phone: (____) - ____ - _____

Nevada Homes for Youth

525 South 13th Street
Las Vegas, Nevada

(702) 380-2889 • Fax: (702) 380-2893

PARENT AGREEMENT

I understand that as part of my child's treatment in Nevada Homes for Youth Residential Treatment Facility and to assist in my child's care and the success of his/her discharge plan that I am required to attend 15 parent group sessions.

By signing this agreement, I agree to attend and participate in the parent group sessions held weekly at the Nevada Homes for Youth office at 525 South 13th Street. This group meets Thursday nights from 5:30 pm until 6:30 pm.

Client Name: _____

Parent Signature: _____ Date: _____

Nevada Homes for Youth Treatment Center
Physical Education Log

Student Name: _____ **Student ID #:** _____

Date of Activity	Activity Completed		Totals	Staff Initials
	1. Sit-Ups: 2. Push-Ups:	How Many: ____ How Many: ____	Total Reps	
	3. Basketball: 4. Jump Roping: 5. Jogging/Walking: 6.Squats:	How Long: ____ How Long: ____ How Long: ____ How Long: ____	Total Time	
	1. Sit-Ups: 2. Push-Ups:	How Many: ____ How Many: ____	Total Reps	
	3. Basketball: 4. Jump Roping: 5. Jogging/Walking: 6. Lunges:	How Long: ____ How Long: ____ How Long: ____ How Long: ____	Total Time	
	1. Sit-Ups: 2. Push-Ups:	How Many: ____ How Many: ____	Total Reps	
	3. Basketball: 4. Jump Roping: 5. Jogging/Walking: 6.Squats:	How Long: ____ How Long: ____ How Long: ____ How Long: ____	Total Time	
	1. Sit-Ups: 2. Push-Ups:	How Many: ____ How Many: ____	Total Reps	
	3. Basketball: 4. Jump Roping: 5. Jogging/Walking: 6. Lunges:	How Long: ____ How Long: ____ How Long: ____ How Long: ____	Total Time	
	1. Sit-Ups: 2. Push-Ups:	How Many: ____ How Many: ____	Total Reps	
	3. Basketball: 4. Jump Roping: 5. Jogging/Walking: 6.Squats:	How Long: ____ How Long: ____ How Long: ____ How Long: ____	Total Time	

Attention: Parents/Guardians, this is the physical education list that your child must participate and fill for NHY. By signing below, you approve of their participation in their own plan to stay healthy and clean.

Parent/Guardian Signature: _____ Date: _____

Nevada Homes for Youth

Yoga Waiver & Release Form

Client Name: _____ Age: _____ Birth Date: _____/____/_____

Emergency Contact Name: _____

Emergency Contact Phone: _____

I understand that yoga includes physical movements as well as an opportunity for relaxation, stress re-education and relief of muscular tension. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, discontinue the activity, and ask for support from the instructor. I will continue to breathe smoothly. I assume full responsibility for any and all damages, which may incur through participation.

Yoga is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions. By signing, I affirm that a licensed physician has verified my good health and physical condition to participate in such a fitness program. In addition, I will make the instructor aware of any medical conditions or physical limitations before class. If I am pregnant, become pregnant or I am post-natal or post-surgical, my signature verifies that I have my physician's approval to participate. I also affirm that I alone am responsible to decide whether to practice yoga and participation is at my own risk. I hereby agree to irrevocably release and waive any claims that I have now or may have hereafter against Nevada Homes for Youth and its Yoga instructors.

I have read and fully understand and agree to the above terms of this Liability Waiver Agreement. I am signing this agreement voluntarily and recognize that my signature serves as complete and unconditional release of all liability to the greatest extent allowed by law in the State of Nevada.

Client Name: _____

Client Signature: _____ Date: _____

Parent Name: _____

Parent Signature: _____ Date: _____

Probation Officer Name: _____

Probation Officer Signature: _____ Date: _____

Nevada Homes for Youth

RULES/POLICIES OF COMPUTER USAGE

1. **For school use only.** Staff is to monitor clients at all times and watch their computer screens. Clients need to sit facing the wall, so the computer screen is seen by staff at all times.

2. **No e-mails** unless prior approval (school use only on Monday-Friday) or approved before p.m. school is over.

3. **Gmail** is to be used for school use only (Monday-Friday) by permission from therapist.

4. **Weekends/Study Hour only**, AIS High School students **can** use computers.

5. **Clients** are to show staff what is going on with the computer at **all times**.

6. **Consequences:** Sub-system **50,000 points** for manipulating **unauthorized** use of computer and it will double for each violation.

COMPUTERS ARE TO BE USED FOR SCHOOL AND CLINICAL ASSIGNMENTS ONLY!

Therapeutic projects: A written explanation of why client is using the computer and the treatment reason. All projects to be worked on during P.M. school, Monday through Friday only. **4:30 P.M. IS THE CUT-OFF TIME.**

CONSEQUENCES: All Rules and Policies must be followed. Any client manipulating or using the computer **unauthorized** will receive **50,000 NEGATIVES** and it will double with each unauthorized use and violation.

We must be able to have working computers at all times for school use. Any printing or documents to be done Monday through Friday during day shifts only.

PLEASE TAKE CARE OF COMPUTERS AT ALL TIMES, ESPECIALLY WHEN PUTTING THEM AWAY.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Nevada Homes for Youth

Dear Parents/Guardians:

All clients are NOT allowed to have or use any electronic devices. Please do not bring cell phones, laptops, tablets, etc. into the meeting with your child (please leave them in your car or at home). All electronic devices are not allowed. Thank you for your understanding.

Queridos Padres/Guardianes:

No se permite a todos los clients tener o utilizar ningún dispositivo electrónico. Por favor, no traiga teléfonos celulares, computadoras portátiles, tabletas, etc. a la reunion con su hijo (por favor deje en el coche o en casa). No se permiten todos los dispositivos electrónicos. Gracias por su comprensión.

Sincerely,

Nevada Homes for Youth

_____

Parent/Guardian Signature Date

_____

Client Signature Date

Nevada Homes for Youth

Participation in Speakers and Events Agreement

I, _____, guardian of the client, _____,
Guardian Name Client Name

give permission for him/her to participate in the guest speakers programs, extracurricular field trips, and social events at Nevada Homes for Youth. I understand that these speakers will be supervised and monitored by Nevada Homes for Youth staff.

Each speaker will sign a confidentiality agreement to not disclose any information. This includes the identity of those who seek services, their names, gender, age, number of clients, addresses, types of services received, and place where services were sought or received, and any other information, including social media, and/or photographs that could identify the individual.

Parent Printed Name: _____ Date: _____

Parent Signature: _____

Client Printed Name: _____ Date: _____

Client Signature: _____

Probation Officer Printed Name: _____ Date: _____

Probation Officer Signature: _____

Staff Printed Name: _____ Date: _____

Staff Signature: _____

Nevada Homes for Youth

To Parents and/or Guardians:

Any and all favors, gifts, and such similar items may **not** be accepted from any client or any parent, relative, and/or guardian of clients enrolled in the program at Nevada Homes for Youth.

In addition, due to confidentiality reasons according to HIPAA Law, no photograph may be taken of any client. If in possess ion of client photographs, photographs of client are **not** allowed to be shared on any social media platform, including Facebook and other social media platforms.

Please sign and date to indicate understanding and agreement to follow and abide by the above policy.

Thank you.

Sincerely,

Nevada Homes for Youth

I, _____, understand and will implement the above statements.

(Print name)

_____

Signature Date

Nevada Homes for Youth

Client Treatment Acknowledgement Form

I, _____, am seeking treatment at Nevada Homes for Youth for
(Print name)

the following reasons:

1. _____

2. _____

3. _____

4. _____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Nevada Homes for Youth

525 South 13th Street
Las Vegas, Nevada
(702) 380-2889 • Fax: (702) 380-2893

Personal Items Waiver

I, _____, (parent/guardian), understand that Nevada Homes for Youth is not responsible or liable for any clothing or personal items left at Nevada Homes for Youth after Parent/Guardian has been notified that _____ (client) is no longer placed at Nevada Homes for Youth.

I agree to pick up all clothing and personal items within two weeks of client's discharge from Nevada Homes for Youth residential program.

_____ _____

Parent/Guardian Signature Date

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuse UNLESS:

1. The patient consents in writing;
2. The disclosure is allowed by a court order or;
3. The disclosure is made to a medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ce-3 for Federal laws and the requirement for the confidentiality of client information set forth in 42 CFR Part 2, 45 CFR. Parts 160, 162 and 164 and any other applicable Federal or state laws governing the confidentiality of client information for the services provided.)

_____ _____

Signature to acknowledge receipt of this document Date

_____ _____

Parent/Guardian Signature Date

Nevada Homes for Youth
Consent for Online and Technology Based Counseling Services

I consent to participating in Online Technology Based Counseling Services. I understand that privacy must be maintained at all times and that any interruption during a counseling session will cause the session to be immediately terminated and I will be responsible for the cost of the session. I also agree that no part of my counseling session may be recorded and or shared in public and that no other person shall be present during my sessions.

I understand all communications will be routed through a secure server and information including links to the secure site will be provided to me in advance of any sessions.
I agree not to use a public network for any sessions or communication to protect my privacy and the privacy of my counselor.

I understand that my treatment is protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160,162 & 164.

I further acknowledge that the information was fully explained to me and this consent is given of my own free will. I have been provided a copy of this form.

_____

Client/LegalGuardian Date

_____

Staff Date