North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure & Certification Section

Change
Licensure Application Packet

Form# DHHS/DHSR/MHL5002
Revised 05/05/2020

Mental Health Licensure and Certification Section
www.ncdhhs.gov/dhsr
Tel 919-855-3795 • Fax 919-715-8078
Location: Williams Building • 1800 Umstead Drive • Raleigh, NC 27603
Mailing Address: 1800 Umstead Drive • 2718 Mail Service Center • Raleigh, NC 27699-2718

N.C. Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section
1800 Umstead Drive ■ 2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

Instructions for Completing a Change Licensure Application

Overview

1. These instructions are provided to assist you in completing a change application.
2. Failure to provide all requested information will result in delaying the processing of the application. If the information does not pertain to your facility mark N/A in the area.
3. Change requests must be **submitted at least 30 days prior to the anticipated change**.
4. A change in the ownership of a license has an associated fee which must be submitted with the application. The Change of Ownership fee is shown on chart at end of instructions. Construction related fees will be invoiced to you at a later date (change of capacity, change of location).

Type of Licensure Application

1. **Facility MHL#:** Enter Facility Mental Health License number.
2. Check the appropriate box/boxes for the action you are requesting. If the action is not listed, fill in the blank beside "Other".
   - Change of Location: See Change of Location Checklists (pages 4 & 5).
   - Change of Capacity: If increase in capacity you must submit photos & floor plan. Capacity increases over 6 beds require a per bed fee of $19.00 for beds over 6.
   - Change of Service Category: New letter of support needed from the LME
   - Change of Facility Name: Complete this application.
   - Change of Licensee/Ownership: Complete this application. Signatures are ***required*** for the current licensee/owner and the prospective new licensee/owner (or designees) in #4 and #5 in the change application. A fee is assessed for a change of ownership which must accompany application.
   - Requested Effective Date of Change: Enter date when you are requesting that the change be effective. This may be related to other changes that are occurring with your business.

Current Information

1. Current Facility Name: Enter name printed on your most current license.
2. Current Facility Site Address: This address is the physical site location as printed on most current license.
3. Current Legal Identity of Ownership/Licensee: This is the name printed on your license as the licensee/owner. Please complete address & phone information.
4. Signature of Current Licensee: Current licensee or designated authority for licensee must sign and date here. For a change in ownership request, see above italicized directions for Change of Licensee/Ownership.
5. Signature of Requested New Licensee: If a change of ownership being requested, the representative of the new licensee must sign here. Please note: there is a change of ownership fee (see "change of ownership fee" table below).

Requested Changes

On the Requested Changes page, please complete ***only*** those changes you are requesting.

1. Facility Name: Enter the name of the facility that will be printed on your license.
2. Facility Site Address: Enter the new physical location of your facility.
   - Note: If you are changing locations, please make sure the building code classification for the new address is in compliance with the program(s) to be licensed.
3. Facility Correspondence Mailing Address: This address will be where you will receive all mail for the facility. Indicate the name to address correspondence.
4. Name of Facility Director: This will be the person who is responsible for managing the facility.
5. Name of Contact Person: This could be you or the person responsible for managing the facility. This person can answer daily process and licensure questions about the facility.
6. Management Company: Enter this information if the facility will be managed by a company other than the licensee.
7. Local Management Entity/Manage Care Organization (LME/MCO): Enter the names of LME/MCOs with which the facility has a contract.
8. Legal Identity of Ownership/Licensee: This is the name that will be printed on the license as licensee/owner.
   (a) Enter name and contact information of new owner.
   (b) Federal Tax ID# - if applicable.

(c) Check if you are registered with the state as profit or non-profit.

(d) Type of entity under which the business is operated. All entities should be registered with the state except proprietorship and private partnership.
(e) Supply information for CEO or President.
(f) If you lease the building, complete the data on the person from whom you lease/rent.

9. Owners, Partners, Affiliates, Shareholders (Confidential Information for Official Use Only):
   - If the ownership has investors or shareholders in the business, fill in the information requested. If ownership is a corporation/company having only 1 person who is sole owner, please fill in as percentage interest is 100%.
   - If this is a non- profit entity, Signature and title and date needed in box.
   - If proprietary ownership, complete the box as if shareholder
10. Extensions in Ownership: Enter information about Affiliates who directly or indirectly control the owner of this facility.
11. Service Categories: Note the change or additions to service category. If change in service category complete "from" and "to" entries. Check the category that describes the service/s your facility will provide. For residential facilities, enter the number of beds under either the Children category or Adult category. Increase of beds above 6 may require invoicing by DHSR for additional fee.
12. Certificate of Need: Note if you have a certificate of need for a required service category, and the CON # and date.
13. Number of Clients: Note the number of clients you will serve and the disability category or categories that you will serve.
14. Number of Others Living in the Facility: Complete only if requesting service category *.5600F or .5100-Private Home Respite*. Include the number and ages of anyone that lives in the facility that is not a client.
15. Ambulatory/ Non-Ambulatory Beds: Complete only if you are requesting a change of Ambulatory Beds to Non-Ambulatory Beds.

Construction Fees: The DHSR Construction Section has a per project fee to review the physical plant requirements for ***24-hour residential facilities only*.** You will receive an invoice from the Construction Section for the appropriate fee. Following is a list of fees:

Type of Facility	Number of Beds	Project Fee
Non-ICF/IID Facilities	1-3	$125.00
Non-ICF/IID Facilities	4-6	$225.00
Non-ICF/IID Facilities	7-9	$275.00
ICF/IID Facilities	1-6	$350.00
Other Residential	10 or more	$275.00 + $.15/sq. ft. project space

Change of Ownership Fees

The Operations and Capital Improvements Appropriations Act of 2006 instituted a fee for all residential and non-residential facilities.

Following is a list of types of facilities that require a change of ownership fee, including the base fee and the per bed fee.

Type of Facility	Number of Beds	Base Fee	Per Bed Fee
Non-residential Facilities	0	$215.00	N/A
Residential Facilities (Non-ICF/IID)	6 beds or less	$305.00	$0
Residential Facilities (Non-ICF/IID)	7 beds or more	$475.00	$17.50
ICF/IID Facilities	6 beds or less	$845.00	$0
ICF/IID Facilities	7 beds or more	$800.00	$17.50

Make check payable to:
NC Division of Health Service Regulation

Send Application with required information to:
Division of Health Service Regulation
MH Licensure & Certification Section
1800 Umstead Drive
2718 Mail Service Center
Raleigh, NC 27699-2718

N.C. Department of Health and Human Services
Division of Health Service Regulation
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Change Application Checklist

Incomplete applications will be returned to sender, without processing, accompanied by a letter explaining the incorrect or missing information. Please complete the correct checklist below if you are requesting a change of location prior to submitting your license application

Requirements for 24-hour Residential Programs—Existing Structures

Note: Before construction of a ***new 24-hour residential*** facility, you must submit blueprints and receive approval from the DHSR Construction Section. For additional information contact DHSR Construction at 919-855-3893.

In addition to your cover letter and application please submit the following:

1. A floor plan that specifies the following:
   a. All levels including basements and upstairs.
   b. Identification of the use of all rooms/spaces.
   c. Dimensions of all bedrooms, excluding any toilets, bathing areas and closets. Clarify double or single occupancy.
   d. Location of all doors and the dimensions of all exterior doors.
   e. Location of all windows including the dimensions of bedroom windows and sill height of bedroom windows above the finished floor.
   f. Location of all smoke detectors noting whether they are battery operated, wired into the house current with battery backup, and if they are interconnected.
2. Exterior photos of each side of the building.
3. Interior photos of the kitchen, living areas, bedrooms, and any other rooms.
4. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
5. **Local Zoning Department approval** for the proposed use**.**
   - ***The zoning compliance letter from your local zoning department must clearly identify:***
     - ***Facility address***
     - ***Zoning code (must be correct zoning code see below chart)***
     - ***Intended usage***

Your application will not be processed if your zoning compliance information does not contain and verify the correct zoning

6. Letter of support from LME/MCO (Only required when changing Counties)
7. Appointments for Fire & Sanitation Inspections.

Change of Location Checklist: **Residential**

	Item	**Completed**
1	Completed Change Licensure Application (form DHSR 5002)	
2	Floor Plan Identifying all spaces in facility (all levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)	
3	Pictures (Interior & Exterior)	
4	Directions to Facility	
5	Zoning Approval (original – within 1 year of application date) *Required for application to move forward*	
6	LME-MCO Support Letter *Only needed if location change is in a different county then the facility is currently located.	
7	Appointments for Fire & Sanitation Inspections. Actual inspections are not needed when submitting the application but will be needed prior to DHSR Construction section approval.	

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Requirements for Day Programs

***Note**: Day Programs for children and adolescents **cannot** be located in a building classified as a Business Occupancy. These programs are required to meet either Group E-Educational Occupancy or Group I-4 - Child Daycare Occupancy under the NCSBC.*

In addition to your cover letter and application please submit the following:

1. A floor plan of the entire building or floor within the building of the space to be licensed that specifies the following:
   a. Identification and dimensions of rooms to be licensed.
   b. Exits from the licensed space and building.
   c. Toilet areas and other required support spaces.
2. Exterior photos of each side of the building. Interior photos of the proposed licensed space.
3. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
4. Local Zoning Department approval or verification the facility is classified under building/planning for intended use.
5. Current local Fire Marshal's Inspection Report for the building.
6. Current local Sanitation Inspection report if serving any food.
7. A preliminary program approval letter is required from the State Opioid Treatment Authority (SOTA) for all Service Category 3600 facilities.
8. New Construction/Renovation: the local Building Officials approval.
9. Existing Structure: If this is an existing Business Occupancy building (as classified under the North Carolina state building code) and it is only a change of tenant use (for a program that is classified as a 'Business Occupancy use') approval from the local Building Official may not be required. Contact your local Building Official and provide them with a copy of your application to verify if your program is classified as a Business Occupancy and if they need to provide any type of documentation.

Change of Location Checklist**: Day Program**

	Item	**Completed**
1	Completed Change Licensure Application (form DHSR 5002)	
2	Floor Plan Identifying all spaces in facility (all levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)	
3	Pictures (Interior & Exterior)	
4	Directions to Facility	
5	Zoning Approval (original – within 1 year of application date) *Required for application to move forward*	
6	Fire & Sanitation Inspections. (Sanitation inspection only needed if facility will be serving food)	

Note: If you are changing locations, please make sure the building code classification for the new address is in compliance with the programs being licensed (see Building Code Classifications page below).

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CHANGE LICENSE APPLICATION FOR MH/DD/SAS FACILITIES

TYPE OF CHANGE: **FACILITY MHL#**:_____

☐Facility Name
☐Capacity*
☐ Licensee/ Ownership**
☐Service Category and Code
☐Ambulatory Bed(s) to Non-Ambulatory Bed(s)
☐Adding a Mental Health Service to a Mental Health Hospital MHH#: _____
☐Location* ☐ Within the Same County ☐ Into a Different County
☐Shareholders
☐Other; Please Specify: _____

Note: *Change of Location & Change of Capacity require a Construction Fee. You will be invoiced for these fees. Do not send money for Construction Section when submitting this application. Increase in Capacity over 6 beds requires a licensure fee.
**Change in Ownership requires a license fee to accompany this application

CURRENT LICENSE INFORMATION (complete requested change(s) on following pages)

1. CURRENT FACILITY NAME: _____

2. CURRENT FACILITY SITE ADDRESS: (NO P.O. BOXES)

Street Address: _____

City: _____ State: ___ Zip Code: _____ County: _____

Phone: _____ Email: _____

3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Name of Owner: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

4. SIGNATURE OF CURRENT LICENSEE: The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____ Title: _____

Signature: _____ Date: _____

Name: _____ Title: _____

Signature: _____ Date: _____

5. SIGNATURE OF REQUESTED NEW LICENSEE (if applicable): The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____ Title: _____

Signature: _____ Date: _____

ALL APPLICATIONS MUST BE MAILED TO ABOVE ADDRESS AND MUST HAVE AN ORIGINAL SIGNATURE

OFFICIAL USE ONLY: DHSR Form 5002

Licensure Categories: _____
Licensure Recommendation: _____ DHSR Consultant: _____
Remarks: _____

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REQUESTED CHANGES

Requested Effective Date of Change*:* _____

- Please note, this is ***requested*** date of change, there is ***no guarantee*** the change will be completed by this date.

In application pages 7 – 11, please complete *ONLY* those changes being requested.

1. FACILITY NAME: _____

- Name which the facility is advertised or presented to the public. This is the name that will be printed on your license. Refer to this facility name in **all** inquiries

2. NEW REQUESTED FACILITY SITE ADDRESS: (NO P.O. BOXES) (Please note you cannot move to the new location until you have received your new license for this location.)

Street Address: _____

City: _____State: ___Zip Code: _____County:_____

Phone: _____Email:_____

*must be installed and operable prior to licensing; *cannot* be a cell phone.

3. FACILITY CORRESPONDENCE MAILING ADDRESS:

Name of Contact Person: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

Email Address (to which all correspondence will be sent)

4. NAME OF FACILITY DIRECTOR :(First, MI, Last)_____

5. SIGNATURE OF LICENSEE OR PERSON WITH SIGNATORY AUTHORITY: The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: (First, MI,Last)_____

Signature: _____Title: _____ Date: _____

6. MANAGEMENT COMPANY: If facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:

Name of Company/Contact Person: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

7. LOCAL MANAGEMENT ENTITY/ MANAGED CARE ORGANIZATION (LME/MCO) (List name(s) of LME/MCOs with which the facility has a contract):_____

8. LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Full legal name of individual, partnership, corporation or other legal entity, which owns the mental health facility business, is required. Owner/Licensee means any person/business entity (Corp., LLC, etc.) that has legal or equitable title to or a majority interest in the mental health facility. This entity is responsible for financial and contractual obligations of the business and will be **recorded as the licensee on the license**.

(a) Name of Owner/Corporation: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

(b) Federal Tax ID number of Owner/Licensee: _____

(c) NATIONAL PROVIDER IDENTIFIER (NPI): _____

For Health Care Providers

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique **National Provider Identifier (NPI)**. If you have questions or need additional information regarding the NPI number, call the toll free number 1-800-465-3203 or visit the website: http://www.ncdhhs.gov/dma/NPI/index.htm

(d) Legal entity is: _____ For Profit _____ Not for Profit

(e) Legal entity is:
_____ Proprietorship
_____ Corporation _____ Limited Liability Company
_____ Partnership _____ Limited Liability Partnership
_____ Government Unit

(f) Name of CEO/President: (First, MI, Last) _____

Title: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

Building Owner: If the above entity (partnership, corporation, etc.) ***does not*** own the building from which services are offered, please provide the following information:
Name of Building Owner:_____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

Lease expires: _____

9. OWNERS, PARTNERS, AFFILIATES, SHAREHOLDERS (Confidential Information for Official Use Only):

Complete the information below on **all** individuals, proprietorship or entities who are owners, partners, affiliates or shareholders holding an interest of 5% or more of the applicant entity. Attach additional pages if necessary. *We ask that you voluntarily provide your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing.* If you are the only owner, complete the information below, listing the percentage interest as 100%. ***Documentation verifying all parties agree to change should be submitted in application.***

Shareholder Name: (First, MI, Last) _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Shareholder Name: (First, MI, Last) _____

Street Address: _____

City: _____State: _____Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Shareholder Name: (First, MI, Last) _____

Street Address: _____

City: _____State: _____Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Non-Profit Companies and For-Profit Companies (If no individual holds an interest of 5% or more please sign the statement below.)

There are **no owners, principles, affiliates or shareholders who hold an interest of 5% or more** of the licensee applying for or renewing a license:

_____ _____ _____
Signature Title Date

10. SERVICE CATEGORIES:

Services subject to licensure under G.S. 122C are shown in the table below and are **found in the Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services**. All applicants (initial and renewal) must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Changing from _____ to _____ Adding _____ Deleting _____

Rule 10A NCAC 27G Licensure Rules for Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.1100 Partial hospitalization for individuals who are acutely mentally ill.				
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness				
.1300 Residential treatment facilities for children or adolescents—Level II (Max. of 12 clients)				
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances				
.1700 Residential treatment Staff Secure for Children or Adolescents—Level III				
.1800 Intensive residential treatment for children or adolescents (Level IV)				
.1900 PRTF – Psychiatric Residential Treatment Facility for minors who are emotionally disturbed or who have a mental illness.				
.2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON Required)				
.2200 Before/after school and summer developmental day services for children with or at risk for developmental delays, developmental disabilities, or atypical development				
.2300 Adult Developmental and vocational programs for individuals with developmental disabilities				
.3100 Non-hospital medical detoxification for individuals who are substance abusers				
.3200 Social setting detoxification for substance abuse				
.3300 Outpatient detoxification for substance abuse				
.3400 Residential treatment/rehabilitation for individuals with substance abuse disorders (CON Required)				
.3600 Outpatient narcotic addiction treatment (preliminary SOTA Authorization letter required)				
.3700 Day treatment facilities for individuals with substance abuse disorders				
.4100 Therapeutic homes for individuals with substance abuse disorders and their children (min. 3 clients)				
.4300 A supervised therapeutic community for individuals with substance abuse disorder				
.4400 Substance Abuse Intensive Outpatient Program				
.4500 Substance Abuse Comprehensive Outpatient Treatment Program				
.5000 Facility based crisis service for individuals of all disability groups				
.5100 Community respite services for individuals of all disability groups				

Rule 10A NCAC 27G Licensure Rules for Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.5200 Residential therapeutic (habilitative) camps for children and adolescents of all disability groups				
.5400 Day activity for individuals of all disability groups				
.5500 Sheltered workshops for individuals of all disability groups				
. 5600 supervised living for individuals of all disability groups (CON required for ICF/IID facility) Only One from the ".5600" categories can be chosen.				
5600**A** Group homes for adults whose primary diagnosis is mental illness (Max. of 6 clients)				
5600**B** Group homes for minors whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600**C** Group homes for adults whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600**D** Group homes for minors with substance abuse problems				
.5600**E** Half-way houses for adults with substance abuse problems				
.5600F Alternative family living – providing service in own private residence (Max. 3 clients)				

11. DO YOU HAVE A CERTIFICATE OF NEED? Required for the following service categories: .2100, .3400, & .5600 (only when ICF/IID facility)

☐ No Yes ☐ If yes, CON Number: _____ Date CON Received: _____

12. Do you plan on serving clients requiring blood sugar checks? Yes ☐ No ☐

*If yes **and** your staff will be conducting blood sugar checks, you must apply for a CLIA waiver before conducting blood sugar checks. Please contact DHSR's Acute & Home Care section's CLIA branch for information on obtaining CLIA waiver: https://info.ncdhhs.gov/dhsr/ahc/clia/index.html

13. NUMBER OF BEDS:

Type	Current License	Requested Change
Ambulatory*		
Non-Ambulatory, 1-3		
Non-Ambulatory, 4 or more		

***Ambulatory: a person who can evacuate the building without physical or verbal assistance during a fire or other emergency.**

14. NUMBER AND AGE(s) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:
(Applicable only in categories where private residence is allowable: .5600 F & .5100 Private Home Respite)

Are any of the above people non-ambulatory? Yes ☐ No ☐

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CONSTRUCTION: PHYSICAL PLANT

Please fill in EACH inspection Department information if change of location:

Zoning Department Official

Department Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Local Building Official

Department Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Local Fire Marshall

Department Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Local Sanitation

Department Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Building Information: Complete for 24-hour residential facilities only:

Has the building housed a licensed facility previously? Yes ☐ No ☐

If Yes: Type of licensed facility:

_____

Previous License #: _____ Dates of Licensure: From: _____ To: _____

Does this building(s) contain facilities licensed for a different use other than the one an initial license is being sought for? Yes ☐ No ☐

If yes, please clarify type of license

_____

Is the building a site constructed home or a manufactured/mobile home?

_____

NOTE: If it is a manufactured/mobile home, contact the DHSR Construction Section for licensure limitations on this type of structure)

If it is a manufactured/mobile home, was it built after 1976? Yes ☐ No ☐

Building Classifications and Service

NOTE: Day Programs for children and adolescents cannot be in a building classified as a Business Occupancy. These programs are required to meet either Group E-Educational Occupancy or Group I-4 - Child Daycare Occupancy under the NCSBC.

Program Code 10 NCAC 27G	Facility Type/Service Category	Day/24-Hour/ Periodic	Building Classification	Code
.1100	Partial Hospitalization for individuals who are acutely mentally ill	Day	Group B – Business Occupancy (Adults) Group E – Educational or I-4 (Minors)	a
.1200	Psychosocial Rehab for individuals with Severe and Persistent Mental Illness	Day	Group B – Business Occupancy	a
.1300	Residential Treatment for Children or Adolescents	24- Hour	Residential – Classification dependent on number & ambulation status	b
.1400	Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances	Day	Group E – Educational Occupancy or I-4	a
.1700	Residential Treatment Staff Secure for Children or Adolescents	24- Hour	Residential – Classification dependent on number & ambulation status	d
.1800	Intensive Residential Treatment for Children or Adolescents	24- Hour	Institutional Occupancy	e
.1900	Psychiatric Residential Treatment for Children and Adolescents	24- Hour	Institutional Occupancy	f
.2100	Specialized Community Residential Centers for Individuals with Developmental Disabilities	24- Hour	Residential or Institutional Occupancy	g
.2200	Before/After School and Summer Developmental Day Services for Children with or at Risk for Developmental Delays, Developmental Disabilities, or Atypical Development	Day	Group E- Educational or I-4	a
.2300	Adult Developmental and Vocational Program for Individuals with Developmental Disabilities	Day	Group B- Business Occupancy	a
.3100	Nonhospital Medical Detoxification for Individuals who are Substance Abusers	24- Hour	Institutional Occupancy	h
.3200	Social Setting Detoxification for Substance Abusers	24- Hour	Residential or Institutional Occupancy	m
.3300	Outpatient Detoxification for Substance Abuse	Periodic	Group B – Business Occupancy	a
.3400	Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders	24- Hour	Residential or Institutional Occupancy	i
.3600	Outpatient Opioid Treatment	Periodic	Group B- Business Occupancy	a
.3700	Day Treatment Facilities for Individuals with Substance Abuse Disorders	Day	Group B- Business Occupancy Group E – Educational or I-4 (Minors)	a
.4100	Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children	24- Hour	Typically Group R – Residential	j
.4300	Therapeutic Community	24- Hour	Typically Group R – Residential	k

Program Code 10 NCAC 27G	Facility Type/Service Category	Day/24-Hour/ Periodic	Building Classification	Code
.4400	Substance Abuse Intensive Outpatient Program (SAIOP)	Periodic	Group B – Business Occupancy (Adults) Group E – Educational or I4 (minors)	a
.4500	Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	Periodic	Group B- Business Occupancy	a
.5000	Facility Based Crisis Services for Individuals of All Disability Groups	24- Hour	Institutional Occupancy	l
.5100	Community Respite Services for Individuals of All Disability Groups	24- Hour	Typically, Residential depending on number of residents	m
.5200	Residential Therapeutic (Habilitative) Camps for Children and Adolescents of All Disability Groups	24- Hour	Wilderness Camp Settings	p
.5400	Day Activity for Individuals of All Disability Groups	Day	Group B- Business Occupancy Group E – Educational or I4 (Minors)	a
.5500	Sheltered Workshops for Individuals of All Disability Groups	Day	Group B- Business Occupancy	a
.5600	Supervised Living for Individuals of All Disability Groups	24- Hour	Residential	o
.6000	Inpatient Hospital Treatment for Individuals who have Mental Illness or Substance Abuse Disorders	24- Hour	Institutional Occupancy	l

Code	Program Type / Description
a	Day Program
b	Level II Clients
c	This program has been deleted
d	Level II clients (previously part of the .1300 program)
e	Level IV clients. Required to be a secured facility and Institutional – Unrestrained Occupancy (previously part of the .1500 program)
f	PRTF clients. May be staff secured or locked; still Institutional – Unrestrained Occupancy (previously part of the .1500 program)
g	Usually these are ICF/IID facilities and required to have a Certificate of Need (CON)
h	Institutional Occupancy since providing medical treatment
i	Typically, not in a six-bed facility since requires CON
j	Program is for women and their children. Usually in apartment/motel situation but if less than six could be a home
k	Program is for adults and is usually in apartment/ motel situation but if less than six could be in a home
l	Requires Institutional Occupancy since requiring treatment
m	Typically, is with another residential program. Could be part of a larger facility that is not residential.
n	Support Services, not residential
o	Has six different programs. .5600A; .5600B; .5600C are limited to maximum of 6 clients. .5600F is limited to maximum of 3 clients in private residence.
p	Residential Camp
q	Any program not listed is not a licensed program by Mental Health

Programs typically licensed in Single-Family Dwellings and falling under G.S. 168 are: .1300, .1700, .2100, .5100 & .5600.

MH Licensure Policies and Procedures Worksheets

Use of form:

Mental Health Licensure requires the licensee to develop written policies and procedures. Policies and procedures must be submitted to the Licensure and Training Consultant at the first review. All subchapters and rules are hyperlinked for convenience in worksheet.

Instructions:

1. Use the policy worksheet to identify the page number on which you address each point for ease in reference and review.
2. Policy and procedure manuals must include table of contents with page numbers or below worksheet.
3. The Yes, No, NA and I (incomplete) columns are for internal use.

Policies should be dated, and the pages numbered. This worksheet is not a substitution for the rules. The licensee is responsible for complying with all applicable rules and statutes. The information below is only a snapshot of the actual rules and is not a substitute for obtaining a licensure rule book.

Name – Facility	Address – Facility (Street, City, State, Zip Code)	Date
Name of LTC	**Program Code**	

Policy / Procedure Checklist

SUBCHAPTER G. RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE FACILITIES AND SERVICES

Policy Page Number Must be Entered	10A NCAC 27G .201 Governing Body	Yes	No	NA	(I)
	1. Delegation of Management Authority (Chain of command).	☐	☐	☐	☐
	2. Admission Criteria for admission into facility.	☐	☐	☐	☐
	3. Admission Assessments including: • **who will perform the assessment; and** • **time frames for completing assessment.**	☐	☐	☐	☐
	4. Criteria for discharging client from facility	☐	☐	☐	☐
	5. Client record management, including: • **persons authorized to document;** • **how to transport records;** • **safeguard of records** • **record accessibility to authorized users and** • **assurance of confidentiality of records.**	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Policy Page Number Must be Entered	Rule	Yes	NO	N/A	(I)
	6. Screenings and assessments, which shall include: • **Individuals presenting problem or need;** • **will provide services to address the needs of the individual;** • **disposition of clients.**	☐	☐	☐	☐
	7. Quality assurance and Quality improvement activities, including: • **QUALITY IMPROVEMENT and QUALITY ASSURANCE committee;** • **QUALITY IMPROVEMENT and QUALITY ASSURANCE improvement plan;** • **methods for monitoring client care** • **qualified supervision for all staff** • **strategies for improving client care;** • **staff credentialing/privileging** • ***review of all fatalities*** • **adoption of standards practice.**	☐	☐	☐	☐
	8. Incident Reporting	☐	☐	☐	☐
	9. Voluntary Non-Compensated client work	☐	☐	☐	☐
	10. Fee assessment and collection	☐	☐	☐	☐
	11. Medical Emergency Plan	☐	☐	☐	☐
	12. Authorization for and follow up of lab tests.	☐	☐	☐	☐

Policy Page Number Must be Entered	Rule	Yes	NO	N/A	(I)
	13. Transportation including the accessibility of emergency information for a client when transporting.	☐	☐	☐	☐
	14. Safety precautions and requirements for facility areas including special client activity areas; (*one area is your Fire/Disaster Plan: What you plan to do if there is a fire or disaster and how you are going to execute).*	☐	☐	☐	☐
	15. Volunteers: services of volunteers, including supervision and requirements for maintaining client confidentiality.	☐	☐	☐	☐
	16. Areas in which staff, including nonprofessional staff, receive training and continuing education.	☐	☐	☐	☐
	17. Client grievance policy and procedures for review of client grievances	☐	☐	☐	☐
	18. Minutes of the governing body shall be permanently maintained.	☐	☐	☐	☐
	19. Policies and procedures for; • **identifying,** • **reporting,** • **investigating and,** • **controlling infectious and communicable diseases of *staff and client.***	☐	☐	☐	☐

NOTES

Policy Page Number Must be Entered	**10A NCAC 27G .0203 Competencies of Qualified and Associate Professionals**	**Yes**	**No**	**NA**	**(I)**
	1. Policy on implementing and creating the individualized supervision plan upon hiring each associate professional	☐	☐	☐	☐
Policy Page Number Must be Entered	**10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS**	**Yes**	**No**	**NA**	**(I)**
	2. Policy on implementing and creating of the individualized supervision upon hire of each paraprofessional.	☐	☐	☐	☐
Policy Page Number Must be Entered	**10A NCAC 27G .0205. ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN**	**Yes**	**No**	**NA**	**(I)**
	3. The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.	☐	☐	☐	☐
	4. The plan shall include: • client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; • strategies; • staff responsible; • a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; • basis for evaluation or assessment of outcome achievement; and • written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	☐ ☐	☐ ☐	☐ ☐	☐ ☐

10A NCAC 27G .0209. MEDICATION REQUIREMENTS					
Page Number Must be Entered	**Medication Dispensing**	**Yes**	**No**	**NA**	**(I)**
	1. Medications dispensed only by written MD order.	☐	☐	☐	☐
	2. Dispensing of medications only by Licensed person.	☐	☐	☐	☐
	3. How take-home Methadone given to client by RN only.	☐	☐	☐	☐
	4. Policy on how Facilities shall not keep prescription drugs for dispensing without a Pharmacist, except for emergency use.	☐	☐	☐	☐
	Medication packaging and labeling				
	5. Policy on Non-Prescribed drug containers not dispensed by a Pharmacist must have original label with expiration dates visible.	☐	☐	☐	☐
	6. Policy on Prescription medications must be dispensed in tamper resistant packaging.	☐	☐	☐	☐
	7. Policy on the label of prescription meds must include: • Client name; • MD name; • dispensed date; • administration directions; • name, strength, quantity & expiration date of drug; • name & address of pharmacy; name of Pharmacist.	☐	☐	☐	☐
	Medication administration				
	8. How prescription or non-prescription drugs shall be administered.	☐	☐	☐	☐
	9. A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: • client's name; • name, strength, and quantity of the drug; • instructions for administering the drug; • date and time the drug is administered; and • name or initials of person administering the drug.	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Policy Page Number Must be Entered	Rule	Yes	NO	N/A	(I)
	10. Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.	☐	☐	☐	☐
	11. Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	☐	☐	☐	☐
	Medication Disposal				
	12. Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	☐	☐	☐	☐
	Medication Storage				
	13. Medications shall be stored: • in a securely locked cabinet in a clean, well-lighted, ventilated room between 59º and 86º F.; • in a refrigerator, if required, between 36º and 46º F. o If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; • separately for each client; • separately for external and internal use; • in a secure manner if approved by a physician for a client to self-medicate.	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Policy Page Number Must be Entered	**Medication review**				
	1. 6-month drug review by a Psychiatrist or Pharmacist required if taking Psychotropic medications	☐	☐	☐	☐
	2. Findings from drug review recorded in client record with corrective action plan.	☐	☐	☐	☐
	3. Staff is responsible for informing MD of review results if medical intervention is indicated.	☐	☐	☐	☐

Policy Page Number Must be Entered	**Medication Errors**	**YES**	**NO**	**N/A**	**(I)**
	4. Policy on significant adverse drug reactions and how reported immediately to a physician or pharmacist.	☐	☐	☐	☐
	SUBCHAPTER D. GENERAL RIGHTS				
Policy Page Number Must be Entered	**10A NCAC 27D .0101. POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS**	**YES**	**NO**	**N/A**	**(I)**
If facility uses Seclusion, Restraints and Isolation Time Out this section MUST be in facility's policy and procedure manual					
	1. How ***ALL*** instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services.	☐	☐	☐	☐
	2. What safeguards are used when medications are known to present serious risk.	☐	☐	☐	☐
	3. Identify restrictive intervention (RI) that is prohibited from use within the facility.	☐	☐	☐	☐
	4. ***If a 24-hour facility***, the circumstances under which staff are prohibited from restricting the rights of a client.	☐	☐	☐	☐
	5. Identify allowed restrictive intervention(s) in your facility.	☐	☐	☐	☐
	6. Staff (position) responsible for informing client of restrictive interventions.				
	7. Due process procedure for a client who refuses the use of restrictive interventions.	☐	☐	☐	☐
	8. Identify staff person (position) responsible for giving written permission for giving written permission for 24hr restrictive interventions.	☐	☐	☐	☐
	9. Identify staff person (position) who is responsible for review client of restrictive interventions.	☐	☐	☐	☐
	10. Process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.	☐	☐	☐	☐

Policy Page Number Must be Entered	Rule Continued	Yes	NO	N/A	(I)
	11. **Following the use of restrictive intervention, the staff shall conduct a debriefing and planning with the client and legally responsible person. This process should be conducted based on the cognitive functioning of the client.**	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27D .0102. SUSPENSION AND EXPULSION POLICY				
	12. Policy documenting each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility.	☐	☐	☐	☐
	13. The policy shall address the criteria to be used for suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include: • Timeframe for resuming services after suspension. • the specific time and conditions for resuming services following suspension; • efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and • the discharge plan, if any.	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27D .0103. SEARCH AND SEIZURE POLICY				
	14. **Policy that specifies the conditions under which searches of the client or his/her living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client.**	☐	☐	☐	☐
	15. Each client is free from unwarranted invasion of privacy.	☐	☐	☐	☐
	16. Specifications on the conditions under which searches of the client or person's area may occur.	☐	☐	☐	☐
	17. Where and how to document a search and seizure. (A) scope of search; (B) reason for search; (C) procedures followed in the search; (D) a description of any property seized; and (E) an account of the disposition of seized property.	☐	☐	☐	☐

NOTES

Policy Page Number Must be Entered	**10A NCAC 27D .0104. PERIODIC INTERNAL REVIEW**	**YES**	**NO**	**N/A**	**(I)**
	18. Procedure on conducting a review at least every 3 years to check for compliance with applicable laws.	☐	☐	☐	☐
	19. The governing body will keep and maintain the three most recent written reports of the findings of reviews.	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27D .0201. INFORMING CLIENTS				
	20. Written client rights shall be made available to each client and or legal representative.	☐	☐	☐	☐
	21. Each client shall be informed of his right to contact the Disability Rights of North Carolina.	☐	☐	☐	☐
	22. Documentation kept in client record that client rights have been explained.	☐	☐	☐	☐
	23. ***Within 72 hours*** or three visits, client will be informed of rules and violation penalties; disclosure rules for confidential info; procedure for obtaining a copy of treatment plan; grievance procedure (including contact person); suspension/expulsion and search and seizure.	☐	☐	☐	☐
	24. ***In facilities using Restrictive Interventions:*** timeframe client will be informed of the purpose, goal & reinforcement structure of a behavior management system; potential restrictions; notification provisions regarding use; notice that the legally responsible person after use of a restrictive interventions; a competent adult may designate an individual to receive information after restrictive interventions and notification provisions regarding restriction of rights.	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27D .0202. INFORMING STAFF				
	25. Policy on informing staff of client rights.	☐	☐	☐	☐
	26. Documentation of receipt of information by each staff	☐	☐	☐	☐

Policy Page Number Must be Entered	**10A NCAC 27D .0301. SOCIAL INTEGRATION**	**YES**	**NO**	**N/A**	**(I)**
	27. Each client ***in a day/night or 24-hour facility*** is encouraged to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community.	☐	☐	☐	☐
	28. Clients shall not be prohibited from appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community.	☐	☐	☐	☐
Policy Page Number Must be Entered	**10A NCAC 27D .0302. CLIENT SELF-GOVERNANCE**				
	29. ***A day/night or 24-hour facility***, allows client input into facility governance and the development of client self-governance groups	☐	☐	☐	☐
Policy Page Number Must be Entered	**10A NCAC 27D .0303. INFORMED CONSENT**				
	30. Clients will be informed about the alleged benefits potential risks and alternative treatments.	☐	☐	☐	☐
	31. Clients will be about the length of time the consent is valid and what the procedure is to withdraw consent: • The timeframe of consents (no more than six months) • written consents for; ➢ Planned interventions ➢ Antabuse and Depo-Perovera	☐	☐	☐	☐
	32. Clients have a right to refuse treatment and not be threaten with termination.	☐	☐	☐	☐

Policy Page Number Must be Entered	**10A NCAC 27D .0304. PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION**	**YES**	**NO**	**N/A**	**(I)**
	33. Staff shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.	☐	☐	☐	☐
	34. Staff shall not subject a client to any sort of abuse or neglect.	☐	☐	☐	☐
	35. Goods or services ***shall not*** be sold to or purchased from a client.	☐	☐	☐	☐
	36. Staff shall use only that degree of force necessary to repel or secure a violent and aggressive client and • ensure if force necessary written the degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client.	☐ ☐	☐ ☐	☐ ☐	☐ ☐
	37. Any violation by a staff of this rule is grounds for dismissal.	☐	☐	☐	☐
	SUBCHAPTER E. TREATMENT OR HABILITATION RIGHTS				
	SECTION 10A NCAC 27E. PROTECTIONS REGARDING INTERVENTIONS PROCEDURES				
	If the facility uses Seclusion, Restraints and Isolation Time Out below 10A NCAC 27E Treatment of Habilitation Rights must be reflected in the facility's policy and procedure manual.				
Policy Page Number Must be Entered	10A NCAC 27E .0101. LEAST RESTRICTIVE ALTERNATIVE				
	1. Facilities shall provide services using the least restrictive, most appropriate while ensuring a safe and respectful environment.	☐	☐	☐	☐
	2. The use of restrictive intervention's shall be accompanied by actions to insure dignity and respect during the after the intervention. Including using the intervention as a last resort; and employing the intervention by people trained in its use.	☐	☐	☐	☐

Policy Page Number Must be Entered	**10A NCAC 27E .0102. PROHIBITED PROCEDURES**	**YES**	**NO**	**N/A**	**(I)**
	3. The following procedures are prohibited: corporal punishment; painful body contact; substances which create painful bodily reactions; electric shock; insulin shock; unpleasant tasting foodstuffs; application of noxious substances (noise, bad smells, splashing with water); physically painful procedures to reduce behavior	☐	☐	☐	☐
	4. The governing body may determine to prohibit use of any interventions deemed unacceptable.	☐	☐	☐	☐
Policy Page Number Must be Entered	**10A NCAC 27E .0103. GENERAL POLICIES REGARDING INTERVENTION PROCEDURES**				
	5. Procedures only employed when clinically or medically indicated as a method of therapeutic treatment.	☐	☐	☐	☐
	6. The determination that a procedure is clinically/medically indicated and the authorization for use of such treatment for a specific client can only be made by a physician or a licensed PHD who has been formally trained and privileged in the use of a procedure.	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27E .0104. SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL				
	7. **Written policy delineates use of restrictive interventions.**	☐	☐	☐	☐
	8. The use of restrictive interventions shall be limited to: • emergency situations, in order to terminate a behavior or action in which a client is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or • as a planned measure of therapeutic treatment ***(NOTE: NO PRTF shall NOT have planned restrictive intervention's § 483.356 - Protection of residents.)***	☐	☐	☐	☐

Policy Page Number Must be Entered	Rule Continued	Yes	NO	N/A	(I)
	9. Restrictive interventions are considered a planned intervention and must be included in the client's treatment/habilitation plan whenever it is used: • More than four times or • More than 40 hours in a calendar month • in a single episode in which the original order is renewed for up to a total of 24 hours in accordance with the limit specified in Item in your policy • as a measure of therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures.	☐ ☐	☐ ☐	☐ ☐	☐ ☐
	10. The planned intervention has consent or approval and shall be considered valid for no more than six months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed	☐	☐	☐	☐
	11. How restrictive interventions will not be used as coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing.	☐	☐	☐	☐
	12. Restrictive intervention's will not be used in a manner that causes harm or abuse.	☐	☐	☐	☐
	13. Define and outline the permissible use of restrictive interventions within a facility.	☐	☐	☐	☐
	14. The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident: • the type of procedure used, and the length of time employed; • alternatives considered or employed; and • the effectiveness of the procedure or alternative employed.	☐	☐	☐	☐
	15. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request.	☐	☐	☐	☐

Policy Page Number Must be Entered	Rule Continued	Yes	NO	N/A	(I)
	16. Identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions.	☐	☐	☐	☐
	17. The duties and responsibilities of responsible professionals regarding the use of restrictive interventions.	☐	☐	☐	☐
	18. The person responsible (position) for documentation when restrictive interventions are used.	☐	☐	☐	☐
	19. The person responsible (position) for the notification of others when restrictive interventions are used.	☐	☐	☐	☐
	20. The person responsible (position) for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention.	☐	☐	☐	☐
	21. Procedures with the use of Restrictive Interventions: • documentation physical disabilities • room used for seclusion • if using Isolation: criteria • whenever a restrictive intervention is utilized, documentation shall be made in the client record to include • how emergency use of restrictive interventions shall be limited.	☐ ☐	☐ ☐	☐ ☐	☐ ☐
	22. Precautions and actions are employed when a client is in seclusion or physical restraint.	☐	☐	☐	☐
	23. Discontinuing immediately at any indication of risk to the client's health or safety.	☐	☐	☐	☐
	24. Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout.	☐	☐	☐	☐

Policy Page Number Must be Entered	Rule Continued	Yes	NO	N/A	(I)
	25. When any restrictive intervention is utilized for a client, who, when and how others will be notified.	☐	☐	☐	☐
	26. How the facility will conduct reviews and reports on any and all use of restrictive interventions.	☐	☐	☐	☐

NOTES

Policy Page Number Must be Entered	10A NCAC 27E .0105. PROTECTIVE DEVICES				
	27. Procedure ensuring when a protective device is utilized for a client • The necessity for the protective device • Facility employee using device has been trained and demonstrated competence in the use for device • Observation and interventions documented in client record • Protocol on maintenance and cleaning of the devices	☐	☐	☐	☐
	28. Procedure documenting if facility is operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee.	☐	☐	☐	☐
	10A NCAC 27E .0106. INTERVENTION ADVISORY COMMITTEES				
	29. Intervention Advisory Committee shall be established to provide additional safeguards in a facility that utilizes restrictive interventions as planned interventions	☐	☐	☐	☐
	30. Document who is required in the membership of your Intervention Advisory Committee.	☐	☐	☐	☐
	31. A procedure that governs the Intervention Advisory Committee and details how client information is disseminated and reasoning for disseminating.	☐	☐	☐	☐
	32. A procedure regarding the Intervention Advisory Committee will document the specific training and orientation given to the Committee.	☐	☐	☐	☐

NOTES

Treatment Rights in 24-hour Facilities

Policy Page Number Must be Entered	NCGS 122C-61: Treatment rights in 24-hour facilities	YES	NO	N/A	(I)
	1. Client will have the right to receive necessary treatment for and prevention of physical ailments based upon the client's condition and projected length of stay.	☐	☐	☐	☐
	2. Clients have the right to have as soon as practical during treatment but not later than the time of discharge, an individualized written discharge plan containing recommendation for further services designed to enable the client to live as normally as possible	☐	☐	☐	☐
Policy Page Number Must be Entered	NCGS 122C-62: Additional rights in 24-hour facilities				
	3. **Adult Clients have the right to:** • Make and receive confidential phone calls • Receive visitor's between 8:00 a.m. and 9:00 p.m. for at least 6 hours daily, 2 hours shall be after 6:00pm. Visiting shall not take precedence over therapies. • Communicate & meet under appropriate supervision with individuals of own choice. • Make visits outside of the facility unless issues related to commitment proceedings or court order. • Be out of doors daily and have access to facilities & equipment for physical exercise several times a week. • Keep and use personal clothing and possessions. • Participate in religious worship. • Retain a driver's license unless otherwise prohibited. • Have access to individual storage space for private use.	☐	☐	☐	☐

Policy Page Number Must be Entered	Rule Continued	Yes	NO	N/A	(I)
	4. Minor Clients have the right to: • Make and receive phone calls. • Under appropriate supervision, receive visitor's b/n 8:00 a.m. and 9:00 p.m. for at least 6 hours daily, 2 hours shall be after 6:00pm. Visiting shall not take precedence over therapies. • Send and receive mail and have access to writing materials, postage, staff assistance. • Receive special education and vocational training. • Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with client needs. • Keep and use personal clothing and possessions under appropriate supervision. • Participate in religious worship. • Have access to individual storage space for personal belongings. • Have access to and spend a reasonable sum of own money. • Retain a driver's license unless otherwise prohibited.	☐	☐	☐	☐

NOTES

Subchapter 27F Specific Rules for 24-Hour Facilities

SUBCHAPTER 27F - 24-HOUR FACILITIES					
Policy Page Number Must be Entered	10A NCAC 27F .0101 Scope				
	1. Article 3, Chapter 122C of the General Statues provides specific rights for each client who receives a mental health, developmental disability or substance abuse service. This subchapter delineates the rules regarding those rights for clients in a 24-hour facility.	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27F .0102. LIVING ENVIRONMENT				
	2. Efforts to make a quiet atmosphere for uninterrupted sleep, privacy areas.	☐	☐	☐	☐
	3. Client may suitably decorate room, when appropriate.	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27F .0103 Health, Hygiene and Grooming				
	4. Clients will have the right to dignity, privacy and humane care in healthy hygiene and grooming.	☐	☐	☐	☐
	5. Client's will have access to shower/tub daily or more often as needed; access to a barber or beautician, access to linens and towels and other toiletries.	☐	☐	☐	☐
	6. Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment will be available.	☐	☐	☐	☐
	7. Ct bathtubs, showers and toilets will be private.	☐	☐	☐	☐

Policy Page Number Must be Entered	10A NCAC 27F .0104 Storage and Protection of Clothing and Possessions				
	8. Staff will make every effort to protect client personal clothing and possessions from loss or damage.	☐	☐	☐	☐
Policy Page Number Must be Entered	10A NCAC 27F .0105 Client's Personal Funds				
	9. Each client will be encouraged to maintain funds in a personal account.	☐	☐	☐	☐
	10. Funds managed by staff will: assure client right to deposit and withdraw money; regulate the receipt and distribution, and deposits of funds; provide adequate financial records on all transactions; assure client funds are kept separate; allow deduction from accounts for payment of treatment/habilitation services when authorized; issue receipts for deposits and withdrawals provide client quarterly statements.	☐	☐	☐	☐
	11. Authorization by client required before a deduction can be made from an account for any amount owed for damages done by the client to the facility, to an employee of the facility, a visitor or another Client.	☐	☐	☐	☐
	SUBCHAPTER 13O – HEALTHCARE PERSONNEL REGISTRY				
Policy Page Number Must be Entered	10A NCAC 13O .0102 Investigating and Reporting Health Care Personnel Registry				
	1. The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	☐	☐	☐	☐

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