



Welcome to **Casa de Vida**,

The staff of Casa de Vida is here to support you in any way needed during this special time in your life. As you know, all of the classes scheduled are mandatory, and this binder is to be used to organize handouts and other information you may acquire while attending class. Please feel free to organize it however you like. If done well, it could become a great reference book for you and your baby.

Philosophy and Statement of Non-discrimination for Casa de Vida

Casa de Vida wishes to provide residence for young, women, particularly pregnant adolescents, who are in need of support services. The policy of the Board of Trustees is one of non-discrimination on the basis of race, color, creed, or national origin.

Casa de Vida reflects a respect for life philosophy in a caring environment, which affirms ethical values in sexuality and family life. We endeavor to help the pregnant adolescent realize she has the capacity to look ahead, to grow, and to control her own life as well as to have ideals and aspirations for her baby. We believe that basic life decisions about her responsibilities, sexuality, and obligations of parenthood involve values that will underlie her decisions and profoundly affect the future quality of her life. Because her self-esteem is often at low ebb, we emphasize the importance of caring by the staff, the medical profession, and the community at large.

Whenever possible, we wish to involve the father of the child and all family members in support of the young mother by means of counseling, support programs, and whatever means that are available to help us achieve these goals.

Good luck!!

CASA DE VIDA PROGRAM REQUIREMENTS

1. Proof of Pregnancy.
2. TB test prior to admission.
3. Drug and alcohol testing prior to admission.
4. Mental health assessment at admission and participation in on-going group and/or individual counseling as outlined in the resident's initial case plan meeting.
5. Enrollment and continued attendance in an accredited school for all residents who have not completed their diploma or GED prior to admission. Girls going to school 20 hours or less a week will be required to work a minimum of 15 hours weekly.
6. Employment and housing fees for all residents who are 18 Years of age or older within 30 days of admission.
7. Work must be a minimum of 32 hours a week for residents *not* attending school, 15 hours a week for students. Proof of on-going employment required throughout your stay.
8. Residents admitted prior to having employment will be given 30 days to find employment and must vacate the house by 9:00 am daily (Mon-Fri) with the Casa de Vida job search form to seek employment or face discharge from the program. Those in adult education morning classes must be out job searching by 12:00 pm daily. A minimum of 5 employment applications must be filled out daily and those companies must be listed in the job search form that residents turn in daily to the social worker on staff. Note: Residents failing to be actively seeking employment could be discharged from the program.
9. Volunteer service: All residents are required to give back to Casa de Vida by working within the house as needed, such jobs may include but is not limited too working in the Clothes Closet, bagging diapers, sorting clothing, folding mailers etc. as needed and asked.
10. Casa de Vida is a residential treatment program for **pregnant** young women. Policy states that housing and employment must be arranged prior to delivery. Once a resident has given birth, residents are encouraged to remain at Casa de Vida for a two-week post-pregnancy period for assistance and support. However, residents **cannot exceed the two-week policy**, and must have housing arranged prior to the two-week date.
11. \$5.00 Key deposit.

Please note: All visitors may be subject to drug and alcohol testing while on Casa de Vida property. Visitors who refuse to submit to the test will be asked to vacate Casa de Vida property. In some cases law enforcement may be called. Failure to maintain employment, school, or volunteer work, may be grounds for a resident to be evicted from the Casa de Vida program.

CASA DE VIDA HOUSE RULES

The following are the house rules for Casa de Vida. We ask that while you are in residence here you follow these rules. The purpose of the rules is to develop a family atmosphere of respect and caring between all who live here. Some of the rules, such as smoking, using drugs etc. are absolute. Other rules, such as mealtime or free time may occasionally be flexible, at the discretion of the housemother and social worker. It is our goal to create a place where everyone is comfortable, but also a place where everyone pulls their own weight and contributes to the needs of the home. Most importantly however, the rules are intended to provide a healthy safe environment for you and your expected baby. Thanks for helping make this happen.

Classes: All classes and programs have required attendance and **come before** all other activities. See the social worker regarding any conflict in your schedule. Those working need to try and schedule work hours around the Casa de Vida house calendar.

Visitors: There is a policy for visitors, which every resident is responsible for having their visitors adhere to. (Please refer to your binder).

No smoking, alcohol, or illicit drugs allowed. If you are suspected of using drugs or alcohol you may be required to take a drug test and if positive you will be referred to appropriate rehabilitation services. Failure to submit to testing or drug treatment will result in immediate termination from the program.

Medication: Resident's are responsible for the purchase and administration of their own medications. This includes any over-the-counter medicines such as Tylenol as well. Please see the social worker for a referral to Care Chest if you are unable to pay for a prescription given to you by your physician. *Casa de Vida staff members are not allowed to give or purchase over-the-counter and/or prescription drugs to residents at any time.*

Curfew: All residents must be home at 9 p.m. Sunday through Thursday. Friday and Saturday evenings' curfew will be at 11 p.m.

- In respect for all living in the home, residents should be in their rooms by **10:00 pm** weekdays and **11:00 pm** on weekends.
- Residents must sign the destination log before they leave the house, and must *leave a phone number where they will be and a time of return.* Residents must sign back in on their return.
- A resident must not leave the house without permission or knowledge by staff. Casa de Vida will not be held responsible for any actions or events that may happen as a result of leaving the premises without said permission.
- **Passes or other special arrangements** for the weekend must be made with the social worker by 3:00pm on Thursday. You must have your parent/guardian call to approve the pass by this time. NOTE: Casa de Vida has the right to revoke passes at anytime.

Behavior in the house:

- No violent, vulgar, foul or abusive language or behavior will be tolerated.
- Residents should be dressed appropriately at all times when not in their rooms.
- There is to be no TV until after 4 p.m., Monday through Friday
- In respect for the housemother's privacy, her room is off limits without invitation.
- To protect all resident's confidentiality, the social worker's office is off limits without supervision.
- Bullying and gossip of other residents is strictly prohibited and grounds for immediate eviction.

Meals: *There is absolutely no cooking after 7:00 pm by any of the residents every day of the week. Residents are responsible for preparing their own breakfasts and lunches.*

- **Breakfast:** You must be done cooking, eating and cleaning up no later than 10:00 am.

- **Lunch:** You can fix lunch for yourself between 11:30 and 2:00pm. You must clean up after yourself as soon as you are done.
- **Dinner: Attendance is required** at the evening meal at 6 p.m. Monday-Thursday. Residents must be home by 5:30pm to prepare for dinner. The housemother must approve any changes to this by 9:00am.
- **Snacks:** You are always welcome to grab a snack, such as fruit, veggies, yogurt or cheese in between meals, if it is **before** quiet time.

Chores:

All residents will have assigned chores that *must be completed* before leaving the house in the morning or by 6:00 pm. Additional projects may be assigned, such as bulk mailings, extra cleaning for special events, etc.

Rooms:

- The housemother and social worker have access to resident's rooms.
- Residents are asked to keep their rooms locked when they are not in them, as well as to keep valuable items in the provided lockers. *Casa de Vida is not responsible for lost or stolen items.*
- The rooms must be kept clean and the bed must be made at all times during the day. **Please follow rules posted in each room. The housemother or social worker will inspect all rooms by 10:00 am Monday through Friday.**
- **Note:** In the event of an accusation of theft, rooms may be searched. Resident's who are not home at the time of the search will be notified in writing that their room was searched while they were away.
- *Any items left in a resident's room after 30 days of termination of services will be considered abandoned and will be disposed.*

Phone rules:

- Residents will share a teen line. Please limit your calls to 15 minutes.
- No incoming or outgoing calls allowed after 10 p.m.
- No calls (cell also) are allowed during class or dinnertime.
- Please respect each other's privacy when on the phone.
- All rules above also apply to personal cell phones.

Volunteer Hours: All residents are required to do volunteer service while living at Casa de Vida. The work and amount of hours vary; housemothers are in charge of assigning this as needed.

I have read the rules of Casa de Vida and have discussed them with the social worker. I understand that the social worker and housemothers have the authority to enforce the above rules and I agree to abide by the rules and understand that if I do not do so, I may be requested to leave.

Signed _____

Date _____

APPLICATION FOR RESIDENCE

NAME _____

DATE _____

ADDRESS _____

PHONE _____ DOB _____ AGE _____

DUE DATE _____ Parenting _____ Adoption _____

Other children: Yes _____ No _____ Ages _____

SS# _____

PHYSICIAN _____

PRENATAL CARE: Yes _____ No _____

MEDICAID: Yes _____ No _____ Pending _____ Name of Plan _____

EMERGENCY CONTACT _____ PHONE _____

RELATIONSHIP _____ ADDRESS _____

MOTHER'S NAME/ADDRESS _____

FATHER'S NAME/ADDRESS _____

SIBLINGS/NAMES AND AGES:

FATHER OF UNBORN CHILD:

NAME _____

ADDRESS _____

PHONE _____

CLIENT INFORMATION:

ALLERGIES _____

MEDICATIONS _____

MEDICAL CONDITIONS _____

LEGAL HISTORY/INCARCERATIONS (Please list dates and charges):

CPS INTERVENTION HISTORY: _____

DRUG /ALCOHOL HISTORY (Please put a \checkmark mark by the drugs you have used):

Marijuana _____

Cocaine _____

Amphetamines _____

Prescription _____

Other (Please list): _____

Alcohol: _____

At what age did you start using? _____

Have you ever received inpatient or outpatient drug and alcohol treatment?

Yes _____ (If yes, where/when _____)

No _____

Have you or are you currently attending a 12-step program? Yes _____ No _____

Sobriety date (If currently not using): _____

Are you receptive to drug and alcohol treatment if necessary?

Yes _____ No _____

If you answered no, why? _____

Are you a tobacco smoker?

Yes _____ No _____

Have you ever had psychological/psychiatric treatment?

Yes _____ No _____

If yes, where and when? _____

Diagnosis: _____

Highest level of education: _____

Are you currently seeking a diploma or GED now? Yes or No (Circle One)

If not, are you receptive to returning back to school? Yes or No (Circle One)

Are you interested in job training programs such as Job Core or JOIN?



I _____, guardian of _____

_____ give permission for my/our daughter to reside at Casa de Vida for the duration of her pregnancy, and up to two weeks after the birth of her infant. I understand that Casa de Vida does not have guardianship of my daughter _____, and that she will return to my home at discharge.

Signed: _____

Witnessed by: _____



Authorization for Release of Medical/Program Information

Patient's Name

Patient's Date of Birth

Patient's Street Address

Social Security Number

City, State, Zip Code

Phone Number

I, the undersigned, hereby authorize _____

To **release** copies of medical records to: to **obtain** copies of medical records from:

Verbal release only of medical information to:

Name of Person or Agency

Phone Number

Address

City, State, Zip Code

Fax Number

The purpose or need for such disclosure is _____

Dates of Service: _____

The person or agency listed above is authorized to release the following: (please check information to be released). The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment.

- Abstract (Summary, Op Report, Paths, Consults, H&P, Lab work
- Emergency Room Records Clinic
- Discharge Summary Mental Health/Psychiatry
- Admission History & Physical Other _____
- Doctor's Office Notes
- AIDS/HIV Report
- Alcohol/Detox/Drug Abuse

Signature

Date

Relationship to patient

Witness

Date

This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the Casa de Vida Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative. **Photo ID may be requested at time of release.**

Date Completed

Completed By

pages

CASA de VIDA
INFORMED CONSENT FOR ASSESSMENT & TREATMENT

Name: _____

Date of Birth: _____

I understand that as a resident of Casa de Vida, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that all information shared with the treatment providers is confidential and no information will be released without my consent. During the course of treatment while at Casa de Vida, it may be necessary for my treatment to be discussed amongst various providers at Casa de Vida. While written authorization will not be requested prior to any such discussion, I understand that I will be made aware that such communication has occurred. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality in accordance with NRS 432B.220(3)(a)-(k) which includes the following:

- A. When there is risk of imminent danger to myself or another person, the treatment provider is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the treatment provider is legally required to take steps to protect the child or elder and to inform the proper authorities.
- C. When a valid court order is issued for medical records, the treatment provider and the agency are bound by law to comply with such requests.

I understand that services are provided by a range of professionals, some of whom are still in training. All professionals-in-training are supervised by appropriately licensed staff.

I understand while treatment may provide significant benefits, it may also pose risks. Treatment may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. If I have any questions regarding this consent form or about the services offered, I may discuss them with my treatment provider.

I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Casa de Vida.

Signature Date _____

Guardian Signature Date _____

STATEMENT OF AUTHORITY FOR THE HOUSEMOTHER

The housemother is entitled to enforce all of the rules set by the staff of Casa de Vida. All residents are given a copy of the rules when they are admitted to Casa de Vida, and the rules must be strictly adhered to during the residency.

The housemother's role is to ensure the smooth running of the home, and foster a homelike atmosphere for all while living here. During your stay the housemother will assign chores to each resident and it is her responsibility to ensure that you have completed the assigned chore. The housemother also is required to do daily room inspections to ensure that the resident's have cleaned their rooms. In the event that chores and room cleaning are not completed in a timely manner, the housemother and/or social worker may issue written warnings to those resident's who do not complete their assigned tasks.

In the role of housemother, it is necessary to monitor the daily activities of all of the residents. This is to ensure the safety of all of the resident's. Please inform the housemother of your comings and goings and your approximate return time. In the event that you run late returning to the house, please call the house to inform the housemother.

In the absence of the social worker, the housemother has been instructed to make appropriate decisions regarding enforcement of the rules and regulations while living at Casa de Vida. Should a resident have difficulty following authority, they may be asked to re-think their desire to remain at Casa de Vida.

Any disrespect for the full-time or weekend housemothers are grounds for immediate eviction and will not be tolerated. Any conflicts that arise that cannot be resolved between the housemother and the resident's should be brought to the social worker's attention immediately.

Please sign and date this form, stating that you understand the authority of the housemother during my residency at Casa de Vida.

Name: _____

Date: _____

Casa de Vida

Policy: Drug Testing

Description: Casa de Vida has a policy against the use of alcohol, illicit drugs and/or misuse of prescription medications; therefore we require that all residents submit to a drug screen prior to moving into the house. Outpatient drug treatment will be required of all residents having positive test results. In addition, weekly drug screens will be done to monitor the drug levels while they are lowering. NOTE: Having a positive test does not exclude you from entering the Casa de Vida program.

Purpose: This policy is in place to protect the client, other residents of the house and most importantly, your unborn child, from the dangers of drug use.

Procedure:

1. If at any time it is suspected that you are abusing substances, you may be asked to take a drug test and must release the results of that test to the Casa de Vida Social Worker.
2. If you refuse to do so, you may be asked to leave the house.
3. If you do test positive, every effort will be made to assist you in receiving the appropriate rehabilitative services. Resident's may be required to attend mandated 12-step programs and treatment facilities as a condition of continued residency in the house.
4. A positive drug test or suspicion of using drugs may result in a report to Child Protective Services and/or any adoption agency that may be involved in your case, in order to protect your unborn child.
5. Visitors suspected of using and/or selling drugs will be asked to leave the facility and will not be allowed to return to Casa de Vida for future visits. In certain cases the police may be called.

Client _____ Date _____

Parent/Guardian _____ Date _____

Date: _____

Dear Resident: All residents over 18 who are working are required to contribute to Casa de Vida for their care while here as outlined on page 13 of your application packet. Please review the attached form and amount that we are requesting that you pay. I think you will agree that it is well below what a standard apartment *without food, electricity or utilities* would cost. Please see me if you have questions or concerns regarding this matter. Typically residents pay on the first of the month but payment arrangements can be made for those that prefer a different date.

Sincerely,

Paula Crandell, LSW, MSW
Casa de Vida

Residents over 18 and working or parents/guardians are required to donate income towards the residents care while here:

**Income Acknowledgment
SLIDING FEE SCALE
Maternity Home / Transition Home**

Number of Family Members

Gross Annual Income	1	2	3	4	5	6
Under \$10,000						
\$11,000	\$100					
\$12,000	\$120	\$100				
\$13,000	\$140	\$120	\$100			
\$14,000	\$160	\$140	\$120	\$100		
\$15,000	\$180	\$160	\$140	\$120	\$100	
\$16,000	\$200	\$180	\$160	\$140	\$120	\$100
\$17,000	\$220	\$200	\$180	\$160	\$140	\$120
\$18,000	\$240	\$220	\$200	\$180	\$160	\$140
\$19,000	\$260	\$240	\$220	\$200	\$180	\$160
\$20,000	\$280	\$260	\$240	\$220	\$200	\$180
\$21,000	\$300	\$280	\$260	\$240	\$220	\$200
\$22,000	\$320	\$300	\$280	\$260	\$240	\$220
\$23,000	\$340	\$340	\$300	\$280	\$260	\$240
\$24,000	\$360	\$360	\$340	\$300	\$280	\$260
\$25,000	\$380	\$380	\$360	\$340	\$300	\$280
Over \$25,000	\$400	\$400	\$380	\$360	\$340	\$300

NO ONE WILL BE DENIED PAYMENT DUE TO INABILITY TO PAY

This certifies that my/our total annual income is \$_____ which includes any benefits and assistance. This income provides for a family of ____adults and ____children.

Per the sliding fee scale below, my/our annual income corresponds to a monthly rent donation to Casa de Vida of _____ . I agree to pay this amount to Casa de Vida on or before the 1st working day of each month.

To the best of my knowledge, the above statements are true.

Signed: _____ Date: _____

ADULT ARREST AND CONVICTION REPORT*

I _____ authorize Casa de Vida to request and review any arrest and conviction reports that may be on record at the Reno Police Department. I understand that this is for the safety of all of our residents, and that the results of the arrest and conviction report will be kept confidential, known only to the staff of Casa de Vida.

Signed _____ Date _____

Witnessed by: _____ Date _____

*For Adult resident's only

Visitor's Policy

Every resident is responsible for his or her visitor's behavior. If the visitor is not following the house rules, it is the resident's responsibility to explain the rules to them. If for any reason the housemother or social worker feels that it is not in the best interest of the household to have a particular visitor, your visitor may be asked to leave and/or not allowed to visit you here.

The following guidelines apply to all residents and their visitors

Visitors' hours are from **1:00pm-4:00pm and 7:00pm– 9:00 pm (Evening visitation is only allowed when there are no evening classes scheduled)**. There may be no more than 2 visitors at a time, unless the visitors are your immediate family such as Mother, Father and siblings.

Visitors (male and female) must remain in the living room or dining room areas. No visitors are to go into the bedroom area past the housemother's room, or in the basement.

Visitors are expected to follow the house rules:

- Friends should behave appropriately, with no violent behavior or vulgar language.
- Guests should be respectful of the other residents and staff.
- Visitor's should not be under the influence of alcohol or other drugs.
- Guests should leave immediately and respectfully if asked at any time to do so by the housemother or social worker. In some cases law enforcement may be called if a guest refuses to vacate the premises or follow the house rules stated in this packet.
- Visitor's should not use the telephone without specific permission by either the housemother or the social worker.
- No meals should be eaten at Casa de Vida. Some meals may be arranged with the housemother at her discretion.
- Guests and/or resident's should not remove any items or food from Casa de Vida, without the specific permission of the housemother.
- Resident's and visitors should not engage in public displays of affection while in the home.

Rev 1/08

TB TEST INFORMATION

As a group home, Casa de Vida requires that all residents have proof of a recent negative TB test on file prior to moving into Casa de Vida. Please give a copy of the completed TB results to the social worker. One location that does TB tests is:

Orvis Nursing Clinic.....401 W. 2nd St. – 327-5000

St. Mary's Health Network (Moana) 770-3000

HAWC Clinic (For established patients only). 329-6300

Renown Urgent Care on Neil Road (For established patients only) 975 Ryland –
982-6394

Concentra.....490 Mill St. 332-6052 *Need a doctor's note from an OBGYN only.

PLEASE NOTE: Skin tests must be read 48 to 72 hours after being done, so you can go on Monday, Tuesday, Wednesday or Friday to have the test done. Please allow for holidays, when determining when to take your test.



CASA DE VIDA ROOM RULES

The housemother or social worker will inspect each room by 10:00 am Monday through Friday. It is your responsibility to keep your room clean.

- Make your bed every morning.
- Keep clothing hung up in closet or folded in dresser.
- Keep items picked up off the floor every day.
- Vacuum room once a week.
- Dust furniture and window seat once a week.
- Wash your sheets once a week and re-make bed.
- Wash your bathroom towels once a week.
- Bathroom – *Organize a schedule with your bathroom mates.*
 1. Clean toilet, sinks, and showers with disinfectant daily.
 2. Sweep bathroom floor daily.
 3. Mop bathroom floor once a week.
 4. Wash bathroom rugs once a week.
- Food and drinks (except water) are not allowed in bedrooms.

- **Please use only your half of the room for your personal belongings. Use your downstairs locker for extra items.**

Revised 11/2008

REFERRAL FORM

Fax completed form to:
Orvis Nursing Clinic
(775) 327-2321 [fax]

401 W. 2nd St.
Suite 100
Reno, NV 89502
(775) 327-5000

REFERRAL SOURCE

CONTACT: Paula Crandell

AGENCY: Casa de Vida

ADDRESS: 1290 Mill Street, Reno, NV 89502

PHONE: (775) 329-1070

FAX: (775) 329-9703

EMAIL: paulacdv@pyramid.net

BILLING INFORMATION

Please submit invoices to the following:

CONTACT: Valerie Luevano

ADDRESS: Casa de Vida -- 1290 Mill Street, Reno, NV 89502

PHONE: (775) 329-3211

FAX: (775) 329-9703

EMAIL: cdvdirector@yahoo.com

PROCEDURE REQUESTED

TEST: TB Skin Test

ANTICIPATED TEST DATE:

PATIENT INFORMATION

NAME: (Last) (First) (MI)

SSN:

ADDRESS: 1290 Mill Street, Reno, NV 89502

PHONE: (775) 329-1070

DOB:

AGE:

AUTHORIZATION

SIGNED:

DATE:

Paula Crandell, LSW, MSW

CASA de VIDA – 1290 Mill Street, Reno, NV 89502
(775) 329-1070, (775) 329-9703 [fax], www.casadevidareno.org



CONSENT TO BILL INSURANCE

CLIENT INFORMATION		
NAME (Last, First, MI):		
DOB:	AGE:	SSN:
ADDRESS:		
PHONE:	MARITAL STATUS:	
GUARDIAN'S NAME:		
GUARDIAN'S ADDRESS & PHONE:		

INSURANCE INFORMATION
INSURANCE:
NAME OF INSURED:
INSURED'S ID NUMBER:
CLIENT'S RELATIONSHIP TO INSURED:
INSURED'S ADDRESS & PHONE:

AUTHORIZATION TO BILL INSURANCE	
I authorize the release of any medical or other information necessary to process insurance claims associated with services rendered by Casa de Vida. I also authorize insurance payments to be rendered to Casa de Vida for services rendered on my behalf.	
CLIENT SIGNATURE:	DATE:
GUARDIAN'S SIGNATURE:	DATE:

GRIEVANCE PROCEDURE

A grievance is defined as an act, omission or occurrence which a permanent employee/client feels constitutes an injustice and can be established on factual information. It may relate to any condition arising out of the relationship between an employer/employee or staff/client, including but not limited to, compensation, working hours, working conditions, membership in an organization of employees or the interpretation of any law, regulation, or disagreement. It does not include position allocation, involuntary transfers, dismissals, demotions, or suspensions.

The grievance procedure and statements made on this form do not include all the rights available to a grievant. Consequently, NAC 284.658 through 284.697, which provide direction for the adjustment of grievances, should be reviewed prior to the filing of a grievance.

Instructions for All Parties (Clients, Employee, and Management)

1. A formal grievance must be filed within 20 working days following origin of the grievance or the date an employee/client feels aggrieved learns of the problem. **Every effort should be made to resolve the grievance by informal discussion during this 20-day period.** NAC 284.678(1)
2. The time limit for filing a grievance and for taking any action required by either party in the grievance procedure may be extended by the mutual agreement of the parties. Use form CDV-140 for this purpose.

Instructions for the Client/Employee Submitting a Grievance (Grievant)

1. When a formal grievance is filed, all the information requested on the CDV-100 form *must* be provided. The description of the grievance should include the names of other persons involved in the act, omission, or occurrence.
2. The normal course of action in the grievance procedure is as follows:
 - Step 1: File with Immediate Supervisor (Social Worker) – If not resolved within 10 working days, take next step.
 - Step 2: File with Executive Director – If not resolved within 10 working days, take next step.
 - Step 3: File with Personnel Committee of Board of Trustees – Within 45 working days of receipt of the request, the Committee will render a decision or schedule a hearing and then render a decision.
3. Following receipt of notification of action at steps 1-2, the grievant has 10 working days to refer the grievance to the next step unless the time limit is extended by agreement of the parties. A grievance may be submitted to the next level if the grievant has not received notification within the 10 working day period in which such action is required. The respondent, at each step, retains the documentation received from the grievant. The grievant is responsible for maintaining copies of the documentation she provided for her records and for filing at the next step in the grievance procedure, including attaching all previous responses when submitting the grievance to the next step.



HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: November 1, 2006

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

If you have any questions about this notice, please contact Casa de Vida's HIPAA Privacy Officer at 775-329-3211.

WHO WILL FOLLOW THIS NOTICE.

This notice describes our institution's practices and that of:

- Any health care professional authorized to enter information into your Casa de Vida chart.
- All employees, staff, volunteers, and other Casa de Vida personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Casa de Vida. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Casa de Vida, whether made by Casa de Vida personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Casa de Vida personnel who are involved in taking care of you at Casa de Vida. We also may disclose medical information about you to people outside Casa de Vida who may be involved in your medical care after you leave Casa de Vida, such as family members, clergy, or others we use to provide services that are part of your care.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at Casa de Vida may be billed to and payment may be collected from you, an insurance company, and/or a third party.

For Health Care Operations. We may use and disclose medical information about you for Casa de Vida operations. These uses and disclosures are necessary to run Casa de Vida and make sure that all of our clients receive appropriate care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may combine medical information about many Casa de Vida clients to decide what additional services Casa de Vida should offer, what services are not needed, and whether certain new treatments are effective. We may disclose information to doctors, nurses, technicians, medical students, and other Casa de Vida personnel for review and learning purposes. We may also combine the medical information we have with medical information from other agencies to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific clients are.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

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

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in Casa de Vida. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with clients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for clients with specific medical needs, so long as the medical information they review does not leave Casa de Vida. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

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

SPECIAL SITUATIONS

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

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

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

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process submitted by someone else involved in the dispute.

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

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

National Security, Protective Services, and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence counterintelligence, protection of U.S. or foreign leaders and other security-related activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health

information. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Casa de Vida's Executive Director. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Casa de Vida will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Casa de Vida. To request an amendment, your request must be made in writing and submitted to Casa de Vida's Executive Director. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment, and health care operations, as those functions are described above. To request this list or accounting of disclosures, you must submit your request in writing to Casa de Vida's Executive Director. Your request must state a time period, which may not be longer than five years and may not include dates before November 1, 2006. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Casa de Vida's Executive Director. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request a copy from Casa de Vida's Executive Director.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Casa de Vida. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Casa de Vida or with the Secretary of the Department of Health and Human Services. To file a complaint with Casa de Vida, contact Casa de Vida's Executive Director. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are, however, required to retain our records of the care that we provided to you.

Contact Addresses:

Casa de Vida HIPAA Privacy Officer
1290 Mill Street
Reno, NV 89502
(775) 329-3211

Casa de Vida Resource List

Medical & Dental

Renown Pregnancy Center: 982-5640

- Prenatal care for low income women. Sliding fee scale. Medicaid accepted.

Children's Behavioral Services: 2665 Enterprise Rd.; 688-1600

- Counseling for families with children, day treatment, and social skills programs.
- In home therapy counseling for early childhood and infant mental health.

HAWC (Health Access Washoe County): 1005 S. Wells; Reno (main location) 329-6300 or 324-2599 (Fourth St. Location); 825-6702 (Dental South)

- Primary and preventative health services offered on a sliding fee pay scale. Some dental services.

Nevada Check-Up: 1000 E. Williams; Carson City; 684-3777 or 1(877) 543-7669

- Low cost health care coverage to low-income children (through age 18).

Nevada Medicaid (through welfare office): 3697 Kings Row; Reno; 684-7200

- Health care coverage to low-income people who qualify.

Northern NV Early Intervention Services: 2667 Enterprise Rd.; 688-1341

- Evaluation and services for children with special medical and developmental needs.

Orvis Nursing Center: 401 W. Second St.; Reno; 327-5000

- Community and primary health care for men, women and children. Sliding fee scale.

St. Mary's Neil J. Redford Clinic: 3915 Neil Rd.; Reno; 770-3780

- Primary health care and prevention for children and adults. Sliding fee scale.

Sun Valley's Children's Clinic: 5295 Sun Valley Blvd.; Sun Valley; 674-5437

- Primary health care and prevention for children and adults. Sliding fee scale.

Teen Health Mall at Washoe County District Health Department: 1001 E. 9th St.; Reno, NV; 328-2470

- Pregnancy testing, emergency contraception, birth control, STD testing & treatment and wellness exams.

UNR Family Medicine Center: 784-1533

- Primary and prenatal services on a sliding fee scale. Many insurance plans accepted.

Teen Pregnancy Prevention

Crisis Pregnancy Center: 853 Haskell Dr. Reno, NV; 826-5144

- Why Wait Program: Abstinence education.

Washoe County District Health Department: 1001 E. 9th St.; Reno, NV; 325-8244 (Kelli Seals)

- Somebody Else's Shoes: Single session workshop including education and stories by pregnant/parenting teen speakers.
- Positive Choices, Positive Futures: Single session workshop for parents. Covers teen development and talking about sexuality.

Adoption Services:

Catholic Community Services: 322-7073

LDS Family Services: (800) 877-6736

State of Nevada: 688-2600

Premier Adoption Agency: 702-346-4922

School & Tutoring & Day Care

Children's Cabinet: 1090 S. Rock Blvd.; Reno; 856-6200 (Jessica Skidmore)

- Tutoring.

Cyysis: 777 W. 2nd St.; Reno; 333-5150

- Washoe County School District program for pregnant and parenting teen girls. Offers credits and child care.

I Can Do Anything (ICDA) Charter High School: 857-1544

- Charter school for teens.

Job Corps: 5005 Echo Ave.; Reno; 972-5627

- Education and job training program for at-risk youth ages 16-24.

Team A: 981 Bible Way; 323-8555

- Charter school for high school students.
- Offers daycare and home based learning.

TMCC Re-entry Program: 829-9041

- College education for special populations (including parenting teens)

Washoe High School: 777 W. 2nd St.; Reno; 333-5150

- Credits and GED studies. Evening classes available. Some childcare offered.

Washoe County School District Even Start Family Literacy Program: 820 15th St.; Reno; 327-5631 or 333-3523

- Education for parents working on a H.S. diploma, GED and/or English classes. Also helps with childcare placement and parenting classes. Call for more information and eligibility.

Children's Cabinet: 1090 S. Rock Blvd. –Child care subsidies for qualifying individuals, 856-6200

JOIN: Provides job training, placement testing and GED preparation-785-6106

Morrison University: 850-0700

Career College of Northern Nevada: 323-8555

Nevada Career Academy: 348-7200

Adult Literacy Program: 829-9033

Labor Ready-322-9678

Nevada State Vocational Rehabilitation Division-775-823-8100

Emotional Support & Counseling

Rainbow Place- 2890 Vassar St.; Reno; 789-1780

- Northern Nevada's gay, lesbian, bisexual and transgender community center.
- Counseling, support services and activities.

Casa de Vida: 1290 Mill St; Reno; 329-1070 (Paula Crandell)

- Individual, family and group counseling for pregnant teens.
- Parenting and educational classes and assistance in completing education and finding resources.

Children's Cabinet: 1090 S. Rock Blvd.; Reno; 856-6200

- Counseling for families and youth.

Family Resource Centers: 353-5563 in Reno; 353-5733 in Sparks and 674-4411 in Sun Valley.

- Community resources, parenting classes and more.

Family Counseling Services: 575 E. Plumb Ln.; Reno; 322-6557

- Counseling and services for general mental health, addictions, families, parents, and sexual abuse. Sliding fee scale and many insurance plans accepted.

Teen MOPS: Meetings held at Grace Church on Robb Dr. Reno; 787-5030

- Support group for pregnant and parenting teens. Meets twice a month.

Washoe County Adoption Services: 337-4400 (ask to speak with an adoption worker)

- Information and assistance with adoptions.
- There are other adoption services in Northern Nevada – ask for more information.

Mentoring Groups:

Young Lives: PO Box 5390; Sparks, NV; 356-2999

- “Club” ministries offer support and guidance to Reno/Sparks teen moms.

Big Brothers/Big Sisters: 352-3202

Truckee Meadows Boys & Girls Club: 9th St=331-3605 Neil=828-3940
In-Home Visits

Apple Seeds: 333-5086

- Home visiting services.

Early Head Start: 401 W. 2nd St.; Reno; 327-5100

- Services include home visits, screenings, support & referral, and childcare.

Washoe County District Health Department: 1001 E. 9th St.; Reno, NV; 328-2628

- Provides home visits by public health nurses. Offers information and support.

Children’s Cabinet: 1090 S. Rock Blvd.; Reno; 856-6200 (Jessica Skidmore)

- Program helps pay for costs of childcare.

Early Head Start: 401 W. 2nd St.; Reno; 327-5100

- Services include home visits, screenings, support & referral, and childcare.

Washoe County School District Hug Early Learning Center: 2880 Sutro St; Reno; 327-5630

- Childcare. Also offers parenting classes and support.

Legal Services

Second judicial District Court State of NV Washoe County: 1 S. Sierra (1st floor); Reno 325-6731

- Family Self Help Center: Info on family court and Nevada law, including child support, visitation, paternity & more.

Washoe Legal Services: 650 Tahoe St.; Reno; 329-2727

- Provides free legal services and representation to low-income residents.

McGee Center: 856-4600

Youth Parole: 688-1421

Jan Evans: 325-7800

Renown Pregnancy Center: 982-5640

Testing Services

Nevada Early Intervention Services.....688-1341

Drug Assistance

Al-Anon/Alateen: 348-7103

- Counseling and assistance for family members and friends of alcoholics.

Alcoholics Anonymous: 355-1151

- Support for those recovering from alcohol addictions.

The Bridge Center: 857-2999

- Adolescent substance abuse therapy, counseling and family support.
- After school mentoring program, drug testing and juvenile drug court services.

Narcotics Anonymous: 322-4811

- Support for those recovering from drug addictions.

Step Two: 787-9411

- Substance abuse treatment program; special program for women and mothers.

Quest: 3500 Lakeside Ct., Suite 101; 786-6880

- Substance abuse and mental health programs for adolescents.

New Frontiers (Fallon) (775) 423-1412

Northstar Program: Provides detox & outpatient drug and alcohol treatment-329-4047

Vitality Center (Elko): (775) 738-8004

Food, Shelter & Utilities

Bunkerhouse-Transitional home for female residents ages 14-18. May take parenting youth. Located minutes outside of Wells, NV Call MapleStar at 775-738-2484 for more information.

CAAW (Committee to Aid Abused Women): 329-4150

- Emergency shelter, transportation, food and clothes for abused women.
- Counseling and legal support and referrals.

Casa de Vida: 1290 Mill St; Reno; 329-1070

- Provides a temporary home for pregnant teens.
- Transitional housing for teen mothers.

Catholic Community Services: 322-7073

- Services for those in need include food, housing, and clothes.

Energy Assistance Program: 1090 E. 8th St., Reno; 786-6023

- Assistance with energy costs for low-income population.

Food Bank of Northern Nevada: 331-3663

- Monthly food assistance (food box) with Commodity Supplemental Food Program

Food Stamps (through welfare office): 3697 Kings Row, Reno; 684-7200 (main office).

- Welfare program that provides monthly help with food (debit card-like system to buy food).

Kids Café: 331-3663

- Free meals to kids ages 1-18 living in low-income neighborhoods.

Project Restart – STARS program; 324-2622

- One time assistance with rent, mortgage, and utility payments or apartment deposit.

Safe Embrace-50 West Liberty St. Reno, NV 322-3466

Reno Sparks Gospel Mission: 329-0485

- Services for the homeless and needy, includes beds, housing, food and clothes.

SAFE: Contact Sierra Pacific to qualify; 834-4444

- One-time assistance with energy assistance (winter months only).

WIC (Women, Infants and Children); 1-800 -8- NEV-WIC

- Food assistance for pregnant & recently pregnant women, infants and children up until age 5.

Hosanna House: 322-3708 (faith based)

Family Promise: 284-5566

24-7 TLC: 786-7723 or 329-2247

H.E.L.P: (Inside Greyhound bus station) 321-8330 Assists in re-connecting individuals with families and support systems, run through RPD.

Nevada Rural Housing: (800) 426-6232

Reno Housing Authority: 331-5138- 18 years of age and above.

Kids to Seniors: 770-6177

City of Refuge Maternity Home: 775-782-2034

Bishop Gallegos Maternity Home: 916-395-9376

Men's Shelter: 329-4141

Women's Drop In Center: 329-4145 / Families: 722-2296

Resource Center: 657-4775

Emergency Situations

Crisis Call Center: 784-8090 or 1-800-992-5757

- Confidential and free number to call in crisis situations.

Safe Place: 1-800-536-4588 or 358-7233

- Can ask for help for any unsafe situation, including alcohol and drug issues, family problems, thoughts of suicide, running away, being bullied or domestic violence.

Casa de Vida:

- Emergency diapers, clothing & formula every three months/bring picture ID.

Care Chest:

- Helps with emergency prescriptions and medical equipment. 7910 N. Virginia. St. 829-2273

Things To Do:

Boys and Girls Club - Teen Center locations at 9th St. in Reno (331-3605) and in Sun Valley (674-8484)

- Fun and exciting activities for teen members 13-18 years old.

Washoe County Library – various locations throughout Reno and Sparks; 327-8300 (Downtown library)

- Computer use and Web access, fun activities and books.

Have other questions about local resources? Call 2-1-1 or search Nevada 2-1-1 online at www.nevada211.org/. They will connect you to resources in your community.



Dear Resident: Casa de Vida is pleased to be able to assist you with papers to assist you with making important decisions regarding your health care wishes. Please feel free to read over the information and to complete the booklet if you are interested in having a durable power of attorney regarding your health care wishes. Please sign below that you have received these forms.

- I have received information on advanced care planning and have completed the necessary paperwork.

OR

- I have received information on advanced care planning and do not wish to complete the paperwork at this time.

Signed

Witnessed By

Date

1290 Mill St. Reno, NV 89503
www.casadevidareno.org
(775) 329-1070

Advanced Care Planning Forms

Dear Fellow Nevadan,
Congratulations. You have taken charge of a significant part of your future well-being by opening this small booklet. You have in your hands the legal tools you need to make your health care wishes known in the event you cannot communicate them directly to your physician and other caregivers. When signed and notarized, this booklet becomes a binding legal document. We urge you to complete it today and make copies for your loved ones, doctor and attorney to have on file – this document only works if it can be located! Then, file your original booklet in a safe place. Be sure to also fill out the wallet card on the back cover and carry it with you at all times. Here's to your health!

Noel Tiano, Th.D. Barbara Thornton, Ph.D.
Director Professor
Nevada Center for Ethics & School of Public Health
Health Policy University of Nevada, Reno
University of Nevada, Reno

Nevada Durable POWER of ATTORNEY for

WARNING TO PERSONS EXECUTING THIS DOCUMENT:

*THIS IS AN IMPORTANT
LEGAL DOCUMENT.
IT CREATES A DURABLE
POWER OF ATTORNEY
FOR HEALTH CARE.
BEFORE EXECUTING
THIS DOCUMENT, YOU
SHOULD KNOW THESE
IMPORTANT FACTS:*

Principal _____

- 1.** This document gives the person you designate as your *attorney-in-fact* the power to make health care decisions for you. This Durable Power of Attorney for Health Care is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any type/s of treatment or placement that you do not desire.
- 2.** The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.
- 3.** Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
- 4.** Unless you specify a shorter period in this document, this power will exist indefinitely from the date you execute this document and, if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

HEALTH CARE DECISIONS

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.
8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
9. This document revokes any prior Durable Power of Attorney for Health Care.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you

THE PATIENT'S RIGHT TO DECIDE

All adult individuals in hospitals, nursing homes, and other health care facilities have certain rights. Under the Patient Self-Determination Act, health care facilities are required to inform you of your rights as a patient and of their policies. Each adult individual has the right to prepare legal documents known as "Advance Directives." These documents allow you to state in advance what kinds of treatment you want or do not want under medical circumstances that would prevent you from communicating your wishes to your doctor. We strongly encourage everyone to exercise their right to make choices surrounding the issues of dying and be mindful of their ability and responsibility to transform death into a subject openly discussed by all.

Principal _____
Principal _____

1. DESIGNATION of HEALTH CARE AGENT

I, *(insert your name)*, _____

do hereby designate and appoint:

Name _____

Address _____

Phone (____) _____ Work (____) _____ ext ____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you.

Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact:

- (1) your treating provider of health care;*
- (2) an employee of your treating provider of health care;*
- (3) an operator of a health care facility, or;*
- (4) an employee of an operator of a health care facility.*

2. CREATION of DURABLE POWER of ATTORNEY for HEALTH CARE

By this document I intend to create a Durable Power of Attorney for Health Care by appointing the person designated above to make health care decisions for me. This Durable Power of Attorney for Health Care shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT of AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraphs 4 or 6.

4. SPECIAL PROVISIONS and LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psycho surgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for Health Care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

5. DURATION

I understand that this Durable Power of Attorney for Health Care will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Durable Power of Attorney for Health Care end on:
_____, 20 ____.

6. STATEMENT of DESIRES

a) With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space on the following page.

Principal _____

Principal _____

IF THE STATEMENT *REFLECTS YOUR DESIRES*, INITIAL THE BOX NEXT TO THE STATEMENT

(1) I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.

(2) If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)*

(3) If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)*

(4) Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld.

(5) I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

MY MEMORIAL SERVICE

If there is to be a memorial service for me, I wish for this service to include the following *(list music, songs, readings or other specific requests that you have)*:

Add other wishes here *(such as your wishes about donating any or all parts of your body when you die)*:

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

6. STATEMENT of DESIRES (continued)

b) It is my intention that this instrument serve both as a self-executing document and as a delegation of power to my attorney-in-fact. This document shall be deemed an exercise of all rights that I may have under the United States Constitution, the Constitution of Nevada, and any other relevant state and federal laws, rules, regulations and decisions, to refuse medical treatment.

c) I desire that my wishes be carried out through the authority given to my attorney-in-fact by this document despite any contrary feelings, beliefs or opinions of other members of my family, relatives or friends.

d) I realize that the situations described in this document are subject to various interpretations, and I am confident that the person(s) named as my attorney-in-fact will exercise the judgment that I myself would exercise if competent.

e) If my attorney-in-fact or my alternate attorney(s) in fact is unavailable, I nevertheless request that my instructions and preferences in this document be observed.

Principal _____
Principal _____

7. DESIGNATION of ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 4, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-fact

Name _____

Address _____

Phone (____) _____ Work (____) _____ ext _____

B. Second Alternative Attorney-in-fact

Name _____

Address _____

Phone (____) _____ Work (____) _____ ext _____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care. However, this shall not be construed as a revocation of any durable power of attorney I may have made for the management of my business and/or personal affairs.

9. WAIVER of CONFLICT of INTEREST

If my designated attorney-in-fact or if any alternate designated attorney-in-fact is my spouse or is one of my children then in that event I waive any conflict of interest that said spouse or child may have in carrying out the provisions of this Durable Power of Attorney for Health Care, by reason of the fact that said spouse or child may be a recipient of my estate whether by Will, the laws of intestate succession or pursuant to a Trust or other arrangement.

You must DATE and SIGN this Durable POWER of ATTORNEY for Health Care)

I sign my name to this Durable Power of Attorney for Health Care on:

_____, 20 _____,

(date)

at _____

(city and state)

Signature _____

Name _____

Address _____

Phone (____) _____ Work (____) _____ ext _____

Social Security Number _____

(This Durable Power of Attorney for Health Care will not be valid for making health care decisions unless it is either (1) signed by at least two qualified witnesses who are personally known to you and who are

present when you sign or acknowledge your signature, or (2) acknowledged before a notary public.)

**10. CERTIFICATE of ACKNOWLEDGMENT of NOTARY PUBLIC
STATE OF NEVADA)**

) ss.

COUNTY OF)

On this _____ day of _____, 20 _____, before me,
_____, (here insert name of Notary Public)

personally appeared _____,
(here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who executed the above instrument, and acknowledged to me that he or she executed the same for purposes stated therein. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY PUBLIC

Principal _____

Principal _____

11. STATEMENT of WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact, (2) a provider of health care, (3) an employee of a provider of health care, (4) the operator of a health care facility, or (5) an employee of an operator of a health care facility.

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community health care facility, nor an employee of a health care facility.

Signature _____

Print Name _____

Residence Address _____

Date _____, 20 _____

Signature _____

Print Name _____

Residence Address _____

Date _____, 20 _____

NOTE: AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION

12. DECLARATION of WITNESS

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature _____

Print Name _____

Residence Address _____

Date _____, 20 _____

Signature _____

Print Name _____

Residence Address _____

Date _____, 20 _____

COPIES: *You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.*

Principal _____

NOTICE

Make sure your loved ones can find this document. Make copies for all concerned and make sure they understand its importance.

Principal _____

DECLARATION/LIVING WILL

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

NOTE: *if you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:*

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other

treatment is withheld pursuant to this declaration.

Signed this _____ day of _____, 20 ____ .

Signature _____

Address _____

The declarant voluntarily signed this document in my presence.

Witness _____

Address _____

Witness _____

Address _____

**Dear Loved Ones,
I want the best quality of life possible during
my last days.**

Therefore, I hereby request as follows....

- (a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering possible. Please consult with my doctor in this regard.
- (b) If my temperature is above normal, I want a cool moist cloth put on my head.
- (c) I want my mouth and lips kept moist.
- (d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.
- (e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide my comfort.
- (f) I want my personal care such as nail clipping, hair combing, teeth brushing, and shaving as long as they do not cause me pain.

1 of 4 Principal _____

**I hope my family and friends would consider
that...**

- (a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.
- (b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.
- (c) Please don't be afraid to hold my hand or hug me.
- (d) Please tell the members of my church or synagogue I am sick and ask them to pray and visit me.
- (e) Please maintain a cheerful atmosphere around me.
- (f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.
- (g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.
- (h) If at all possible, allow me to die in my home.
- (i) Please arrange for me to watch on television, or listen to my favorite sports events.
- (j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.
- (k) I want to have my favorite types of music played when possible.
- (l) I want to have religious readings read to me when I am near death.
- (m) I want to have my favorite poems read to me from time to time.

2 of 4 Principal _____

**I want you to know the following about my
thoughts and concerns**

if I am disabled and cannot convey these thoughts to you verbally...

- (1) I want you to know that I love you.
- (2) I would like to be forgiven for the times I have hurt you.
- (3) I forgive you for what you may done to me in my life.
- (4) I want you to know that I do not fear death itself.
- (5) I want all of my family members to recommit their love for one another.
- (6) Please remember me the way I was before I had a terminal illness.
- (7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.
- (8) Don't be afraid to seek counseling, if you have trouble with my death.

If friends want to know how I want to be remembered tell them the following...

The following person(s) know my funeral plans...

3 of 4 Principal _____

At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...

I also have the following requests ...

These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this _____ day of _____, 20 _____

Signature _____

Print Name _____

4 of 4 Principal _____

I have been given a copy of the Advanced care Planning Forms and wish not to complete the forms at this time.

Signed

Witnessed by

Date:

For additional information, please contact:

The Nevada Center for Ethics & Health Policy
University of Nevada, Reno/339 – Reno NV. 89557-0133
www.unr.edu/ncehp
www.HealthEthics.org
RENO Tel. (775) 327-2309 Fax (775) 327-2203