THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Input from Stakeholders

PURPOSE: The purpose of this policy and procedure is to ensure that The Counseling Source, Inc. has a planned, systematic, organization-wide approach to obtaining input from stakeholders including persons served and personnel. This plan will direct the organization's focus on collecting, analyzing, and using feedback to meet or exceed the expectations of persons served.

POLICY: The Counseling Source Inc. will conduct ongoing personnel, customer, and client/consumer feedback surveys. The feedback obtained from these surveys will be used to determine the expectations of persons served, determine areas of service delivery that are in need of improvement and to modify and/or establish improved methods of service delivery to meet or exceed the expectations of persons served. This program will use various means of data collection to accomplish this task.

PROCEDURE:

1. The Executive Director, in collaboration with the Quality Improvement Coordinator will determine the populations to survey for key indicators of performance.

2. The procedure for soliciting input will include, but not be limited to, the following:
   - Client Satisfaction Surveys
   - Facility Satisfaction Surveys for Long Term Care Facilities, Schools, and Centers for Developmentally Disabled
   - Employee Satisfaction Surveys

3. These key areas that will be surveyed are as follows:
   - Clinical Service: Overall satisfaction with services from the point of contact through discharge including the effectiveness of treatment/services provided
   - Administrative support during the course of treatment
   - Request for suggestions for areas in need of improvement
   - Employee satisfaction

4. Key information can also be obtained from the following areas to assess overall program performance and satisfaction of clients/consumers, employees, and customers:
   - Clinical Record Audits
   - Peer Review Results
   - Incident Reports
   - Involuntary Terminations
   - Client Complaints/Grievances

5. The Executive Director will work with the Quality Improvement Coordinator to summarize results of administered surveys and incorporate plans for improvement in the overall strategic planning for the agency to improve level of service in the identified areas.

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 3/2/02

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Accessibility of Services

PURPOSE: The Counseling Source will have a written Accessibility Plan that addresses elimination of client barriers.

POLICY: The Counseling Source's Accessibility Plan will ensure that all services are available, accessible, appropriate and acceptable for clients. Input will be collected from persons served and actions will be taken to remove any barriers that are identified in a timely manner. The Counseling Source's organizational leadership will review the Accessibility Plan on an annual basis and make adjustments as necessary.

PROCEDURE:

1. The Counseling Source is committed to serving clients in their natural environment when possible/appropriate.
2. When serving the client in their natural environment is not possible, arrangements will be made to provide services in one of our outpatient settings. The client's geographical location will be taken into account in determining which outpatient site will be most appropriate.
3. Each site in which services are provided will be handicap accessible or appropriate accommodations will be made as necessary on an individual by individual basis so as there are no architectural or environmental barriers.
4. Routine services are typically provided Monday-Friday, 8:30 am-5:00 pm, however, appointments after hours are available upon request. Emergency or urgent services are provided 24 hours/day, 7 days/week.
5. When the individual is referred to The Counseling Source prior to discharge from the inpatient setting, TCS staff will be involved in, as appropriate, discharge planning and coordination of the provision of outpatient services.
6. No otherwise qualified individual with a disability shall, solely by reason of his/her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity of The Counseling Source. This includes if the individual has a mental or physical impairment that substantially limits one or more major life activities, has a record of such impairment; or is regarded as having such impairment.
7. Referred individuals with a hearing impairment or communication disorder, or who speak a language other than English as a primary means of communication will have appropriate accommodations through either existing trained Counseling Source staff, or through contracted interpreters. This will be done at no additional cost to the referred individual.
8. When warranted by the client's financial circumstances, the client's eligibility for a sliding fee scale payment schedule will be assessed upon provision of required financial documentation.
9. Accessibility, availability and appropriateness of services provided will be in line with the mental health service needs of the populations served by The Counseling Source.
10. Minimum criteria for *acceptability* of services shall include, but not limited to: (1) Provision of services shall be culturally sensitive with responsive treatment planning and service delivery. (2) This includes displaying sensitivity to ethnic and cultural differences among people. (3) Freedom of choice among therapeutic alternatives for the person receiving services shall be promoted and no person served shall be denied access to any service based on their refusal to accept other services recommended by The Counseling Source.
11. Minimum criteria for *appropriateness* of services shall include, but not limited to: (1) The provision of services will occur in the least restrictive setting as possible. (2) Delivery of service in the natural environment of the person receiving services as appropriate. (3) The provision of services will respect and attempt to maintain continuity of therapeutic relationships. (4) The provision of services will take the perceived needs of the person receiving services as well as their cultural assessment into consideration.
12. The minimum criteria for *appropriateness* of services *for persons with severe mental disability or children with severe emotional disturbance* shall also include assessment of needs and advocacy with other systems or organizations to meet those needs if the agency does not provide such services. Such needs and advocacy shall include, but are not limited to: (1) Mental health service needs, (2) housing, (3) employment and; /or educational status, (4) health, (5) income, (6) recreation, (7) cultural characteristics, (8) spiritual needs, (9) family issues and (10) transportation needs. The Counseling Source will be committed to reducing the stigma

of people with disabilities. A accessibility plan will be updated annually by The Counseling Source's organizational leadership team with the purpose of identifying barriers in providing services to clients or potential clients.

13. A question on the client satisfaction survey will inquire if the person served felt as though there were specific barriers to receiving services at The Counseling Source. Additionally, The Counseling Source will accept feedback at any time from persons served regarding barriers.
14. Barriers can include: (1) Architectural, (2) Environmental, (3) Attitudinal, (4) Financial, (5) Employment, (6) Communication, (7) Transportation, and/or (8) Any other barrier identified by the Persons served, personnel, or other stakeholders.
15. When barriers are reported by persons served, personnel or other stakeholders, The Counseling Source's organizational leadership will investigate within 14 business days. If a barrier is determined to exist, The Counseling Source will be committed to removing this barrier, or make appropriate and acceptable accommodations for the individual, within 60 days of the report. Written documentation of the reports, investigations and corrective action shall be maintained.
16. An accessibility plan will be updated annually about the identified barriers that will include: (1) time lines for the removal of barriers, (b) Progress made in the removal of barriers, and (3) Areas needing improvement.
17. If barriers cannot be removed, or appropriate accommodations cannot be made, the individual will be referred to another provider with resources that are accessible for the person.

REFERENCED STANDARDS AND REGULATIONS: Ohio Department of Mental Health Administrative Code 5122:26-17, CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/17/2006

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Information Management

PURPOSE: In accordance with HIPAA, The Counseling Source will maintain written policies and procedures regarding the management of Protected Health Information (PHI) for both paper and electronic formats to ensure confidentiality of sensitive information.

POLICY: The Counseling Source will ensure that all PHI is secure and that staff follow procedures outlined in the HIPAA policies manual.

PROCEDURE:
1. The Counseling Source applies appropriate safeguards to protect the records, both written and electronic, of persons served and to ensure the confidentiality of administrative records. (Please see: HIPAA Policy and Procedures Manual)

REFERENCED STANDARDS AND REGULATIONS: CARF Behavioral Health Standards Manual; HIPAA Policy and Procedures Manual

EFFECTIVE DATE: 4/24/2006

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Performance Improvement

PURPOSE: As a CARF accredited agency, The Counseling Source, Inc. maintains a commitment to providing the highest quality mental health services to the populations served. In keeping with this commitment, TCS regularly assesses the evolving needs of the agency/clientele, as well as potential actions for improvement.

POLICY: The Counseling Source, Inc. will develop and implement a Performance Improvement Plan, which will be updated annually.

PROCEDURE:

1. The Performance Improvement Committee will define key indicators which will be targeted during a given time period.

2. These key indicators will be driven by the agency's Strategic Plan and the following values:
   - A continuous concept of quality services
   - Efficiency of resource allocation
   - Consumer driven and directed services
   - Diversity/cultural competency (reflecting characteristics of persons served)
   - Consumer Satisfaction
   - Consumer Safety and Protection
   - Risk Status
   - Clinical Processes
   - Service Capacity
   - Staff Involvement in identifying and resolving problem areas

3. Data for key indicator selection can come from any of the following areas:
   - Consumer Satisfaction Surveys
   - Facility Satisfaction Surveys
   - Clinical Record Audits
   - Peer Review Results
   - Incident Report Forms
   - Involuntary Terminations
   - Client Complaints/Grievances
   - Doc Tracker generated reports

4. The Executive Director will obtain baseline data with regard to initial company performance in the given problem area.

5. The Executive Director in collaboration with the interdisciplinary Quality Improvement Committee will define the expected level of performance in measurable terms. This performance goal will be based on an industry benchmark, organization history, or a target set by the organization. Extenuating factors should also be considered when conducting the analysis.

6. The Performance Improvement Committee will design a system, based upon input from the previously defined stakeholders, which will provide the necessary training, technical support and/or added/enhanced process(es) to attain this expected level of performance in the identified area.

7. It will be the responsibility of the entire Counseling Source staff to participate and assist in the Performance Improvement process. The Executive Director will be responsible for managing the process.

8. The Performance Improvement Committee will be responsible for analyzing the baseline and outcome data on an on-going basis.

9. The Executive Director will solicit feedback from the stakeholders in regard to effectiveness or plan, need for redesign of the plan or other suggested changes.

10. At the point in time the expected level of performance in the key indicator area is obtained and sufficiently maintained, a new indicator will be selected and defined.

REFERENCED STANDARDS AND REGULATIONS:
OhioMHAS, CARF Behavioral Health Standards Manual

REVIEWED: March 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

Title: Client Rights: Grievance Process

PURPOSE: To ensure the protection and promotion of rights of the individuals served at The Counseling Source, Inc., and responsive and impartial resolution of client grievances.

POLICY: The Counseling Source will uphold the rights of persons receiving services and a grievance procedure for those persons according to relevant federal, state, and local statutes as well as accrediting bodies. This shall also be consistent with laws and regulations related to persons with Human Immunodeficiency Virus (HIV).

PROCEDURE: CLIENT RIGHTS AND GRIEVANCE PROCEDURES

RIGHTS:

1. It is the policy of The Counseling Source to adhere to the client rights defined and described in Ohio Administrative code. A copy of the definitions and specific rights is provided to each client upon admission and considered the policy of The Counseling Source.

2. The Client Rights Officer shall be located at 10921 Reed Hartman Highway, Suite 133, Cincinnati, Ohio 45242, telephone number 513-984-9838 or 800-618-0688. Hours of availability are 9:00 A.M. to 5:00 P.M.

3. Responsibility of the Client Rights Officer shall include accepting and overseeing the process of any grievance filed by a client or other person or agency on behalf of a client. Additionally, the client rights officer will have the responsibility for assuring compliance with the client rights and grievance procedure rule.

4. A copy of the Client Rights and Grievance procedure shall be distributed to each client at intake or next subsequent appointment in writing or orally and to applicants upon request. In the event a client continues in services longer than one year, annually a copy of the Client Rights will be provided to the client. Agency staff will explain the client rights policy and/or provide a copy at any time upon request.

5. In an emergency situation, the client or applicant shall be verbally advised of the immediately pertinent rights such as the right to consent or refuse treatment and subsequent consequences. Written copy and verbal explanation of this policy shall be given to the client in a subsequent meeting.

6. A copy of the client rights will be posted in the lobby of The Counseling Source, Inc., office.

7. Staff will be provided with training related to client rights and grievance procedures. This will include every staff person, including administrative, clerical, and support staff and that they clearly understand, specified, continuing responsibility to immediately advise any client or any other person who is articulating a concern, complaint, or grievance, about the name and availability of the agency's client rights officer and the complainant's right to file a grievance.

8. The Counseling Source, Inc. does not discriminate with regard to clients served on the basis of race, gender, ethnicity, socioeconomic status, or medical status including HIV. Likewise, consideration will be given to a client's culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status and language in the implementation of this procedure. If a translation of the rights is necessary, this will be provided upon request.

9. The Counseling Source, Inc. will not enroll any client in a research project without prior written informed consent, allowing the client to make an expression of choice. (See Research policy/procedure for further instructions.)

GRIEVANCES:

1. The Client Rights Officer shall be available to assist the griever in the process of filing a grievance, investigation on behalf of the griever, and representing the griever at the agency hearing if desired by the griever. In the event the Client Rights Officer is the subject of the grievance, an alternative Client Rights Officer will be the Executive Director.

2. Grievances are to be filed with the Client Rights Officer who is located as described above.

3. All grievances will be heard by an impartial clinician having no involvement with the client or situation that is the subject of the grievance. The procedure for hearing grievances shall include in person and/or telephone contact with the griever (and/or a representative as appropriate), and as appropriate, contact with others who are the subject of the grievance (including agency staff) and review of records.

4. Time line for resolution of grievances shall not exceed twenty working days from the filing of the grievance. Written notification of the resolution of the grievance shall be provided to the client or the griever, if other than the client (with the client's permission). Written resolution of the grievance shall be sent by certified mail to the client or griever's last known mailing address.

5. There is no specified time limit for the filing of a grievance.

6. Should the griever feel that the person hearing the grievance does not adequately resolve the grievance, an appeal may be filed with the Executive Director. The Executive Director shall have ten days from the filing of the appeal to further investigate the grievance and shall provide written resolution to the griever by certified mail.

7. All written resolutions shall be in language that is understandable to the client/griever.

8. The griever may file a complaint with any or all of the several outside entities, specifically the Community Mental Health Board, the Ohio Department of Mental Health, the Ohio Legal Rights Service, the U.S. Department of Health and Human Services, and appropriate professional licensing or regulatory agencies. Relevant addresses and telephone numbers are provided and are attached to the Client Rights and Grievance Procedure documents. Information about the grievance may be provided to these outside entities upon request.

9. Copies of the grievance procedure will be provided to each client upon admission and to an applicant upon request. Agency staff shall explain the grievance procedure at any time upon request and in language that is understandable to the client.

10. Client grievances and appeals will be recorded in a log by the Clients Rights Officer and reviewed monthly at The Counseling Source's Quality Improvement Committee. Annually, efforts will be made to determine trends in complaints and to identify areas for performance improvement.

REFERENCED STANDARDS AND REGULATIONS: ODMH Administrative Code 5122: 26-18, ODMH Administrative Code 5122:2-1-02, CARF Behavioral Health Standards Manual; Client Rights

EFFECTIVE DATE: 4/28/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Client Rights: Staff Abuse/Neglect

PURPOSE: To provide mental health services in a safe, nurturing and supportive environment free from abuse or neglect.

POLICY: The Counseling Source, Inc., will accept, investigate and appropriately resolve any reports made regarding staff neglect and abuse of persons served.

PROCEDURE: All persons served shall be free from physical, verbal, mental, emotional, and fiduciary abuse and neglect or humiliation, retaliation. All persons served will be treated at all times with courtesy, respect, and full recognition of dignity and individuality. All agency staff are responsible for reporting to the administration any known or suspected abuse or neglect involving persons served.

In cases of reported abuse or neglect, the following procedures will be followed:

1. The Executive Director will immediately initiate an investigation of the reported situation. This investigation will include interview of all parties involved and documentation of the results of the interviews.
2. The staff member against who allegations of abuse or neglect are being made will be suspended pending the outcome of the investigation.
3. The alleged victim of the abuse or neglect will be notified of the procedures for investigation and of the outcome of the investigation. In those cases where the persons served has a guardian, these notifications will be made to the guardian.
4. The investigations will be conducted in a timely manner and generally completed within one week of the report of abuse or neglect. Results of the investigation and action taken will be documented in writing.
5. Should the investigation indicate that the staff member is guilty of abuse or neglect, his/her employment will be terminated immediately and reports made to appropriate law enforcement agencies and certification or licensure boards. Should the staff member not be found guilty of abuse or neglect, then that staff member will be reinstated and any necessary corrective action will be taken.
6. All alleged abuse or neglect of clients by staff will be reported to OhioMHAS within 24 hours and the results of the investigation of the allegations will also be reported to OhioMHAS when the investigation is completed.
7. Any alleged abuse of clients by staff will be reported to authorities as required by applicable local, state or federal laws (such as child abuse and elder abuse). This also applies to situations in which potential abuse or neglect of persons served, which allegedly occurs outside of this agency, come to the attention of agency staff.

REFERENCED STANDARDS AND REGULATIONS: ODMH OAC 5122-26-18; CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/28/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Health and Safety: Physical Plant Safety (including Fire Safety, Hazardous Materials and General Safety Measures)

PURPOSE: To ensure that The Counseling Source, Inc., meets all applicable federal, state and local requirements for health, safety and accessibility so that services can be provided in a safe and comfortable environment.

POLICY: The Counseling Source, Inc., will be in compliance with all applicable federal, state and local requirements for health, safety and accessibility.

PROCEDURE:

- Safety Officer: The Safety Officer is responsible for coordinating the safety activities of the company and verifying that the agency is in compliance with all health and safety rules and regulations.
- Safety Inspections:
    A. The Safety Officer completes self-inspections at least quarterly at The Counseling Source, Inc. office.
        1. A resulting report shall include:
            - Areas covered
            - Recommendations cited
            - Actions necessary for improvement
            - Results from Improvement Actions
- Fire Safety:
    - **Fire Drills**: Drills will be conducted on a rotating basis at least semi-annually. Drills will be unannounced and will occur at various times of the workday. All present for the drill will evacuate as per the evacuation procedures described below under evacuation procedures. The effectiveness of the fire evacuation procedures shall be evaluated after each drill.
    - **Fire Inspection**s: An annual fire inspection by a certified fire authority shall be conducted. A resulting written report will be required that identifies the area(s) inspected, recommendations for areas needing improvement (if any) and actions taken to respond to the recommendations(s). Any deficits shall be corrected as soon as possible.
    - **Fire Precautions**:
        - All fire exit doors shall be unlocked and clearly marked.
        - Fire extinguishers shall be inspected annually and recharged or replaced as appropriate. Sufficient equipment shall be present for fire detection and suppression.
        - Staff serving contract facilities/schools/etc. are responsible for knowing the fire plan of assigned locations.
- Hazardous Materials:
    - Handling and disposal of hazardous materials shall be according to applicable federal, state or local laws and regulations.
    - Infectious waste disposal and standards for universal precautions shall be according to specifications of OHSA and the Ohio Department of Health and the safety measures for hazardous areas of the facility.
    - All hazardous materials will be stored in locked areas inaccessible to clients.
    - In the case of hazardous areas in the facility, appropriate warning signs and/or barriers will be provided to keep hazardous areas off limits.
- General Safety Procedures:
    - All staff utilizing electrical equipment will be instructed in proper use. General maintenance inspections will be completed utilizing an inspection form.
    - The use of extension cords is prohibited.
    - Safety issues will be addressed as part of staff orientation and training.
    - Other types of emergencies:

- Tornado: At the sound of the emergency warning sirens or by weather alert radio, clients will be escorted to corridor immediately outside of the office (suite 133). Clinical staff providing service shall remain with the clients until the warning has ended.
- Severe rainstorms, floods, blizzards, ice storms and snowstorms: At the discretion of the Executive Director, typical business may be suspended in periods of these types of natural disasters. This may be communicated via cell phones, pagers, home phones and voice mail. In these instances, emergency/crisis services will continue utilizing the 24-hour on-call system.
- Power Failures: In the event of Power Failures, the emergency floodlights on the exit lights shall provide adequate illumination in the administrative office for temporary operations. Staff will contact Duke Energy to notify of the outage.
- Bomb threat: In the event of a bomb threat, the person taking the call should listen carefully and write down what the caller says. If possible, signal another person to call 911 and report the threat and also contact the operator so that the call can possibly be traced. Evacuate the building as per the instructions of the police and/or fire department. Refer to Bomb Threat Call Procedures document.
- Fire: In the case of a suspected fire, evacuate the building as per the procedures described above and call 911.
- Medical Emergencies: In the case of a medical emergency affecting either a staff member or a client, 911 will be notified as well as the emergency contact person for this individual. Emergency CPR or first aid will be administered, as appropriate, until Life Squad personnel arrive.
- Explosions and Gas Leaks: Staff will contact Cincinnati Gas & Electric and 911 to notify of the situation. Evacuate the building as per the instructions of the police, fire department, CG&E. Continuation of business operations shall be at the discretion of the Executive Director. This decision may be communicated via cell phones, pagers, home phones and voice mail. In these instances, emergency/crisis services will continue utilizing the 24-hour on-call system.
- Biochemical Threats, Acts of Terrorism and Use of Weapons: In the event of any of these situations, staff will call 911 to advise of the situation. If the threat comes via the telephone, this person will signal another person to call 911. Staff should take cover, evacuate the building or use other protective strategies until emergency assistance arrives.

- Storage areas will be neat and uncluttered.

- First Aid:
  - Basic first aid supplies will be available at The Counseling Source, Inc., office
  - First aid, CPR, and Universal Precautions expertise can be obtained from contract facilities that employ medical personnel (such as nursing facilities, assisted living facilities and schools).
  - At least one staff trained in first aid, CPR and Universal Precautions shall be available at the administrative office and other sites where medical personnel are not available.
  - Emergency Information regarding personnel and clients can be obtained by contacting an administrative staff person during business hours and the Executive Director after-hours.

- **Evacuation procedures (from TCS office) are as follows**:
  - Clinical staff members providing services in the office are to assure that the client(s) in their care are safely evacuated. Office staff will assist in evacuating clients as needed.
  - Exit the office by any exit door. Close the door after exiting.
  - Once in the corridor, exit the building by any of the three exits marked by lighted red exit signs. This includes exits at both ends of the corridor and an exit to the outside in the middle of the corridor. Proceed outside.
  - Exit into the parking lot and assemble at the maintenance garages at the West End of the parking lot.
  - The most senior staff person present will take an accounting for all persons involved.
  - Temporary shelter will be sought in a neighboring building in the complex as necessary.
  - 911 shall be contacted (or other emergency response authority as appropriate)
  - Await further instruction from the fire department, other emergency response team and/or agency administrative staff
  - In the event of evacuation, emergency on-call services will continue 24 hours/day. Regular phone lines of The Counseling Source will continue to be in operation however may be forwarded to alternative locations or to the answering service.

- Tests of Emergency Procedures: Tests of all emergency procedures are conducted at least once per year on each shift in operation at each location The Counseling Source primarily controls. This will include actual or simulated physical evacuations that are included in the procedures.
- Training:
    - During new hire orientation and annually thereafter, staff will be trained on the following:
        - Health and safety practices,
        - Identification of unsafe environmental factors
        - Emergency Procedures
        - Evacuation Procedures
        - Identification of Critical Incidents
        - Reporting of Critical Incidents

REFERENCED STANDARDS AND REGULATIONS:
ODMH OAC 5122-26-12; CARF Behavioral Health Standards Manual; Bomb Threat Call Procedures document

EFFECTIVE DATE: 4/26/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Health and Safety: Extreme Weather

PURPOSE: To ensure that The Counseling Source, Inc., has a plan to maintain the health and safety of meets all applicable federal, state and local requirements for health, safety and accessibility so that services can be provided in a safe and comfortable environment.

POLICY: The Counseling Source, Inc., will be in compliance with all applicable federal, state and local requirements for health, safety and accessibility.

PROCEDURE:

1. At Orientation and annually thereafter, training will occur about the risk of heat/cold weather-related problems for those on psychotropic medications, identification of clients who are at greatest risk, and about appropriate prevention and treatment of heat/cold weather-related emergencies.

2. During times of officially declared weather emergencies, The Counseling Source Staff will identify clients who are at high risk of weather-related problems based on the any of following criteria:
    a. Homelessness
    b. Client spends a large amount of time outside
    c. Client lives in a dwelling without air conditioning (in times of a heat emergency)
    d. Client lives in a dwelling with inadequate heating (in times of winter weather advisories)
    e. Client must leave dwelling to obtain essential medication/treatment

3. During weather emergencies, the responsible staff member will then attempt to make any appropriate contacts/arrangements for the client including but not limited to:
    a. Phone the community-based (non-residential) clients at least weekly to ensure their safety. If the staff member is unable to contact the client, the police will be requested to check on the client.
    b. Attempt to arrange a stay in a temporary dwelling with adequate facilities until the weather emergency is lifted.
    c. Contact the client's case manager to assist in the alternative placement or services for the client.

REFERENCED STANDARDS AND REGULATIONS:
ODMH OAC 5122-26-12; CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/4/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Health and Safety: Incident Reporting

PURPOSE: To ensure the compliance with OHMAS and county mental health boards standards in completing and processing all incident reports.

POLICY: The Counseling Source clinicians will complete Incident Report Forms as indicated by the following procedure within 24 hours of being notified of the incident. The Executive Director (or designee) will review the report, determine if it is a Major Incident Report or a Critical Incident Report, as well as determine who the report should be also submitted to externally. If necessary, the report will be forwarded via fax within 24 hours of the clinician being notified of the incident (excluding weekends and holidays). The QI committee will review all incident reports.

DEFINITIONS:

Major Incident: An incident which, due to its nature and seriousness, must be forwarded to the county mental health board who has financial responsibility for the client or, in the case of a non-Medicaid client, to the county of residence. This includes an event that poses a danger to the health and safety of clients and/or staff and visitors of the agency, and is not consistent with routine care of persons served or routine operation of the agency.

Reportable Major Incident: An incident that meets the established OHMAS criteria to be reported to them as well as the county mental health board.

Critical Incident: An incident of less severity but still reportable to the agency for quality assurance review and monitoring.

PROCEDURE:

1. Clinician either faxes or hand delivers incident report within 24 hours of being notified of the event to the office to the attention of Intake Coordinator. The necessity to file an Incident Report should follow this criteria:

   A. Client deaths related to suicide, homicide, trauma, accident. If there is no known cause of death, report when the coroner rules. Natural or anticipated medical-related deaths do not require completion of an incident reporting form, but should be documented in the client record.

   B. Any incident involving neglect, defraud, or verbal, physical or sexual abuse, including allegations, but ONLY if such incidents or allegations involve TCS staff. Incidents involving others (family members, staff of other institutions, etc.) should be reported to CPS or APS as warranted, but do not require an additional report to the OhioMHAS unless a TCS staff member is involved.

   C. Suicide attempts do NOT require an incident report, given that TCS does not provide residential treatment services. Ideation and attempts should be reported immediately to appropriate parties within the host institution to ensure that appropriate safety precautions are instituted. These efforts should be documented in the client record.

   D. Medication Errors/Adverse Drug Reactions if they result in hospitalization, permanent harm or death, but only if such errors were the result of TCS staff actions.

2. Intake Coordinator forwards the reports to OhioMAS for review. Reports are also reviewed on a monthly basis by the Quality Improvement Committee.

3. Training:

A. All newly hired clinicians shall receive training on this procedure and the appropriate completion of incident forms.
B. Training will be completed with existing staff when changes occur in the policy, procedure and/or forms.

REFERENCED STANDARDS AND REGULATIONS: ODMH OAC 5122-30-16 and 5122-26-13; CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 1/1/04

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Health and Safety: Infection Control

PURPOSE: To ensure compliance with applicable specification of OHSA and the Ohio Department of Mental Health and Addiction Services with regard to infection control.

POLICY: All staff will be educated on and utilize appropriate universal precautions for infection control in their daily operations.

PROCEDURE:
1. Training on utilization of appropriate universal precautions for infection control shall occur upon orientation and annually thereafter.
2. Instructional reference materials will be provided as a component of this training.
3. Attestation form will be signed by each staff upon completion of training.

REFERENCED STANDARDS AND REGULATIONS:
ODMH OAC 5122-26-14; CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/25/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Corporate Compliance

PURPOSE: The goal of the Corporate Compliance Program is to ensure a Company culture that is ethical in all respects and one that refuses to tolerate non-compliance, in any respect, with the Standard of Conduct.

POLICY: The Counseling Source, Inc. will have a written document to educate employees on the Company's Standard of Conduct that gives the employees the information and process to prevent, detect and report conduct that is not consistent with the Standard of Conduct. The employee and the management staff, through a joint process can then resolve the issues that are inconsistent with the Standard of Conduct through an organized and consistent process.

The document will include, but not be limited to the following Ethical Standards:

- Equal Employment Opportunity
- Statement on Harassment
- Conflict of Interest
- Fraud and Deception
- Proprietary Information
- Competition and Solicitation
- Accepting Gifts or Gratuities
- Substance Abuse
- Statement on Workplace Violence
- Rules and Regulations
- Disciplinary Procedure
- Complaints and Disputes Procedure

The plan will include, but not be limited to the following Legal Standards:

- Operating Policies and Procedures
- Medical necessity
- Billing for Services Rendered
- False Claims
- Anti-kickbacks
- Cost Reports
- Billing Codes
- Bundling of Services
- Licensing
- Covered Services
- Carriers
- Retention of Records

PROCEDURE:
Staff training for the Corporate Compliance Program will be conducted in the new employee orientation and on an annual basis.

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/7/2006

REVIEWED: February 201

THE COUNSELING SOURCE, INC.

CORPORATE COMPLIANCE PROGRAM

The Counseling Source, Inc. Corporate Compliance Program is a program established to educate employees on the Company's Standard of Conduct. The Program gives the employees the information and process to prevent, detect and report conduct that is not consistent with the Standard of Conduct. The employee and the management staff, through a joint process can then resolve the issues that are inconsistent with the Standard of Conduct through an organized and consistent process.

The goal of the Corporate Compliance Program is to ensure a Company culture that is ethical in all respects and one that refuses to tolerate non-compliance, in any respect, with the Standard of Conduct.

THE COUNSELING SOURCE, INC.
STANDARD OF CONDUCT

The Counseling Source, Inc. management and employees are committed to the delivery of high quality services. In delivery of those services, it is the policy of The Counseling Source, Inc. to comply with all legal requirements, and to conduct its business with the highest level of integrity. The Standard of Conduct applies to all aspects of its operations including client care, billing, maintenance of accurate records, and all other areas of the business of The Counseling Source, Inc. Therefore, The Counseling Source, Inc. is committed to conducting its business and operations in accordance with both the law and the highest standards of business ethics.

As noted above, the Standard of Conduct has two aspects:

Ethical Standards – behavioral principles and expectations for employee conduct.

Legal Standards – policies and procedures that define operational processes and procedures that help the Company to adhere to legal and regulatory requirements.

THE GOAL OF THE CORPORATE COMPLIANCE PROGRAM

To bring the expectations of the Standard of Conduct into the conscious awareness of each employee of The Counseling Source, Inc. and to ensure accountability of performance of all aspects of the Standard of Conduct.

ETHICAL STANDARDS

It is the responsibility of the management team to ensure that each employee's behavior reflects a very high ethical standard. No conduct that limits, restricts, or interferes with our ability to deliver the highest quality of care to our clients or interferes with another person's ability to deliver care to our clients is acceptable. The ethical standards are outlined as follows:

- Equal Employment Opportunity
  All aspects of employment are governed on the basis of merit, qualifications, and competence and are not influenced by race, color, religion, age, sex, national origin, sexual orientation, ancestry, military status, veteran status, or disability.

- Statement on Harassment
  A positive working relationship is based on mutual respect. No harassment of any employee by another employee or supervisor on the basis of race, color, religion, age, sex, national origin, sexual orientation, ancestry, military status, veteran status, or disability.

- Conflict of Interest
  We all have a duty of loyalty to the Company to further its goals and to work on behalf of the interest of the Company. Each employee is expected to avoid an actual conflict, or the appearance of a conflict between the Company's interest and the financial or other personal interest of the employee.

- Fraud and Deception
  Each employee is expected to avoid conduct or behavior that defrauds the Company. The types of behavior that The Counseling Source, Inc. considers fraudulent, includes but is not limited to the following:
    - Engaging in outside employment without the written permission of the Executive Director
    - Participating in outside activities that distract an employee from the performance of his/her job duties or cause him/her to use The Counseling Source, Inc. resources for other than The Counseling Source, Inc. purposes.
    - Wasting time or being absent from work without permission
    - Dishonesty, misrepresentation, or making false statements
    - Falsification of Time Cards

- Proprietary Information
  All information received from The Counseling Source, Inc. is confidential information and is the property of The Counseling Source, Inc. Information concerning the business practice may not be shared except as may be required in the normal course of business.

- Competition and Solicitation
  The Counseling Source, Inc. is a competitive business and spends significant time and money training employees. Therefore, all employees must agree to refrain from competing directly or indirectly with The Counseling Source, Inc., from soliciting any client or business away from The Counseling Source, Inc., and from seeking to influence any Counseling Source, Inc. employee to leave The Counseling Source, Inc. employment.

- Accepting Gifts or Gratuities

Employees may not ask for or accept gifts, cash, cash equivalents, payments, services, vacations, or pleasure trips from suppliers, vendors, customers, families or any other person, firm or corporation that does or seeks to do business with the Company. Employees may accept common courtesies usually associated with customary business practices.

- Substance Abuse
  The use, possession, or distribution of an illegal controlled substance in the workplace is unacceptable.

- Statement on Workplace Violence
  The Counseling Source, Inc. will make every effort to maintain a safe workplace for its employees and clients. Any physical, verbal, or mental abuse or intimidation of co-workers, clients, or families is unacceptable. Fighting or disorderly conduct on the job is unacceptable.

- Rules and Regulations
  The Counseling Source, Inc. has established workplace rules and regulations to assure a safe and efficient business operation to comply with public law and to protect the well being of all employees and clients. All employees must comply with these rules and regulations; otherwise they may be subject to disciplinary action.

- Disciplinary Procedure
  Under normal circumstances, The Counseling Source, Inc. supports a policy of progressive discipline in which the employee is given notice of deficiencies and is provided an opportunity to improve. However, management may choose, in its discretion, to immediately terminate an employee depending on the seriousness of the issue.

- Complaints and Disputes Procedure
  The majority of complaints and disputes can and should be resolved with an employee's immediate supervisor. More formal provisions have been established to resolve difficult problems. Employees may give notice of their complaint to their immediate supervisor and, if not satisfactorily resolved, to the Executive Director.

LEGAL STANDARDS

It is the responsibility of all employees of The Counseling Source, Inc. to comply with all federal and state laws and regulations, with an emphasis on preventing fraud and abuse. The legal standards are outlined as follows:

- Operating Policies and Procedures
  All employees are required to become aware of the operating policies and procedures relative to his or her position in the Company and comply with those policies and procedures.

- Medical necessity
  The Company will bill only for services that are warranted by a client's current and documented medical condition

- Billing for Services Rendered
  The Company will bill only for **medically necessary** services that are actually rendered.

- False Claims
  The Company will not make false statements on medical claim forms to obtain payment or higher payment to which it is not entitled.

- Anti-kickbacks
  The Company will not:
    - submit claims for clients who are referred to the Company under contracts or financial arrangements that induce such referrals, or
    - accept money (or in kind gifts) in exchange for referring clients

  in violation of anti-kickback statutes, or, similar federal or state laws or regulations.

- Cost Reports
  The Company will submit cost reports that accurately reflect actual and allowable operating costs.

- Billing Codes
  The Company will use billing codes that accurately reflect the service delivered and provide for the appropriate payment rate.

- Bundling of Services
  The Company will bill for tests or procedures that are required to be billed together as a single bill and not in a piecemeal or fragmental fashion.

- Licensing
  The Company will bill only for services that are rendered by a licensed clinician or a properly supervised non-licensed clinician.

- Covered Services
  The Company will not bill for non-covered services as covered ones to circumvent coverage limitations.

- Carriers
  The Company will not bill the wrong carrier to receive higher reimbursement rates.

- Retention of Records
  The Company will maintain all medical documentation required by federal or state laws to substantiate the service provided and demonstrate the medical need.

IMPLEMENTATION OF THE CORPORATE COMPLIANCE PROGRAM

In order to ensure accountability of the ethical and legal standard in accordance with the Standard of Conduct, we must:

I. Understand the roles of those who are involved with administering the Program and each employee's role in the operation of the Program.

A. Compliance Officer
- Oversee implementation of the Program
- Oversee on-going development of ethical and legal standards
- Monitor Program's effectiveness
- Investigate and resolve compliance issues (any actual or suspected deviations form the Standard of Conduct)
- Report compliance issues to the Executive Director
- Coordinate Program training and education, document education (completion of "Compliance Certification" Form), and ensure inclusion of training as part of the orientation process and annual review process.
- Cooperate in any investigation
- Act in accordance with the Standard of Conduct
- Complete Corporate Compliance Investigation Report

B. Compliance Liaison
- Available to employees who have reportable compliance issues
- Addresses questions and suggestions regarding the Program
- Reports all compliance issues to the Compliance Officer
- Assists Compliance Officer with resolution of compliance issues
- Cooperate in any investigation
- Act in accordance with the Standard of Conduct

C. Supervisors
- Available to employees with reportable compliance issues
- Address questions and suggestions regarding the Program
- Reports all compliance issues to the Compliance Liaison or the Compliance Officer
- Assist with resolution of compliance issues
- Cooperate in any investigation
- Act in accordance with the Standard of Conduct

D. Employees
- Receive and acknowledge Corporate Compliance Program training.
- Promptly report all actual or suspected compliance issues in accordance with Program procedures
- Document compliance issue
- Complete "Compliance Certification" Form

- Cooperate in any investigation
- Act in accordance with the Standard of Conduct

E. Compliance Committee
- Review results of investigation and determine disciplinary action, if indicated

II. Outline the procedure for reporting deviations from the Standard of Conduct

A. If actual or suspected deviations from the Standard of Conduct are observed, employees should discuss their concerns with:
- their supervisor
- the Compliance Liaison
- the Compliance Office

B. Employees should document their concerns (in narrative format) with help from their supervisor, the Compliance Liaison, or the Compliance Officer and complete the "Compliance Certification" Form.

C. Employees should cooperate with management during its investigation (every effort will be made to maintain the anonymity of an employee making a report).

Compliance Officer: David Ludwin

Compliance Liaison: Cynthia Bair, Ph.D.

Compliance Committee

Executive Director: David F. Turner, Ph.D.
Compliance Office: David Ludwin
Compliance Liaison: Cynthia Bair, Ph.D.

Clinical Staff Representatives

III. Describe process for resolution following the report by employee

A. The compliance issue will be reported to the Compliance Officer in writing.

B. The Compliance Officer will discuss the compliance issue with the Compliance Liaison and begin the investigation process.

C. The Compliance Officer will review any documentation that is relevant to the compliance issue.

D. The Compliance Officer will interview any employees, clients, or other individuals that are relevant to the investigation (every effort will be made to maintain the anonymity of an employee making a report).

E. The results of the investigation will be reviewed by the Compliance Committee to determine course of action based on the findings.

The Counseling Source, Inc. is committed to ensuring that we provide the highest quality of care in a manner that is fully consistent with all applicable laws and the ethical standards as outlined in our Standard of Conduct. Full implementation of this Corporate Compliance Program will assist us in achieving this goal.

CORPORATE COMPLIANCE CERTIFICATION

I understand and agree that it is my duty to disclose promptly to either my supervisor, the Compliance Liaison, or the Compliance Officer any conduct that is known or reasonably suspected by me to be unlawful or contrary to the Company's Standard of Conduct. I acknowledge that my duty to make such prompt disclosure is part of my responsibility as a Counseling Source, Inc. employee, and that my failure to report known or suspected unlawful or improper conduct, as required above, may be grounds for discipline by The Counseling Source, Inc.

( ) I am aware of conduct by The Counseling Source, Inc. or by The Counseling Source, Inc. employees in the course of their employment, that I know or reasonably suspect to have been unlawful or improper under The Counseling Source, Inc. Standard of Conduct, consisting of the following:

_____

_____

_____

_____

_____

_____

Please attach additional documentation as needed.

_____
Employee Name (Please Print)

_____
Employee Signature

_____
Date

Please return form to Corporate Compliance Officer – David Ludwin

Every effort will be made to maintain the anonymity of the employee making a report.

CORPORATE COMPLIANCE CERTIFICATION

ANNUAL REVIEW

I understand and agree that it is my duty to disclose promptly to either my supervisor, the Compliance Liaison, or the Compliance Officer any conduct that is known or reasonably suspected by me to be unlawful or contrary to the Company's Standard of Conduct. I acknowledge that my duty to make such prompt disclosure is part of my responsibility as a Counseling Source, Inc. employee, and that my failure to report known or suspected unlawful or improper conduct, as required above, may be grounds for discipline by The Counseling Source, Inc.

During the past year,

( ) I have not become aware of any conduct by The Counseling Source, Inc., or by The Counseling Source, Inc. employees in the course of their employment, that I know or reasonably suspect to be unlawful or improper under The Counseling Source, Inc. Standard of Conduct.

( ) I am aware of conduct by The Counseling Source, Inc. or by The Counseling Source, Inc. employees in the course of their employment, that I know or reasonably suspect to have been unlawful or improper under The Counseling Source, Inc. Standard of Conduct, consisting of the following:

_____

_____

_____

_____

_____

_____

_____
Employee Name (Please Print)

_____
Employee Signature

_____
Date

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Cultural Competency and Diversity

PURPOSE: To ensure that cultural competency is demonstrated in the employment and training practices as well as service delivery.

POLICY: All employees will receive training in cultural diversity and sensitivity upon hire and on an annual basis. Cultural competency will be demonstrated in the employment and training of employees and service delivery.

PROCEDURE:

- Job openings will be accessible to all potential applicants through on-line job posting agencies, and through direct mail to licensed clinicians regardless of ethnicity, race, religion, age, gender, and disabilities.
- Employees will receive cultural diversity and sensitivity training upon hire and at the annual employee training.
- Every reasonable effort will be made to meet a client's request for gender specific or specialized area of training of a treating clinician.
- Any concerns/grievances that are reported will be processed through the agency's "Client's Rights and Grievance Procedure" or the "Corporate Compliance Program."

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 12/6/2004

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Policy Review and Update

PURPOSE: To ensure that all company policies and procedures are reviewed on an annual basis and that all changes/revisions are reviewed with all employees.

POLICY: The Executive Director will review all company policies and procedures on an annual basis and will make changes as needed to meet the needs of clients served and any regulatory agency or accrediting body requirements.

PROCEDURE: The Executive Director and his designees will review and revise, as indicated, all agency policies and procedures on an annual basis. All policy updates will be reviewed in ongoing staff training or in written correspondence with the employees based on the complexity of the policy revision.

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/7/2006

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Legal Requirements - Investigations

PURPOSE: To ensure that The Counseling Source, Inc. is in compliance with all the legal requirements in relation to external investigations and release of information.

POLICY: The Counseling Source, Inc. will ensure that all employees are aware of the appropriate procedures for responding to or participating in external investigations and release of information.

PROCEDURE:

1. When a request for information is received by an employee in the form of a subpoena, search warrant, or other type of investigation, the employee will notify the Executive Director immediately.
2. The Executive Director will contact the corporate attorney to review the request for authenticity and to guide the employee in the provision of requested information or participation in investigation.
3. Based on the type of request, the information will be provided verbally or in writing in compliance with the HIPAA Privacy Practices Policies and Procedures.
4. All questions regarding the process or procedure will be directed to the Executive Director.

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/9/2006

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Financial Planning and Management – Budget and Budget Review

PURPOSE: To establish and maintain an annual budget process that ensures organizational solvency and compliance with all regulatory agencies. The budget is used to:

- Monitor against the actual results during the calendar year
- Plan for future changes
- Forecast future cash flow

POLICY: The Counseling Source will develop and maintain an annual budget.

PROCEDURE:

1. The annual budget will be completed for each calendar year. The budget is prepared by the organization's accountant with input from the Executive Director. Factors that are considered include historical trends in revenue and expenses, projected clinician staffing levels, the need to add additional or different services to meet the needs of individuals served or to discontinue services that may no longer be seen as needed in the community.

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 7/1/11

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Financial Planning and Management – Related Entities

PURPOSE: To ensure full disclosure of the relationship between the parent company, The Rehab Continuum, Inc. and its subsidiary, The Counseling Source, Inc.

POLICY: The Counseling Source, Inc. will provide information to all regulatory agencies as requested regarding the financial reliance and all legal and other responsibilities to demonstrate the organization's commitment to excellence and transparency as outlined below:

The parent company, The Rehab Continuum, Inc., was originally incorporated as Rehab To Go, Inc., in 1990 in Cincinnati, Ohio. Rehab To Go, Inc. formed two wholly owned subsidiaries in 1993 - The Counseling Source, Inc. and The Therapy Source, Inc. In 1995, the company name Rehab To Go, Inc. was officially changed to The Rehab Continuum, Inc.

The Counseling Source, Inc. is a wholly owned subsidiary of The Rehab Continuum and is therefore responsible for any and all of the debts and actions of The Counseling Source, Inc. On a periodic basis, The Counseling Source obtains cash advances from The Rehab Continuum. The cash advances are used to fund working capital and other needs. These advances are repaid to The Rehab Continuum, as cash is available. For purposes of filing Federal Income Tax Returns, The Counseling Source's annual financial results are consolidated with those of The Rehab Continuum. An annual adjustment is made to reflect the tax benefit or tax cost of The Counseling Source's annual financial position.

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 2/2018

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Financial Planning and Management – Coding Compliance/ Billing Audit

PURPOSE: To ensure that billing records match service information in the records of persons served.

POLICY: The Counseling Source will conduct a billing audit annually that will compare the billing and coding to determine accuracy of information in the records of persons served.

PROCEDURE:

1. A random billing audit will be conducted annually on a sample of the charges entered into the billing system. The billing codes and dollar amounts in the billing system (XaktClaim) will be manually audited against the information on the progress notes in the client records.
2. The results of the audit will be documented and any input errors will be corrected with the respective payer sources.
3. An error rate greater than 5% will result in a data input system review to ensure appropriate and accurate data entry. Billing entry processes will be modified as necessary to ensure accuracy.

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 1/01/2010

REVIEWED DATE: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Financial Planning and Management – Fee Structures

PURPOSE: To ensure the establishment and maintenance of a fee structure that is communicated, in writing, to persons served.

POLICY: The Counseling Source will develop and maintain a fee structure that will be reviewed on an annual basis. The fee structure and out-of-pocket cost for services will be clearly communicated to persons served prior to the delivery of services in non-emergent situations.

PROCEDURE:

1. The Executive Director will review the fee schedule on as annual basis to determine the need for adjustments. The fee schedule (private charges) will be based on the market rate for mental health counseling services. A sliding fee scale will also be maintained for clients who qualify based on limited income and no insurance coverage. Please see policy, "Accessibility."
2. Prior to the initiation of services, the client will be made aware of the out-of-pocket costs for services, in writing, on the "Consent for Evaluation and Treatment Fee Agreement and Insurance Authorization Form."

REFERENCED STANDARDS AND REGULATIONS:
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/15/2006

REVIEWED DATE: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Financial Planning and Management – Annual Financial and Compliance Audit

PURPOSE: To determine that the organization's financial position is accurately represented in its financial statement.

POLICY: The Counseling Source, Inc. will complete an annual financial and compliance audit.

PROCEDURE:

1. The audit will be performed by a qualified independent certified public accountant. The audit report covers the balance sheet and the related changes in stockholder's equity, income, and cash flow for the years then ended, and the related notes to the financial statements.
2. The audit will be conducted in accordance with auditing standards generally accepted in the United States of America and Government Auditing Standards issued by the Comptroller General of the United States and the Financial and Compliance Audit Guidelines of the Ohio Department of Mental Health. In addition, the independent auditor issues a report on internal control over financial reporting and on compliance and other matters based on an audit of financial statements performed in accordance with Government Auditing Standards.
3. The annual audit results and management letter are sent to the State of Ohio.

REFERENCED STANDARDS AND REGULATIONS:
CARF Manual

EFFECTIVE DATE: 5/18/2006

DATE OF NEXT REVIEW: 1/15/2007

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Financial Planning and Management – Risk Management

PURPOSE: To manage risk and reduce the severity of a loss if one were to occur.

POLICY: The Counseling Source will conduct an annual review of potential risks to the company and manage the risk appropriately through appropriate planning and insurance.

PROCEDURE:

1. The company will maintain Professional Liability Insurance for all clinical staff. This policy will be reviewed each year, prior to renewal, for adequacy of coverage.
2. The company will maintain General Liability Insurance with additional riders as required or deemed necessary to reduce risk. This policy will be reviewed each year, prior to renewal, for adequacy of coverage.
3. The company will maintain a Surety (Dishonesty) Bond for all employees. This policy will be reviewed each year, prior to renewal, for adequacy of coverage.
4. The company will maintain a key person life insurance policy for the Executive Director. This policy will be reviewed each year, prior to renewal, for adequacy of coverage.
5. On an annual basis, the Executive Director will review the need for additional insurance coverage with the entities providing coverage to determine if any additional coverage is recommended.
6. For additional risk management planning and disaster recovery planning, please see the "HIPAA Security Policies and Procedures."

REFERENCED STANDARDS AND REGULATIONS:
CARF Manual

EFFECTIVE DATE: 5/16/2006

DATE OF NEXT REVIEW: 1/15/2007

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Financial Planning and Management – Internal Control Practices

PURPOSE: To reduce risk and to ensure consistent practices with all financial activities.

POLICY: The Counseling Source will follow established practices and procedures for all financial procedures.

PROCEDURE:

1. Receiving Cash: Cash payments may be received for outpatient therapy visits in the office. Selected personnel are authorized to receive cash payments. The client will receive a written receipt and the company will maintain a copy of the receipt. The cash will be locked in the Office Manager's desk and will be deposited in the bank on a weekly basis at minimum.
2. Receiving Checks and other payments: Checks may be received from clients for outpatient services and from external payer sources on a periodic basis. Payments may also be received electronically from insurance companies. Checks will be endorsed for deposit only, copied, and deposited on a weekly basis into the checking account using scanning software provided by the bank. The copy of the check, along with the back up or explanation of benefits will be filed with the bank deposit slip. Payments are applied to outstanding accounts receivable balances as follows:
3. Payments from the state of Ohio and insurance companies are generally applied by using electronic files received from these organizations. The electronic file is generally applied before the check is received from the state of Ohio or insurance companies.
4. All other payments are applied manually at the time payment is received.
5. Check writing: the office manager will compile (on a periodic basis) a listing of vendor invoices to be paid and will give the list to the Executive Director for approval. The Executive Director will then authorize which vendor invoices are to be paid. The office manager will print the checks and give them to the Executive Director for signature. At the time the checks are signed, the Executive Director reviews the check and corresponding vendor invoice for appropriateness. The Executive Director will then have a second individual review and sign the check. The signed checks are then returned to the office manager for office mailing.
6. Credit Cards: The Executive Director is responsible for the corporate credit card at all times. With the Executive Director's authorization, other administrative staff may use the card for purchases.
7. Lines of Credit: The company will maintain a line of credit through the bank to assist with working capital needs. The Executive Director and the corporate accountant will monitor the line of credit on an ongoing basis. This line of credit will also be reviewed and renewed on an annual basis by the bank.
8. Capital Equipment: The Executive Director must approve all capital equipment purchases.
9. Routine Expenses and Consumable Items: The Office Manager has the authority to make routine purchases for office supplies, printing of forms and other consumable items.

REFERENCED STANDARDS AND REGULATIONS:
CARF Section 1, Criterion I, 6 a-b

EFFECTIVE DATE: 5/16/2006

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Behavioral Health Counseling and Therapy Service

PURPOSE: To establish appropriate guidelines for the provision of Behavioral Health Counseling and Therapy Service

POLICY: The Counseling Source, Inc., will provide Behavioral Health Counseling and Therapy Service consistent with the procedure outline and in accordance with standards put forth by CARF and regulations by OhioMHAS.

PROCEDURE:

1. The definition of Behavioral Health Counseling and Therapy Service according to OhioMHAS is: "interaction with a person served in which the focus is on treatment of the person's mental illness or emotional disturbance. When the person served is a child or adolescent, the interaction may also be with family members and/or parent, guardian and significant others (with consent of parent/guardian) when the intended outcomes is improved functioning of the child or adolescent and when such interventions are part of the ISP."
2. "Behavioral Health Counseling and Therapy Service shall consist of a series of time-limited, structured sessions that work toward the attainment of mutually defined goals as identified in the individualize service plan." This can include:
   a. Individual Counseling/Therapy
   b. Family Counseling/Therapy
   c. Group Counseling/Therapy
   d. Psychoeducation
3. At The Counseling Source, Behavioral Health Counseling and Therapy Service shall be provided by one of the following disciplines:
   a. Licensed Social Worker
   b. Licensed Independent Social Worker
   c. Counselor Trainee
   d. Licensed Professional Counselor
   e. Licensed Professional Clinical Counselor
   f. Psychology intern/fellow
   g. Psychology assistant/assistant
   h. Licensed Psychologist
4. Behavioral Health Counseling and Therapy Service will be supervised by one of the following disciplines:
   a. Licensed Independent Social Worker with Supervision credential
   b. Licensed Professional Clinical Counselor with Supervision credential
   c. Licensed Psychologist
5. Behavioral Health Counseling and Therapy Service may be provided in the agency or in the natural environment of the person served, and regardless of the location shall be provided in such a way as to ensure privacy.
6. Behavioral Health Counseling and Therapy Service for children and adolescents, the agency shall ensure timely collateral contacts with family members, parents or guardian and/or with other agencies or providers (with consent of parent/guardian) providing services to the child.
7. For all clients, when appropriate, and with the consent of the person served, the program coordinates treatment with other services.
8. Records of the persons served document on an ongoing basis the specific treatment interventions that are provided. (See policy and procedure for "Screening and Access to Services - Progress Notes" for further details.)

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health and Addictions Services (OhioMHAS) Administrative Code
CARF Behavioral Health Standards Manual

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Clinical Supervision

PURPOSE: To establish standardized methods of clinical supervision for the purpose of protecting the welfare of clients and to ensure competent, quality services are safely provided.

POLICY: Each clinical supervisor will provide adequate supervision and training to their assistant(s) and/or those they mentor per the guidelines established by their licensure board and The Counseling Source.

PROCEDURE:

Licensed Social Workers:

1. Supervisee will be provided no less than one hour of face-to-face supervision for each 20 hours of direct client contact. Supervision shall occur weekly (except for periods of vacation by supervisor or supervisee).
2. LSW may have Clinical Supervision by an independent social worker, a professional clinical counselor, a psychologist, a psychiatrist or a registered nurse with a master's degree with a specialty in psychiatric nursing. (Clinical Supervision is defined as "supervision of social workers performing social psychotherapy and social workers employed in a private practice, partnership, or group practice means the quantitative and qualitative evaluation of the supervisee's performance; professional guidance to the supervisee; approval of the supervisee's intervention plans and their implementation; the assumption of responsibility for the welfare of the supervisee's clients; and assurance that the supervisee functions within the limits of their license. The assessment, diagnosis, treatment plan, revisions to the treatment plan and transfer or termination shall be cosigned by the supervisor and shall be available to the board upon request.")
3. A LSW may receive Training Supervision for the purposes of obtaining a license while providing services to clients. The training supervisor is responsible for the professional growth of the supervisee. Training supervision for the purposes of obtaining licensure as an independent social worker must be provided by a LISW. This can be provided if appropriate staffing is available at TCS (or via contract with a LISW outside the organization if approved by TCS Executive Director).

Licensed Professional Counselors:

1. A supervisee who is working toward the status of Licensed Professional Clinical Counselor or a Licensed Professional Counselor will receive Training Supervision.
   (a) Training Supervision is defined as requiring "extensive time and involvement on the part of the supervisor in order to help supervisees improve their skills and/or learn new skills."
   (b) A LPCC or LPC may provide training supervision per current regulations set forth by the Licensure Board.
   (c) Licensed Professional Counselors who engage in the diagnosis and treatment of mental and emotional disorders must do so under supervision of a LPCC-S.
   (d) Licensed Professional Counselors who are engaging in training supervision for licensure as LPCC must be under the supervision of a LPCC-S. This can be provided if appropriate staffing is available at TCS (or via contract with a LPCC-S outside the organization if approved by TCS Executive Director).
   (e) Each Supervisor will follow all current regulations set forth by the Licensure Board for Registration of Supervision
   (f) Training Supervision will include one hour of face-to-face contact between the supervisor and supervisee for every 20 hours of work by the supervisee.
2. Work supervision will be provided to all Licensed Professional Counselors "who are engaging in the diagnosis and treatment of mental and emotional disorders and who are not registered with the board for training purposes."

3. Work supervision will be provided no less than one hour of face-to-face for each 20 hours of direct client contact. Supervision shall occur weekly (except for periods of vacation by supervisor or supervisee).

Assistants and Psychology Assistants:

1. Assistants and Psychology Assistants will be provided work supervision. The quantity of this supervision will be based on the supervisor's professional judgment of the supervisee's credentials, years of experience and the complexity of the cases under supervision but supervisor shall have direct knowledge of all clients serviced by supervisee. This knowledge may be acquired through direct client contact or through other appropriate means such as tape recordings, videotapes, test protocols, or other client-generated material.
2. This supervision shall be no less than one hour of face-to-face supervision for each 20 hours of direct client contact. Supervision shall occur weekly (except for periods of vacation by supervisor or supervisee).

Psychology Interns and Post Doctoral Fellows

1. Psychology Interns and Post Doctoral Fellows will be provided training supervision. This will consist of a written agreement describing the goals and content of the training experience, including clearly stated expectations for:
    a. The nature of experiences offered through supervision
    b. The expected working arrangements, quantity, and quality of the trainee's work
    c. The financial arrangements between the supervisee and his/her employer.

   This agreement will be provided to TCS administration.
2. The frequency and duration of training supervision shall be of adequate breadth of experience to enhance the supervisee's professional attitudes, responsibility, communication skills, critical judgment, and technical skills. This supervision shall be no less than 5% of weekly client contact time (equivalent of one hour of face-to-face supervision for each 20 hours of direct client contact). Supervision shall occur weekly (except for periods of vacation by supervisor or supervisee).
3. Group supervision does not substitute for the requirement of face-to-face training supervision for Psychology Interns and Post Doctoral Fellows.
4. Training supervision will require the use of the Supervisory Disclosure Form which will be provided to each client seen by supervisee.
5. Umbrella supervision may be employed if it is part of the training agreement for the post doctoral fellow. Umbrella supervision is a type of training supervision for a post doctoral fellow who is learning the skills of supervising others. This experience will be overseen/supervised by a licensed psychologist.

General Guidelines applicable to All Clinical Employees/Students:

1. It is the supervisor's responsibility to make reasonable efforts to ensure that the supervised work of the supervisee is conducted only for clients for whom the supervisee is competent to provide services.
2. It is the supervisor's responsibility for determining the competencies of the supervisee and shall not assign the supervisee tasks that the supervisee is not competent to perform.
3. It is the supervisor's responsibility to sign off on all documentation completed by supervisee who is an unlicensed Assistant, Psychology Assistant, Post-Doctoral Fellow or Psychology Intern, or who has a LSW or LPC. This documentation includes:
    (a) Diagnostic Assessments
    (b) Diagnostic Assessment Updates
    (c) Assessment Progress Notes
    (d) Treatment Progress Notes
    (e) Individualized Service Plans
    (f) Letters dealing with the welfare of the client

4. A supervisor shall require the supervisee to have consultation with relevant professionals other than the supervisor when counseling or intervention is indicated concerning personal problems.
5. All supervisees serving under a Psychologist shall be registered with the Board of Psychology under the supervisor if receiving: work supervision, mental health worker supervision or training supervision.
6. Supervision Logs must be maintained for each supervisory session and entered into Doc Tracker.
7. As per supervision regulations, if a supervisee presents an issue during supervision which could have legal or ethical implications, it is the supervisor's responsibility to consult with TCS Executive Director.

REFERENCED STANDARDS AND REGULATIONS:
Social Work, Counseling, and Psychology Licensing Board Requirements

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Crisis Intervention/Emergency Services

PURPOSE: To ensure availability of crisis intervention/emergency services

POLICY: The Counseling Source, Inc., will provide 24 hour on-call emergency services.

PROCEDURE:

1. The Counseling Source will provide 24 hour on-call emergency services
    - A. During Business Hours: The responsible clinician will be notified by administrative staff of any client emergencies via company smartphone.
    - B. During After-Hours:
        1. An After-hours call sequence shall be established by the Executive Director and adjusted in periods of vacation or leave of absences.
        2. An answering service shall be utilized in times outside of business hours.
        3. When called, the answering service will notify the clinician that has the primary responsibility of emergency services. This clinician will decide to handle the emergency him/herself or contact the responsible clinician.
        4. The clinician who fields the emergency call will notify the treating clinician of the nature and the outcome of the call.

REFERENCED STANDARDS AND REGULATIONS:
OhioMHAS Administrative Code
CARF Behavioral Health Manual

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Referrals

PURPOSE: To establish procedures for receiving and processing referrals for admission for services.

POLICY: The Counseling Source, Inc. provides its services to individuals with presenting mental health problems and/or alcohol or other drugs/addictions (AOD), and subsequent mental health/AOD diagnoses. Referrals can originate by fax, telephone, and email from nursing facilities, schools, other providers, or self-referrals within the community.

PROCEDURE:

1. Referrals for services are prioritized as follows:
    A. By the date of receipt for Routine Referrals;
    B. By the severity of the referred person's symptoms which is determined by the referring source and the assigned clinician. The severity of symptoms are categorized and responded to by the evaluating clinician as follows:
        1) Urgent Referral – Indicates severe symptoms in which the referred person is considered a danger to self or others. An appointment is scheduled within 24 hours of the receipt of the referral and is treated as an emergency. It is indicated on the fax referral sheet that the referring individual should call the office as well as fax the referral form for all urgent referrals. There is a 24-hour answering service that will relay urgent referral information to the clinician that is on call.
        2) Priority Referral – Indicates that serious symptomatology is displayed. An appointment is scheduled within one week of received referral.
        3) Routine Referral – Indicates less serious symptoms and an appointment is scheduled within two weeks of receipt of referral.
2. The Intake Coordinator, in conjunction with the assigned clinician, and under the supervision of the Executive Director, is responsible for making admission decisions and monitoring referral follow-up.
3. In the event it is determined that an individual's mental health and/or AOD needs require a different level of care than TCS is equipped to provide, then an appropriate referral will be made.
4. A referred person can also be deemed ineligible for services if that person does not abide by the policies of The Counseling Source, Inc. after being informed of those policies.
5. The Intake Coordinator receives referrals via fax, telephone, and email from nursing facilities, schools, other providers, or self-referrals within the community.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/28/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Client Eligibility

PURPOSE: To establish client eligibility criteria to ensure all services are accessible to those individuals meeting the criteria.

POLICY: The Counseling Source will establish and review at least annually the Client Eligibility Criteria.

PROCEDURE: All referred individuals must meet the following Eligibility Criteria to be considered for services by The Counseling Source, Inc.:

1. The referred individual must have a presenting problem which is mental health and/or AOD related issue.
2. The referred individual (or guardian, if applicable) must agree to and sign the Consent for Treatment/Fee Agreement prior to the commencement of services (with the exception of Urgent referrals, which can begin in the absence of the signed Consent/Fee Agreement but must be signed at the next contact date.)
3. The referred individual must supply insurance/financial information for the purposes of billing the appropriate parities, or be agreeable to pay privately for the services.
4. The referred individual may be subject to a Sliding Fee or Reduced Fee Agreement after review of necessary financial documents.
5. Referred individuals with a hearing impairment or communication disorder, or who speak a language other than English as a primary means of communication will have appropriate accommodations through either existing trained Counseling Source staff, or through contracted interpreters. This will be done at no additional cost to the referred individual.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 12/23/2002

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Assessment

POLICY: A Diagnostic Assessment is performed with the client, and other appropriate persons with the documented permission of the client, to gather sufficient information in order to properly assess the client's mental health and/or AOD needs, including the need for continued treatment to be conducted under the guidelines of an Individualized Service Plan.

The Diagnostic Assessment for a client participating in Counseling services, the Community Support Program, or Pharmacological Management will include information about the client's:

- Presenting Problems
- Urgent needs, including suicide risk with severity of suicide intent and precautions initiated
- Personal Strengths
- Individualized Needs
- Abilities and/or Interests
- Preferences
- Previous Behavioral Health Services, including diagnostic and treatment information, and efficacy of current or previously used medication
- Physical Health History, including current medical needs
- Diagnosis(es)
- Co-occurring disabilities and/or disorders
- Mental Status
- Current level of functioning
- Pertinent current and historical life situation information including age, gender, employment history, legal involvement, family history, history of abuse, neglect, and violence, relationships including natural supports
- Issues important to the person served
- Use of alcohol, tobacco, other drugs
- Need for, and availability of, social supports
- Risk-taking behaviors
- Level of educational functioning
- Advanced Directives
- Medication use profile
- Medication allergies or adverse reactions to medications
- Adjustment to disabilities and/or disorders
- Interpretive Summary including recommendations that are based on the assessment data, and identifies any co-occurring disabilities and how they will be addressed in the development of the individual plan

PROCEDURE:

1. The Diagnostic Assessment will be conducted prior to the initiation of individualized mental health services and within thirty days from client's admission to the program.
2. Diagnostic Assessment report with the appropriate information will be available within fifty days from client's admission to the program.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/20/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Client Orientation

PURPOSE: To establish the method by which each person admitted receives an orientation to his or her services.

POLICY: Upon admission, each client and when applicable, their personal representative/guardian will be provided with written documents that explain the processes for service delivery. This information will be provided prior to the initiation of services except in the event of an emergency.

PROCEDURE:

1. The evaluating clinician will obtain the informed Consent for Evaluation and Treatment/Fee Agreement and Insurance Authorization from persons served and/or parent or guardian at the time of initiation of services or prior to evaluation. The document will outline the following:
   A. Treatment will include an evaluation and treatment, if recommended.
   B. The client will participate in the development of the Individual Service Plan.
   C. Acknowledgement of receipt of information regarding the risks and benefits of treatment and their right to refuse or withdraw from treatment at any time.
   D. Authorization of review of records for quality assurance purposes.
   E. Authorization to exchange information with an inpatient hospital should the client be admitted to assure continuity of care.
   F. Acknowledgement that repeated cancellations without 24-hour prior notice may result in termination of services.
   G. Authorization to contact and exchange information about care with the client's physician and staff of referring agencies or facilities.
   H. Acknowledgement of receipt of a copy of the Client Rights and Grievances Policy and Procedures.
   I. Authorization to act as an agent in obtaining payment from all third party payers.
   J. Acknowledgement of financial responsibility and, when applicable, estimated cost to client.
   K. Authorization for release of information to the local Mental Health Board for publicly funded services.
   L. Authorization for release of clinical records as necessary to process claims.
   M. Agreement to notify The Counseling Source, Inc. of changes in insurance coverage or financial status.
   N. Acknowledgement that with prior warning, The Counseling Source, Inc. may terminate services due to non-payment of bill.
2. Should the client refuse treatment or withdraw consent for treatment, the potential consequences of the refusal or withdrawal will be reviewed with the client.
3. Documentation of consent for treatment, refusal to consent, or withdrawal of consent, shall be kept in the individual client record.
4. In the event of an emergency referral (risk of harm to self or others), the client can be seen without a signed consent for mental health services/AOD services. However, at the next subsequent contact, the client will need to complete the consent form for continuation of services.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/28/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Screening and Access to Services - Waiting Lists

PURPOSE: To outline the use of waiting lists with potential clients at The Counseling Source, Inc.

POLICY: The Counseling Source, Inc. does not maintain a waiting list for services.

PROCEDURE:
1. The majority of TCS clients receive on-site mental health/AOD services eliminating the need to maintain a waiting list.
2. Appointment times for outpatient clients are limited. Therefore, outpatient client referrals are prioritized by the severity of symptoms and the date of referral. If the outpatient schedule is at capacity, the Intake Coordinator provides the referred individual with contact information for other providers.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/28/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Individualized Service Plan (ISP)

PURPOSE: To develop and implement an appropriate method to develop client treatment plans.

POLICY: The development of the Individualized Service Plan will be a collaborative process between the client and service provider(s) based on a diagnostic assessment, a continuing assessment of needs, and the successful identification of interventions/services.

PROCEDURE:

1. The Individualized Service Plan will be developed with the active participation of the person serviced and
   - Is prepared using the information from the primary assessment and interpretive summary
   - Is based on the current mental health/AOD needs and desires of the persons served, the family (when appropriate), natural support systems, and other needed services
   - Involves the family of the person served, when applicable or permitted
   - Identifies any needs beyond the scope of the program
   - Specifies the services to be provided by the program
   - Specifies referrals for additional services
   - Is communicated to the person served in a manner that is understandable
   - Is reviewed periodically with the person served for continuing relevance and is modified as needed.

2. The Individualized Service Plan shall document, at minimum, the following:
   A. A description of the specific mental health and/or AOD needs of the client
   B. Goals or Anticipated treatment outcomes based upon the mental health and/or AOD needs identified above. Such outcomes shall be mutually agreed upon by the provider and the client. If these outcomes are not mutually agreed upon, the reason(s) needs to be fully documented in the client record
   C. These should be expressed in the words of the person served
   D. Reflective of the informed choice of the person served or parent/guardian
   E. Appropriate to the person's age
   F. Based upon the person's:
   G. Strengths
      - Needs
      - Abilities
      - Preferences
   H. Specific service or treatment objectives that are:
      - Reflective of the expectations of the person served and the treatment team
      - Reflective of the person's age
      - Reflective of the person's development
      - Reflective of the person's culture and ethnicity
      - Responsive to the person's disabilities/disorders or concern
      - Understandable to the person served
      - Measurable
      - Achievable
      - Time specific
      - Appropriate to the treatment setting
   I. Name(s) and/or description of all services being provided. Such service(s) shall be linked to a specific mental health/ AOD need and treatment outcome
   J. Frequency of specific treatment interventions
   K. Mandated and/or court-ordered treatment
   L. Evidence that the plan has been developed with the active participation of the client. As appropriate, involvement of family members, parents, legal guardians/custodians or significant others shall also be documented

M. As relevant, the inability or refusal of the client to participate in service planning and the reason(s) given
N. The signature(s) of the agency staff member(s) responsible for developing the Individualized Service Plan, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable.

3. The Individualized Service Plan must be completed with five sessions or 45 days whichever is shorter.
4. The Individualized Service Plan shall be reviewed at the client's request, when clinically indicated, and/or when a recommended service is terminated, denied, or no longer available to the client.
5. A new Individualized Service Plan shall be written at minimum every twelve months. Beyond the initial five sessions or 45 days (whichever occurs first) time frame allowed for the initial ISP development, there shall be no services rendered in the absence of an ISP.
6. A review of an existing Individualized Service Plan shall occur at regular intervals to evaluate the client's progress. If no progress has been made, the clinician and client should consider if treatment is still warranted or if the Individualized Service Plan should be changed. Evidence that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians/custodians or significant others should be noted. As relevant, the inability or refusal of the client to participate and the reason(s) given should be noted, as well as the date on which the review was completed and the documented evidence of clinical supervision, as applicable.
7. At the completion of an ISP (when the target date has been reached or termination of services is occurring), the clinician shall update whether the client has met or not met each of the goals/objectives as well as the appropriate dates for each and the date of discontinuance of the ISP.

REFERENCED STANDARDS AND REGULATIONS:
ODMH OAC 5122-27-05; CARF Section 3, Criterion C, 1-3

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Progress Notes

PURPOSE: To define the purpose and contents of Progress Notes

POLICY: Progress notes shall be completed in a timely and comprehensive manner so as to document the service provided.

PROCEDURE:

1. Progress notes shall reflect progress or lack of progress toward the achievement of identified treatment outcomes.
2. Documentation on Progress Notes shall be completed for each service contact and shall include:
    - The date of the service contact and the date of documentation of the progress note, if different
    - Client progress or lack of progress toward Individualized Service Plan goals
    - Significant events or changes in the life of the person served
    - A narrative description of the specific therapeutic interventions performed
    - Clinical observations, including a description of the response by the client to the service provided
    - The signature and credentials of the provider of the service and the date of the signature
    - As appropriate, the clinical supervisor's signature, credentials, and date of signature.
3. Progress Notes shall be completed by all staff members providing service.
4. Progress Notes shall be recorded upon each service contact.

REFERENCED STANDARDS AND REGULATIONS:
ODMH OAC 5122-27-06
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/20/15

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Facility Transfer

PURPOSE: To establish the procedure to ensure that services are continued in the event that a client is transferred to another treatment or residential facility.

POLICY: Upon notification of transfer, the primary clinician will be responsible for initiating the facility transfer procedure to ensure continuity of care.

PROCEDURE:

Upon notification of planned transfer to a facility that the primary clinician serves, he/she will:

1. Ascertain from client if he/she wants to continue service. Do this either by talking with the client prior to a scheduled move or via phone at the new facility when transfer is made without prior notification.
2. If the client chooses to continue with services, contact the Charge Nurse of the new facility to obtain a physician's order for continued service
3. Resume services as soon as the physician's order is complete.
4. Make contact with the client within 14 calendar days of your notification of transfer.
5. Complete a Status Change form to indicate new facility name/address.

Upon notification of planned transfer to a facility that the primary clinician does not serve, he/she will:

1. Ascertain from client if he/she wants to continue service. Do this either by talking with the client prior to a scheduled move or via phone at the new facility.
2. If the client wants to continue, within 5 calendar days of your notification of the move (or impending move) email transfer@thecounselingsource.com regarding re-assignment of this client and provide the following information:
    - Client name
    - Current facility
    - New facility
    - Effective date of transfer
    - Clinician to whom the client is being transferred, if known.
3. The clinician will complete a Transfer Summary.

When the Intake Coordinator is notified of a client transfer to another facility, he/she will:

1. Ascertain if The Counseling Source, Inc. currently serves the facility.
    A. If we do:
        1. Contact the lead clinician for that facility and provide the transfer information.
        2. Contact the Transferring Clinician with the new clinician's name.
        3. Contact the New Clinician to convey information related to transfer.
        4. Email the New Clinician the following documents:
            - Most recent Mental Health Evaluation (Diagnostic Assessment)
            - A populated Mental Health Evaluation worksheet
            - Most recent ISP

    B. If we do not:
        1. Notify the Executive Director so he can contact that facility's administrator for permission to continue seeing the client.
        2. If permission is granted, the Executive Director will identify who will go to the facility to provide the service and inform the Intake Coordinator of the clinician assignment.
        3. The Intake Coordinator will then follow the procedure for notifying the new treating clinician and will forward the documents as outlined above.
        4. The new treating clinician will contact the Charge Nurse of the new facility to obtain a physician's order for continued services and resume treatment as soon as the order is received.
        5. If permission is not granted, the Executive Director will inform the clinician to contact the client to offer outpatient services.

6. If the client chooses to continue services on an outpatient basis, the clinician will notify the Intake Coordinator to schedule the appointment.
7. If the client does not choose to continue services on an outpatient basis, the clinician will complete a termination summary.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 2/25/2004

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Discharge Summary

PURPOSE: To establish the required components of the Discharge (Termination) Summary and time lines for completion.

POLICY: At the conclusion of each treatment case, the responsible clinician shall complete a Discharge/Termination Summary on the established form in a timely manner.

PROCEDURE:

1. The Discharge/Termination Summary shall include, but limited to, the following information:
    - Date of admission of the client
    - Date of the last service provided to the client
    - Date of discharge from program
    - Presenting condition
    - Services provided
    - Reasons for Discharge
    - Results of the services provided
    - Extent to which establish goals and objectives were achieved
    - Status of Person served at discharge
    - Recommendations made to the client, as appropriate to the Individualized Service Plan, including referrals made to other community resources
    - Recommendations for further services or supports
    - Medications prescribed by the agency upon the client's termination from service
    - Upon involuntary termination from service, documentation that the client was informed of his/her right to file an appeal
    - Dated signature and credentials of the staff member completing the summary
    - Dated signature and credentials of the clinical supervisor of the staff member providing the direct service (if applicable)

REFERENCED STANDARDS AND REGULATIONS:
ODMH OAC 5122-27-07; CARF Section 3, Criterion G, 4(I) 1-8
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/29/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Psychiatric Services (Pharmacological Management Service for Children and Psychiatric Diagnostic Interview)

PURPOSE: In order to ensure comprehensive mental health services for children seen in Butler County Schools, Psychiatric Services will be provided by a psychiatrist.

POLICY: Children in Butler County Schools may be referred to the psychiatrist for a Psychiatric Diagnostic Interview and Pharmacological Management Services.

PROCEDURE:

Admission Criteria:

1. A Diagnostic Assessment must be completed prior to initiation of Psychiatric Diagnostic Interview and Pharmacological Management Service.
2. The parent/guardian must consent to Psychiatric Diagnostic Interview and Pharmacological Management Service (as noted on a signed TCS Consent form).
3. Client must be exhibiting signs/symptoms of a DSM-V diagnosis.
4. Clinician may consult with psychiatrist for appropriateness of referral based upon acuity of symptomatology, while not disclosing the identity of the child.

Referral Process:

1. Clinician, or designated school staff, will identify a client as potentially benefiting from Psychiatric Diagnostic Interview and Pharmacological Management Service.
2. The client must have a Diagnostic Assessment (or Update) completed for the current enrollment that is no older than one year prior to the initiation of Psychiatric Services.
3. Clinician or administrative staff will provide a copy of the following to psychiatrist
    a. Full Diagnostic Assessment Form and any subsequent Diagnostic Assessment Update(s)
    b. Fax Referral Sheet (from when client was first referred) – check to ensure all information is still accurate
    c. Signed Consent From (which includes Pharmacological Management Service and Psychiatric Diagnostic Interview)
    d. Copies of any current Authorization for Release of Information Forms
4. Initial Appointment will be scheduled through TCS office in collaboration with parent/guardian (client as well as parent/guardian must be present for psychiatrist visits).
5. It is not necessary for clinician to be present for client's visit with psychiatrist.
6. NOTE: If it is brought to the treating clinician's attention that the client will be transported to the psychiatric appointment by a non-custodial parent/guardian, the treating clinician should attempt to obtain a Release of Information permitting the non-custodial parent/guardian to communicate with the psychiatrist.

Psychiatrist Process:

1. Psychiatrist will be faxed a final copy of schedule of visits by the preceding afternoon. Initially, appointments will be scheduled in 30-minute increments. Subsequent appointments may be scheduled for 15 to 30 minute increments at the discretion of the psychiatrist. Additionally, longer appointments may also be scheduled based upon the acuity of the case.
2. Psychiatrist will review background data provided by the clinician and will initially perform a Psychiatric Diagnostic Interview at client's first visit.
3. Subsequent visits will be billed as Pharmacological Management Service. Pharmacological Management Service will include the following interventions:

a. Prescription of medications and related processes which include:
    1. Consideration of allergies, substance use, current medications, medical history and physical status

2. Behavioral health education to individuals and/or families, (e.g. purpose, risks, side effects, and benefits of the medication prescribed) and
3. Collaboration with the individual and/or family, including their response to the education, as clinically indicated.

b. Administration and supervision of medication and follow-up as clinically indicated.
c. Medication monitoring consisting of monitoring the effects of medication, symptoms, behavioral health education and collaboration with the individual and/or family as clinically indicated.

4. Psychiatrist may also bill for face-to-face collaboration with parent/guardian; family and significant others involved with the client (as identified in the ISP).
5. Psychiatrist will provide documentation of clinical services rendered by way of the SOQIC form.
6. Clients will be seen for Pharmacological Management Service a minimum of four times per year with no break in service greater than 120 days.
7. A Pharmacological Management Service goal/objectives will be initiated and incorporated into an ISP, or an existing therapy or Pharmacological Management ISP, with collaboration with client and parent/guardian.
8. Psychiatrist will schedule follow up sessions with parent/guardian and client at the time of visit.
9. Psychiatrist will provide to TCS an updated schedule by the end of the week in which services have been rendered.
10. No medications will be kept on the premises or handed directly to client or parent/guardian.
11. Prescription Blanks shall be kept on the psychiatrist's person or in a locked, secured area.
12. Prior to follow-up psychiatrist visits, the clinician will collaborate with psychiatrist regarding client's behavior; symptoms and mental status since last Pharmacological Management Service date. This can be achieved via psychiatrist's cell phone or by faxing a report.
13.

Administrative Process:

1. Upon request of clinician, administrative staff may assist in gathering and sending initial data required for referral to psychiatrist.
2. Administrative staff will schedule client appointments for psychiatrist between on-site-visit dates. Administrative staff will make reasonable attempts to remind the parent/guardian of the scheduled visit.
3. Administrative staff will fax to psychiatrist the schedule by the preceding day.
4. Administrative staff will direct phone calls from parent/guardian regarding need for medication refill to the psychiatrist's office at 513-727-1987.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 10/12/04

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy - Individual Service Plan (ISP) Process

PURPOSE: To ensure coordination of services for children receiving psychiatric and pharmacological management services with the physician and behavioral health counseling with a counselor.

POLICY: The ISP for each child receiving pharmacological management services will be reviewed and incorporated into the existing plan or a pharmacological management ISP (SOQIC) form will be developed to ensure integration of services.

PROCEDURE:

1. After a client is seen for the Initial Psychiatric Interview by the psychiatrist, the treating clinician will review the evaluation, in conjunction with the current DAF (or Update) and the current ISP, to determine if Pharmacological Management services can be added to the current ISP goal. If pharmacological services cannot be added to the current ISP goal, an additional ISP goal must be instituted.

2. If the client is not being seen for behavior health counseling, a new pharmacological management SOQIC form will be instituted.

3. If the current ISP goal incorporates the services the psychiatrist is providing, an ISP Revision form will be completed to add the services/frequency of Pharmacological Management services. The ending date of the ISP will be consistent with the original ISP.

4. If the current ISP goal DOES NOT incorporate the services of the psychiatrist, an ISP Revision form will be completed to add a Pharmacological Management goal. The ending date of the ISP will be consistent with the original ISP.

5. In both situations as outlined above, the responsibilities are as follows:
   A. The treating clinician will make the above determinations and provide written ISPs to the psychiatrist on the occasion of his first session date with the client.
   B. The psychiatrist will obtain the signatures of the client and the parent/guardian on the initial ISP revision.
   C. At the next ISP due date, the clinician will write an ISP/goal which will incorporate the services provided by the psychiatrist. This way, the due dates will always be consistent.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 12/1/04

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy – Record Keeping

PURPOSE: To ensure appropriate documentation of prescription and non-prescription medications is readily accessible for the safety of the persons served.

POLICY: The Medical Director will maintain documentation of prescription and non-prescription medications and have the information readily accessible to appropriate personnel to ensure the safety of the persons served.

PROCEDURE:

1. Information regarding the medication prescribed is documented on the Form SQ-04-080 as follows:
    - Manufacturer's name and/or the generic name
    - The dosage
    - The route through which this medicine is provided
    - The frequency.
    - The number of pills.
    - The number of refills.
    - An identification of whether this is a new or a continuing medication.

2. Any discontinued medications, including the rationale for discontinuation will also be documented on the Form SQ-04-080.
3. The Form SQ-04-080 will be signed by the prescribing psychiatrist and records are kept within The Counseling Source.
4. All nonprescription medications should also be assessed to determine the possibility of potential interactions.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 8/3/2004

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy - Access to Services

PURPOSE: To ensure appropriate access and administration of medication.

POLICY: The Counseling Source, Inc. will work in conjunction with the Medical Director to coordinate Pharmacotherapy Services to the clients served.

PROCEDURE:

1. Access to Pharmacotherapy services is provided through direct referral from counselors within the system of The Counseling Source, the client and the client's guardian, a relative, a physician, or designated school staff.
2. The continuity of the Pharmacotherapy service is determined solely by the team that is composed of the guardian, the client, the counselor, if applicable, and the physician.
3. The medication plan is integrated into the overall treatment plan in coordination with the treating counselor if there is one assigned to the case. It stands alone if there is no counselor involved.
4. There is identification and documentation of drug reactions initially provided on form SQ-04-080 in the presence of the client and the client guardian. The actions to follow, in the case of an emergency, are provided directly to the client's guardian who then gives permission to the school to which the client attends, through a nurse or through a guidance counselor. Access is also provided to the counselor who has access to the physician. The emergency number is provided on a business card, allowing access to the physician 24 hours per day, seven days per week, and 365 days per year through the answering service provided on the business card. That answering service number is identified as "emergency." Further access is provided through an 800 number, which addresses the need to provide essentially a free access to the physicians through The Counseling Source, itself.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 8/23/2004

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy – Administration and Compliance

PURPOSE: To ensure that Pharmacotherapy Services are provided in compliance with all applicable laws and regulations.

POLICY: The Medical Director will adhere to all applicable laws and regulations and maintain written policies and procedures for prescribing, dispensing or administering medications.

PROCEDURE:

1. A physician licensed within the State of Ohio, who is in good standing with the State of Ohio, its medical board, and its local jurisdiction, will prescribe medication. All local, state, and federalized regulations pertaining to medication and pertaining to controlled substances must be followed by this physician who is under the governance of the Ohio board that oversees medical physicians.
2. There is an ongoing review of the past use and present use of medication. That review includes the following:
    A. Identifying the number of pills remaining within a prescription provided;
    B. The number of refills connected to that prescription;
    C. The effectiveness of the medication;
    D. Any side effects (both in the initial assessment as well as an ongoing assessment).
        - Allergies and adverse reactions are identified in the initial form, SQ-04-080. They are reviewed with each face-to-face contact. They are documented in a non-face-to-face contact if that information is provided through the physicians on form SQ-04-110.
    E. Coexisting medical conditions are reviewed. Physicians who are concurrently treating the client are identified and efforts are made to coordinate provision of treatment in the form of Pharmacotherapy with the other prescribing physician. The clients within this program are minors with the exception of some 18 year olds or older school students. Therefore, a guardian must provide permission in accordance with HIPAA in order to share information.
    F. In the event of female clients who are pregnant, coordination with the involved obstetrician is maintained and documented.
    G. Poison Control Center information is provided through the answering service number on the business card shared with the client and the client's guardian. That number is connected to the Middletown Regional Hospital, which has access to Poison Control information.
    H. The client will be informed of any special dietary needs and restrictions associated with the medications being prescribed.
    I. Necessary laboratory studies or tests are documented on form SQ-04-080 as well as SQ-04-110.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 8/23/2004

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy – Treatment Guidelines and Protocols

PURPOSE: To ensure that safe, quality Pharmacotherapy Services are being provided.

POLICY: The Medical Director will maintain and regularly monitor the treatment guidelines and protocols to ensure adherence to best practices in medication administration and Pharmacotherapy services.

PROCEDURE:
1. The Counseling Source, Inc., through the efforts of a qualified physician, allows for prescriptions to be written and given to the client or the client's guardian.
2. A "Diagnostic Assessment Form" takes history in reference to medication use.
3. All services will be provided by a board-certified child/adolescent psychiatrist.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administration Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 8/23/2004

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy - Medication Handling

PURPOSE: To ensure appropriate handling of medication and prescription blanks by The Counseling Source, Inc. personnel.

POLICY: The Counseling Source, Inc., will provide Pharmacological Management Services with appropriate safeguards are in place to eliminate the possibility of medication mismanagement or abuse.

PROCEDURE:

1. The Counseling Source, Inc. will not handle any medications either within the administrative office or in any of our contract facilities/schools.
2. All prescription blanks will be either kept on the person of the psychiatrist or in a locked, secure area.
3. Prescription Blanks will be dispensed periodically to the psychiatrist by administrative staff. A tracking mechanism will be utilized to ensure no blanks are missing.
4. The Psychiatrist will be responsible for providing education about use of medications to clients we serve for pharmacological management services.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/26/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy - Medication Review

PURPOSE: To ensure appropriate review of the use of medication for persons served.

POLICY: The Medical Director will ensure regular review of clients receiving medication to monitor the efficacy, side effects, and any contraindications of prescribed medications.

PROCEDURE:

1. Each client is regularly reviewed by a physician. This frequency is usually every four weeks. In the event of additional need, the client is seen more frequently. It is the intent to see the client in the presence of the client's guardian, within the school in which he attends. When this is not possible, the client and guardian come to a school closest to the home school for services to be rendered. In the event that the guardian is unavailable at any school and the need for medication is emergent, medication management could occur at the physician's office. The client's guardian has the absolute right to accept or refuse medication recommended. The following areas are considered at each review:
    A. Needs and preferences of each person are reviewed;
    B. The efficacy of the medication is described;
    C. The presence of side effects and the percentage known are described as well;
    D. If there are contraindications, that medication is not offered;
    E. A mental status evaluation is conducted to determine the organic effects of medication including any form of side effect secondary to the use of antipsychotic medication.
2. In the interest of state-of-the-art use of medication, the newest medications with the least side-effect profile are initially used. That would include the atypical antipsychotic medications; the SSRIs, (serotonin reuptake inhibitor medications); the stimulants and non-stimulants for such conditions as attention deficit disorder; and any other medication provided to the client and guardian. The response of each is documented along with documentation of whether or not the information is understood and whether or not the medication is agreed upon or refused by the client and/or guardian.
3. Every effort will be made to achieve the least restrictive medication regimen determined to effectively manage the client's symptoms.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/26/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pharmacotherapy – Education

PURPOSE: To ensure appropriate education and training are provided regarding prescribed medications.

POLICY: The Medical Director will provide and document provision of education and training regarding prescribed medications to person's served and ancillary staff.

PROCEDURE:

1. Ongoing education is included in the assessment follow-up of each client in regard to the medication being provided.
2. The education is documented on the medical somatic psychiatric progress notes identified as SQ-04-110.
3. Medication information is provided to the counselor if that client is in treatment with the counselor.
4. Training and education is provided to the client and the client's guardian for all medications prescribed. This training and education includes:
    A. The manner in which the medication works, so far as it is known.
    B. The risks of each medication associated with that medicine.
    C. The intended benefits and side effects.
    D. Any interactions which are adverse between multiple medications and food (this is addressed and the medication withheld).
    E. The importance of ongoing compliance with the agreed upon medicine regimen is discussed.
    F. Laboratory monitoring occurs as needed.
    G. Alternatives to the use of medication are explained and offered.
    H. When there is a regression and relapse and reentry of symptoms, that is explained and the information connected to noncompliance with medication discussed as well.
    I. Risks associated with simultaneous use of alcohol, tobacco, and/or illicit drug use are discussed. There is an ongoing admonition of the use of alcohol, tobacco, and illicit drugs, both on the level of a clinical health hazard as well as a legal jeopardy that the client may be putting himself under.
5. Throughout the course of Pharmacotherapy provision, each parent or guardian is included in the decision making.
6. Guardians have the right to deny the use of Pharmacotherapy, and in the absence of an immediate medical emergency, that decision holds.
7. In the event that the child's life or immediate welfare is in danger, it is the Medical Director's responsibility to inform county child protective services of the guardian's decision to refuse medication.
8. There is no instance in which the Medical Director/The Counseling Source forces medication onto any client.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 8/23/2004

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Seclusion and Restraint - Mechanical and Physical

PURPOSE: To outline the use of mechanical restraint and seclusion with clients at The Counseling Source, Inc.

POLICY: The staff of The Counseling Source, Inc. shall not use any mechanical restraint, seclusion, physical restraint or major aversive behavioral interventions with clients.

PROCEDURE: Staff of The Counseling Source, Inc., shall find alternative methods other than use of mechanical restraint, seclusion, physical restraint or major aversive behavioral interventions to intervene with clients.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administration Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/26/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Records of Persons Served

PURPOSE: To establish appropriate contents of a Client Chart and to outline methods to maintain it.

POLICY: The Counseling Source, Inc. will maintain a complete and adequate individual client record for each client served. This shall include all client health and mental health information obtained or created regarding a client. The records will be stored and maintained in such a way that adequate information is available to substantiate clinical service and client confidentiality is maintained.

PROCEDURE:
1. Access to client records and client records areas are limited to clinicians involved in service provision to the client; administrative staff completing tasks related to record maintenance, billing, and quality improvement; and those persons authorized by the client to have access to the record. When archived paper charts are removed from the file room, they must be signed in and out by the staff member to monitor the whereabouts of the record.

2. The individual client record shall communicate information in a manner that is:
   - Organized
   - Clear
   - Complete
   - Current
   - Legible

3. All documents generated that require signatures include original or electronic signatures. The use of carbonless paper forms is considered to have generated "original" signatures as well.

4. The individual record includes, but not limited to:
   - Date of Admission
   - Information about the individual's personal representative, conservator, guardian, or representative payee, if any of these have been appointed, including the name, address, and telephone number
   - Information about the person to contact in the event of an emergency, including the name, address, and telephone number.
   - The name of the person currently coordinating the services of the person served.
   - Location of any other records.
   - Name of the individual's primary care physician
   - Healthcare reimbursement information, if applicable.
   - The person's health history
   - Current medications
   - Pre-admission screening, when conducted
   - Documentation of orientation
   - Assessments
   - Individual plan, including reviews
   - Progress notes
   - Transition plan, when applicable
   - Correspondence pertinent to the person served
   - Authorization for release of information forms
   - Documentation of internal or external referrals
   - Upon Discharge, a Discharge/Termination Summary (for required components of this summary, please reference the Discharge Summary Policy/Procedure)

5. Deadlines for completing components of the client record are outlined by the electronic documentation system

6. Compliance with appropriate completion and timely submission of clinical documents can be monitored using the following:
   - Clinical Batch Management
   - Caseload Reports, including Items Coming Due in 30 Days, Items Overdue, and Missing, Late, and Incomplete Documents

7. Archived paper records shall be stored in a locked room and in locked file cabinets alphabetized by client last name. Records of terminated clients will be stored in placed in alphabetical order in storage boxes by year of termination. Storage boxes will be maintained in the administrative office suites or other locked storage space. Reasonable efforts will be employed to protect records from fire, water damage and other hazards, such as use of smoke detectors and fire extinguishers. As the office suite is located on the basement level, reasonable protection from the threat of tornado is afforded.

8. Employees accessing records outside of office hours are responsible for assuring security of the records after use.

9. Records stored in the Administrative Offices are never to leave the premises.

10. Any duplicate information or reports from the main record of a person served are maintained by the clinician. Such materials are:
    - Not substituted for the main record
    - Considered secondary documents, with the main record of the person served receiving first priority
    - Maintained in such a manner as to protect confidentiality

11. All client information maintained in electronic or automated information systems will be password protected with access limited to those staff of The Counseling Source having clinical or administrative needs for the information. When not in use, automated client data bases will be closed to prevent unauthorized access to client information. (See HIPAA Security Policies and Procedures for further details.)

12. Client records for adults shall be maintained by The Counseling Source for a period of at least seven years or until completion of any audits in process. Client records for minors shall be maintained for at least seven years after the attainment of the age of majority or until the completion of any audits in progress. In the event a pending legal process has been initiated relating to a former client, the record shall not be destroyed until seven years after the resolution of such litigation. All retention and destruction of records shall comply with applicable state and federal laws.

13. The HIPAA Privacy Officer and the HIPAA Security Officers shall have day to day responsibility for the storage and maintenance of Clinical records with oversight by the Executive Director. The HIPAA Privacy Officer and the HIPAA Security Officer will be responsible for implementing the policies and procedures pertaining to the records.

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 4/29/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Outpatient Treatment

PURPOSE: To provide a variety of service modalities in a location that meets the needs and assists the person served in achieving his or her functional goals.

POLICY: The Counseling Source, Inc. will provide an array of services on an outpatient bases delivered by qualified clinicians as defined by the Ohio Department of Mental Health and the program standards as outlined below.

PROCEDURE:

1. Outpatient treatment programs consist of:
   - Individual Counseling/Therapy
   - Family Counseling/Therapy
   - Group Counseling/Therapy
   - Psychoeducation
2. Outpatient treatment programs are provided in locations that meet the needs of persons served, including:
   - Clinic Office
   - Schools
   - Nursing Homes
   - Community Resource Sites

3. When applicable, and with the consent of the person served, the treating clinician will coordinate treatment with other services, including but not limited to the following:
   A. Medical Doctors for medication management
   B. Social Services, Nursing, Physicians and Physical, Occupational and Speech therapists in nursing facilities
   C. Teachers, school psychologists, and counselors in school settings
   D. Vocational counselors in community settings

4. The program uses treatment interventions that are in compliance with the OhioMHAS regulations. See policies on "Screening and Access to Services – Assessment" policy and "Outpatient Treatment – Behavioral Health Counseling" policy.

5. Records of the persons served document on an ongoing basis the specific treatment interventions that are provided. (See policy and procedure for "Screening and Access to Services - Progress Notes" for further details.)

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/20/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Community Psychiatric Supportive Treatment (CPST) Service

PURPOSE: "To provide specific, measurable and individualized services to each person served." Services will "address the individualized mental health needs of the client."

POLICY: The Counseling Source, Inc. will provide an array of services delivered by community based, mobile individuals as defined by the Ohio Department of Mental Health and the program standards as outlined below.

PROCEDURE:

1. CPST should be focused on:
    - the individual's ability to succeed in the community
    - identifying and accessing needed services
    - showing improvement in school, work and family and integration and contributions within the community

2. Criteria for Enrollment in CPST:
    - Client is age 6 years or older
    - Client suffers from documented mental health symptoms which are diagnosable using the DSM-5
    - Suffering from problems related to:
        - Inability to live successfully in the community
        - Inability to access needed services
        - Problems with school, work or family
    - NOTE: Problems encountered need to be as a result of the mental health or alcohol and other drug issue. The problems cannot be in relation to normal developmental stages or problems of the parent/guardian. Client may participate in only CPST services if clinically indicated. There is no requirement to also receive Counseling Services.

3. Specific Services included in CPST: OHMAS Certification Standards include 10 activities that a clinician can provide and bill for under CPST. These are:

    A. On-Going Assessment of Needs

    This can include assessing need for social support, transportation, vocational assistance, income support, housing, etc. The CPST assessment needs to be separate from the diagnostic assessment completed on the client. This includes assessing what additional needs (beyond mental health counseling) the client has that are limiting his/her "ability to live successfully in the community" and function appropriately at school, work or home.These would be services the client is unable to access on his/her own. Examples of areas to be assessed would include need for: a mentor, a tutor, vocational counseling, Healthy Start benefits, etc.

    B. Assistance in Achieving Personal Independence in Managing Basic Needs as Identified by the Individual (Client) and/or Parent or Guardian

    This needs to be specifically stated on the ISP as a goal. Typically "achieving personal independence" would be applicable to an adult, or an adolescent who is preparing for adulthood/independent living. However, even in the latter scenario, the problems encountered must be related to pathological problems interfering with the client achieving personal independence on his/her own.

    C. Facilitation of Further Development of Daily Living Skills, if identified by the Individual and/or Parent or Guardian

    This needs to be specifically stated on the ISP as a goal. This relates to *skill building* or teaching of the daily living skills. This can be provided to the parent IF there will be a direct benefit to the

client. An example would be teaching behavioral management to parent/guardian. If this takes an extended time or is complicated by the parent/guardian's deficits, document this to justify.

D. Coordination of the ISP, Including: SERVICES IDENTIFIED IN THE ISP (such as collaboration with other service providers related to specific treatment goals of the client which are documented on the ISP)

1. ASSISTANCE WITH ACCESSING NATURAL SUPPORT SYSTEMS AND THE COMMUNITY (such as referrals to the needed services identified in the "Ongoing Assessment of Needs")
2. LINKAGES TO FORMAL COMMUNITY SERVICES/SYSTEMS (such as referrals to the needed services identified in the "Ongoing Assessment of Needs")

"It is very important that the development and the ongoing implementation of the ISP be carefully coordinated to assure continuity of care and consistency in the development of the client's treatment goals. It is generally the role of the primary CPST worker to assure this important coordination. "This can include but not limited to CSB involvement, attorney/judge in custody case, other community agencies currently involved with the client.

E. Symptom Monitoring

"This allows the CPST worker to actively engage and document the mental health related symptoms of the client." However, a large amount of pure observation can be deemed problematic by Medicaid. An example of Symptom Monitoring would be assessing (not just "observing") a child in class or at home interacting with siblings/parents.

F. Coordination and/or Assistance in Crisis Management and Stabilization as Needed

This involves providing coordination and/or assistance during or immediately after a crisis with the client. Examples include assisting with obtaining a psychiatric hospitalization and coordinating services upon discharge from the hospital back to the community.

G. Advocacy and Outreach

This allows the worker to "advocate for the client in all situations within the community the client is unable to advocate for themselves due to the symptoms of their mental illness." Examples include advocacy with other agencies or professionals. This should link back to the "On-Going Assessment of Needs," specifically documenting that the clients has difficulty advocating for his/herself due to mental illness.

H. As Appropriate to the Care Provided to Individuals and, when appropriate, to the Family, Education, and Training specific to the Individual's Assessed Needs, Abilities and Readiness to Learn

This is not intended to be treatment to the family or significant other. Rather it can be *skills training or education* provided to the family related to the needs/limitations/behavioral management of the client, etc. This needs to be specifically documented in the ISP as a goal. Examples include: Educating parent/teacher on the specific DSM IV diagnosis the child has and ways to help, behavioral modification techniques, etc.

I. Mental Health Interventions that Address Symptoms, Behaviors, Thought Processes, Etc., that Assist an Individual in Eliminating Barriers to Seeking or Maintaining Education and Employment

Skill building with the client related to mental health issues that interfere with education and employment. This needs to be specifically documented in the ISP as a goal. Examples include:

1. Teaching the client skills to cope with mental health symptoms, behaviors or thought processes and problems encountered in dealing with disability.
2. Teaching the client appropriate social skills to increase interpersonal relationships with peers, family, etc.
3. Educating and assisting the client through the recovery process
4. Teaching/Assisting the client in the development of a personal support system

5. Assisting/Teaching the client how to acquire employment, income and/or money management skills that are interfered with by the client's mental illness
6. Educating the client on mental health diagnosis

J. Activities that Increase the Individual's Capacity to Positively Impact His/Her Environment
This needs to be specifically documented in the ISP as a goal. This can include:
1. Activities to empower the client
2. Activities to increase client's self-esteem
3. Activities to educate the client on how to positively impact his/her environment

Documentation Requirements:

- Diagnostic Assessment or Diagnostic Assessment Update:
  1. Must document the need for CPST intervention to assist with the mental health treatment of the client.
  2. Must indicate under "Recommendations" section that CPST services are recommended along with frequency, duration and focus.

- ISP (Individual Service Plan):
  1. Must document a goal/objectives related to CPST services to be provided. It must be clear that this goal relates to the mental health treatment of the client.
  2. Must list Community Psychiatric Supportive Treatment (CPST) as a "Service" on the ISP with accompanying Frequency & Duration
  3. If CPST services are being delegated to another staff person, must be documented on ISP

- Progress Notes:
  1. Must fill out a CPST note for each service provision
  2. Must specify on the note clearly how the CPST services provided by the clinician directly relates to the client's mental health needs
  3. Must clearly indicate which of the 10 CPST activities was provided on the service date

Method of Service Delivery:

1. Location: "CPST Services are not site specific, however, they must be provided in locations that meet the needs of the persons served."
2. Service Delivery: "May be face-to-face, by telephone, and/or by video conferencing"
3. Responsible Clinician: Must have a clinician responsible for the client's case coordination as documented on ISP
4. Frequency & Duration: CPST Services will "vary with respect to hours, type and intensity or services, depending on the changing needs of each individual."
5. TCS Clinicians approved by OhioMHAS as CPST providers include:
   - Social Work Assistant
   - Licensed Social Worker
   - Licensed Independent Social Worker
   - Counselor Trainee
   - Licensed Clinical Counselor
   - Licensed Professional Clinical Counselor
   - Licensed School Psychologist Assistant
   - Licensed School Psychologist
   - Psychology Intern/Psychology Fellow
   - Psychology Assistant/Assistant
   - Psychologist
6. Those that are approved by ODMH to supervise CPST services include:
   - Licensed Social Worker
   - Licensed Independent Social Worker
   - Licensed Professional Counselor
   - Licensed Professional Clinical Counselor

- Psychologist

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Children and Adolescents

PURPOSE: To establish added guidelines to ensure a consistent array of behavioral health services designed specifically to address the treatment needs of children and adolescents.

POLICY: The Counseling Source will provide behavioral health services which are tailored to the particular needs and preferences of children and adolescents and are provided in a setting that is both relevant to and comfortable for this population.

PROCEDURE:

1. Assessments of each child or adolescent served include information on his or her:
    a. Developmental history, such as developmental age factors, motor development, and functioning.
    b. Medical or physical health history
    c. Culture/ethnicity
    d. Treatment history
    e. School history
    f. Language functioning, including: speech and hearing functioning
    g. Visual functioning
    h. Immunization record (or specification that the school is in possession of the required documentation by law)
    i. Learning ability
    j. Intellectual functioning
    k. Family relationships
    l. Interactions with peers
    m. Environmental surroundings
    n. Prenatal exposure to alcohol, tobacco, or other drugs
    o. History of use of alcohol, tobacco, or other drugs
    p. Parental/guardian custodial status
    q. When applicable, parents'/guardians' ability/willingness to participate in services.
2. Assessments are appropriate with respect to the child's or adolescent's:
    a. Age
    b. Development
    c. Culture
    d. Education
3. The clinician of a child or adolescent being seen in a school setting will take appropriate steps to ensure continuity of his or her education. This can include, but not limited to, coordination with teacher of assignments, rotating session times, etc.
4. For Mental Health Education services, the education provided shall:
    a. Be appropriate to the person served
    b. Meet any applicable federal or state requirements
    c. Include provisions for:
        1. Evaluation
        2. Group instruction
        3. Individual instruction
5. Based upon the assessed needs of the child or adolescent served, the program will include the development of:
    a. Community living skills
    b. Social skills
    c. Social supports
    d. Vocational skills
6. The environment where children and adolescents are seen is appropriate to meet the needs of this population, including:
    a. The physical plant

b. The furniture
c. The equipment

REFERENCED STANDARDS AND REGULATIONS:
Ohio Department of Mental Health Administrative Code 5122
CARF Behavioral Health Standards Manual

EFFECTIVE DATE: 5/20/2005

REVIEWED: February 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Texting of client PHI (Protected Health Information)

PURPOSE: To inform employees of the company's expectations surrounding text messaging of client's PHI in order to maintain client confidentiality and security of client information.

PROCEDURE:

1. Employees of The Counseling Source should never use text messaging for the transmittal of PHI. Employees should maintain a thorough understanding of the potential risk involved in texting client PHI and how texting of PHI could potentially jeopardize client confidentiality.
2. It is understood that some clients/guardians and other involved parties may use text messaging as their primary source of communication with employees. The use of text messaging by clients, guardians, and others cannot be controlled by employees. In the event of a client, guardian, or other involved party using text messaging to transmit PHI, it may be appropriate for the employee to have a conversation with the client/guardian/other about the potential risk involved with texting of PHI, while explaining that their responses will be limited and will not include PHI. Employees should never reply to these text messages using PHI and should not restate the original stated PHI in their responses.

EFFECTIVE DATE: May 2017

REVIEWED: March 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Responding to a subpoena

PURPOSE: To outline the process by which The Counseling Source (TCS) employees respond to a subpoena.

PROCEDURE:
1. Staff who receive a subpoena for a court appearance or the production of documents will promptly deliver it to the TCS office by FAX, electronic communication, or other methods.

2. Contact should be made with the Executive Director to arrange for the subpoena to be submitted to TCS attorney for review.

3. Staff will then communicate with the identified TCS attorney handling the subpoena for guidance on how to proceed with the subpoena.

4. Do not produce any documents that contain confidential communications received from a client or the counselor's advice to that client without first consulting with TCS attorney. **Note: a parent's execution of a release pertaining to a minor child does NOT authorize waiver of this privilege—only the minor child can authorize the release of privileged information.**

5. If possible, the TCS attorney can assist staff in communicating with the court or individual who has delivered the subpoena and either seek to quash the subpoena or arrange for other methods of communication such as sending treatment records in lieu of staff appearing in court.

6. Staff should never take it upon themselves to speak with the attorney or other person who requests communication without first having contacted the Executive Director or the assigned TCS attorney.

EFFECTIVE DATE: May 2017

REVIEWED: April 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Weapons Policy

PURPOSE: To inform employees of The Counseling Source, Inc.'s position on carrying weapons in the workplace.

PROCEDURE: Employees of The Counseling Source, Inc. may not possess or use weapons during the course of their work day. This applies to employees while in TCS offices or in any of the field-based settings served by TCS. This policy applies to all employees of the TCS, regardless of whether they maintain a valid license to carry a concealed weapons permit. The Counseling Source prohibits the presence, possession or use of weapons on company property and on the affiliate properties/facilities served. Note that the definition of "weapons" includes, without limitation, (i) guns, (ii) knives or swords with blades over four inches in length, (iii) explosives, and (iv) chemicals which may be used with the intent of causing harm to another individual.

LIMITATION: Notwithstanding the foregoing, this policy does not prohibit employees of The Counseling Source who have a valid concealed weapons permit from transporting or storing a firearm or ammunition in that person's privately owned motor vehicle in Ohio if and only if:

> (1) Each firearm and all of the ammunition remains inside the person's privately owned motor vehicle while the person is physically present inside the motor vehicle, or each firearm and all of the ammunition is locked within the trunk, glove box, or other enclosed compartment or container within or on the person's privately owned motor vehicle; and
>
> (2) The vehicle is in a location where it is otherwise permitted to be.

Please remember that despite the foregoing limitation, Ohio law still restricts where guns and other weapons can be taken. By way of example only, although exceptions to the general rule exist, the general rule is that weapons may not be brought into a school safety zone.

REFERENCE: Consultation with attorney at Porter & Wright occurred in the writing of this policy.

EFFECTIVE DATE: May 2017

REVIEWED: March 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Social Media Policy

PURPOSE: To provide company expectations and general guidance for employees on the use of social media. For purposes of this policy, "social media" may include, but is not limited to, the use of social networks, blogs, personal websites, wikis, online forums, virtual worlds, and any other online medium allowing the user to express his or her personal views or beliefs. The Counseling Source acknowledges the use of social media as an important tool for communicating and connecting with others. The following procedures outline the company's expectations of the social media user relative to employment at The Counseling Source:

PROCEDURE:

1. The employee who engages in the use of social media should adhere to the following in respect to The Counseling Source as the employer:

   - The Counseling Source should not be identified as a place of employment on the employee's personal social media account.
   -Personal, non-clinical use of social media on company-owned computers or mobile devices is prohibited.
   -The publishing of confidential information relative to The Counseling Source, current or former clients, o-workers, and facility staff is strictly prohibited. In addition, special care should be taken to ensure no information is posted that could lead to indirect identification of current or former clients, co-workers, and facility staff.
   -There should be no online correspondence or "friending" of clients, current or former. In addition, there should be no online correspondence or "friending" of clients' family members, friends, and members of their support network.
   -There should be no online correspondence or "friending" of facility/school staff. If a facility staff person requests contact through a social media forum, the employee should politely explain in person that this is against company policy.
   -Use of The Counseling Source logo is prohibited.
   -Discriminatory content (including age, sex, race, color, creed, religion, ethnicity, sexual orientation, gender identity, national origin, citizenship, disability, or marital status or any other legally recognized protected basis under federal, state, or local laws, regulations or ordinances) will not be tolerated under any circumstances.
   -Employees are prohibited from posting defamatory, pornographic, proprietary, harassing, libelous, or anything that may be potentially harmful to the company or affiliates.
   -Employees should never act as a company spokesperson or engage in commentary that might be construed as being representative of the viewpoints of The Counseling Source.

2. The employee should consider implementation of the following guidelines in their use of social media:
   a. If applicable, it is recommended that employees consider changing their privacy settings from "public" to "private" and take available measures to maintain privacy.
   b. The use of social media should not occur during the work day with the exception of those instances in which it has specific therapeutic value to the clients being served.
   c. The employee should practice good clinical judgment should social media be used as a clinical tool. The use of social media in this context is clearly differentiated from the personal use of social media during the workday.

3. If the employee should become aware of a posting or content that is incorrect or could be potentially harmful to The Counseling Source or its affiliates, this information should be reported at once to the Executive Director for further investigation.

4. The employee is subject to discipline, up to and including termination of employment, should the employee fail to comply to the Social Media Policy. It should be known that the company has the right to monitor employee's participation in social media sites without consent of the employee.

EFFECTIVE DATE: May 2017

REVIEWED: March 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Record Release

PURPOSE: To ensure that all requests for disclosure of Protected Health Information (PHI) are properly verified, appropriately executed, and accurately and consistently tracked within the agency's centralized Record Release Tracker database.

PROCEDURE:

1. Mental health records will be released only upon written request. While use of the agency's standard Release of Information form is preferred, any written correspondence containing the requirements for a valid authorization will be accepted. Such requirements include the following:
   a. Specific identification of the client
   b. Specific identification of TCS as the provider who will be making the disclosure
   c. Specific identification of the information to be disclosed *Note: Information pertaining to HIV status/treatment and/or Substance Abuse treatment will be excluded from the disclosure unless expressly authorized as part of the request.*
   d. The request must be in writing, signed and dated by the client or parent/guardian.

All record requests should be submitted to TCS administrative office, 10921 Reed Hartman Highway, Suite 133, Cincinnati, Ohio 45242 or directly to the treating clinician who will, in turn, forward all relevant information to the administrative office.

2. TCS representative will ensure all required components of the written request are present and the document has been signed and dated by the client or parent/guardian.

3. TCS representative will determine with reasonable certainty that the person authorizing the request, indeed, has the legal authority to do so. Achieving reasonable certainty may involve the following:
   a. When the request has been made in the presence of a TCS representative familiar familiar with the client and/or parent/guardian, no additional verification is needed.
   b. When the request has been made via mail, fax, or email, efforts will be made by the TCS representative to ensure names and addresses are consistent with the identifying information contained in our client database.
   c. For instances in which a request has been made and the TCS representative cannot reasonably verify that the person authorizing the request retains the appropriate authority to do so, the TCS representative reserves the right to request the following:
      1. Proof of guardianship
      2. Photo identification
      3. Notarization of request

4. Once reasonable certainty of the legitimacy of the request has been achieved, the TCS representative will proceed with processing the request.

5. Only the minimum information required to meet the identified terms of the request will be disclosed.

6. Psychotherapy notes belonging to the clinician (such as those contained in the clinician's process notebook) are afforded a higher level of privacy in accordance with HIPAA and therefore will not be released unless expressly requested and appropriately authorized.

7. A cover letter or a fax cover sheet will accompany all disclosures made clearly identifying the components of the client record that are being provided in response to the request for disclosure. *Note: A cover letter is not required for records provided to the client or parent/guardian for personal use.*

8. The following priorities and time frames shall apply to requests for disclosure of PHI:
    1. Emergency requests involving emergency care of client: immediate processing.
    2. Priority requests pertaining to current care of client: within one workday.
    3. Client request for access to own record: within 15 working days.
    4. Subpoenas and depositions: as required
    5. All other requests: within 15 working days.

9. An authorization may be revoked at any time. The revocation must be made in writing and cannot be implemented retroactively.

10. If the request is processed through the agency's administrative office, a courtesy notification will be provided to the appropriate clinician when a client requests information from the mental health record, requests direct access to the complete medical record, or in the event legal action is instituted.

11. If the request is processed directly by a TCS clinician, a copy of the written request and details of the resulting disclosure must be submitted to the administrative office within 24 hours of the disclosure to the HIPAA Security Officer's attention. The HIPAA Security Officer or appointed administrative staff will log all relevant details of the request and resulting disclosure in Record Release Tracker to ensure a comprehensive and accurate accounting of all PHI released by the agency is maintained in a centralized database.

12. TCS record retention policy maintains that records will be retained for seven years. Requests for records pre-dating that time frame may be unable to be fulfilled.

13. Clients may request either paper copies or electronic versions of his/her record.

14. TCS reserves the right to charge a fee (per page) for excessive or lengthy requests.

EFFECTIVE DATE: May 2017

REVIEWED: April 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Pet Policy

PURPOSE: To inform employees of the company's position on bringing pets into the workplace.

PROCEDURE: Employees of The Counseling Source should not bring their pets into the workplace, including the main operating office or facilities served. There may be rare occasions in which an employee may be inclined to bring a pet into the workplace, such as an activity involving pets sponsored by the facility. In this event, the employee must receive prior approval from the Executive Director before bringing his or her pet into the workplace. Prior approval from the Executive Director will include an email requesting permission to bring the pet into the workplace and the reason for the request. Pets should not be brought into the workplace unless formally approved by the Executive Director.

EFFECTIVE DATE: May 2017

REVIEWED: March 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Employee Disciplinary Procedures.

PURPOSE: To ensure a common understanding of what types of behavior and conduct are expected and to consistently enforce a set of standards that creates a positive work environment and earns the respect and confidence of co-workers, clients, customers and visitors.

POLICY: The Employee Code of Conduct, Corporate Compliance Plan and the HIPAA Privacy and Security Policies and Procedures outline employee expectations. Failure to comply with the Employee Code of Conduct, Corporate Compliance Plan and the HIPAA Privacy and Security Policies and Procedures may result in performance counseling up to and including termination.

PROCEDURE: The disciplinary procedure generally has the following steps, however, depending on the seriousness of the issue, any of the steps may be bypassed and your employment terminated.

1. First Verbal Warning. If your job performance is substandard you will receive a verbal warning addressing the issue of concern. Your supervisor will communicate with you to review, areas for correction or improvement, and will give you advice on how to correct or improve job performance in the identified area(s).
2. Second Verbal Warning. If your job performance does not improve, you may receive a second verbal warning with specific instruction as to how to correct or improve performance in the identified areas.
3. Third Verbal Warning. If the first two verbal warnings do not resolve the problem, they you may receive one additional verbal warning. Your supervisor will discuss the warning with you and tell you what steps you can take to avoid termination of your employment. Failure to resolve the problem after the third verbal warning will result in termination of employment.

Types of conduct and behavior that The Counseling Source, Inc. considers inappropriate includes but is not limited to the following:

Employee Code of Conduct

- Excessive tardiness and/or absenteeism
- Improper attire or appearance
- Failure to wear ID badge
- Wasting time or being absent from work without permission
- Careless or unsafe work habits
- Conduct disruptive to fellow employees
- Unsatisfactory work performance
- Reporting a false reason for an absence
- Failure to exercise reasonable courtesy in dealing with clients, customers, or other employees
- Revealing or disclosing confidential information
- Violation of Client's Rights
- Use or possession of alcohol or other controlled substances or being under the influence of alcohol or other controlled substances during work hours
- Malicious or deliberate abuse of The Counseling Source, Inc. property
- Negligence involving patient care
- Dishonesty, misrepresentation, or making false statements
- Insubordination
- Harassment
- Sleeping on the job
- Falsification of Time Cards
- Falsification of client records
- Theft or removal of The Counseling Source, Inc. property without authorization

- Workplace Violence
- Possession of firearms or weapons during work hours
- Leaving work without permission
- Failure to attend mandatory training
- Violation of any policy or procedure in The Counseling Source, Inc. Employee Handbook
- Violation of any policy or procedure in The Counseling Source, Inc. Policy and Procedure Manual.
- Failure to comply with **Corporate Compliance Plan**
- Failure to comply with the **HIPAA Privacy and Security Policies and Procedures**

This list cannot be all encompassing and The Counseling Source, Inc. reserves the right to take appropriate action for conduct that is not specifically delineated in the policy when an employee's action warrants such action.

EFFECTIVE DATE: May 2017

REVIEWED: March 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Eligibility for Services: Restricting Rights or Access to Services

PURPOSE: To outline circumstances during which an individual's rights or access to services may be restricted.

POLICY: The Counseling Source, Inc. will maintain written guidelines describing circumstances or scenarios in which an individual's rights or access to services may be temporarily or permanently restricted. Such guidelines will also clearly identify conditions that must be satisfactorily met for reinstatement of services.

PROCEDURE: The following factors may result in temporary or permanent restriction of services:

- A pattern of repeated missed appointments, including client refusal, client failure to show, and/or client cancellation
- Threats directed toward TCS Staff, other clients, and/or facility staff
- Violent actions directed toward TCS Staff, other clients, and/or facility staff
- Involvement in conflicting or duplicative mental health services
- Extensive non-payment for services rendered

Reinstatement of services is dependent on the following:

- In the case of repeated missed appointments for any of the reasons outlined above, an attendance plan will be developed in collaboration with the treating therapist. If agreed upon conditions are met, and it is determined that the client remains genuinely invested in ongoing services, treatment will continue in accordance with the treatment plan.
- In the case of threatening behavior exhibited by the client, the client will be reassessed once his or her behavior has been deescalated. If the treating therapist determines that the client remains an appropriate candidate for services, services will be reinstated contingent upon approval by The Executive Director.
- While violent actions directed toward others are likely to result in a permanent restriction of services, the client may request special permission from The Executive Director to resume services on a probationary basis.
- In the event of conflicting or duplicative mental health services, the client will be advised of the ethical considerations inherent in this arrangement. The various options will be discussed with the client's best interests in mind. If a client chooses to remain engaged with both providers, the necessary Release of Information must be obtained in order to ensure continuity of care and to minimize potential risks associated with this arrangement.
- In the case there is no payment for services for two consecutive months, the responsible party will be notified of the nonpayment. This notice will advise responsible party that the client has two sessions remaining prior to termination of services for nonpayment. The termination will be discussed and closure brought to the therapeutic relationship. Assuming the outstanding charges have not been made in full within 14 days of notification services will be terminated. Services may be reinstated upon receipt of full payment of the outstanding balance and the continued availability of the clinician's time.

EFFECTIVE DATE: May 2017

REVIEWED: March 2018

THE COUNSELING SOURCE, INC.
POLICY AND PROCEDURE

TITLE: Client Suicidality/ Threat of Harm to Self

PURPOSE: To establish and maintain best clinical practices in the event of suspected suicide risk or threat of harm to self.

PROCEDURE: The clinician should refer to the following policy if a clinician suspects a risk of suicide or if a client reports a threat of harm to self. The policy is broken down into two different sections, as procedures for residential and school-based clients will differ slightly from procedures for non-residential/non school-based clients.

For nursing facility/residential settings/school-based clients:

1. Upon discovery of threat, the clinician will assess risk level of client either through the use of the clinical process or through the use of the *Brief Risk Assessment*.
2. If threat is reported and clinician is concerned for client safety/welfare, the clinician should always ensure client safety first and foremost and should not leave the client unattended until client is deemed to be safe.
3. Upon discovery of threat and assessment of risk level, the clinician should notify the appropriate staff person immediately to ensure continued supervision of client.
   (a) In nursing facility/residential settings, the appropriate staff person to notify is the facility Social Worker, DON, or Administrator. If key staff people are unavailable, the clinician should go through the chain of command at the facility to notify staff who can then contact the Social Worker, DON, or Administrator.
   (b) In schools, the appropriate staff person is the Principal, Guidance Counselor, or teacher who should have some familiarity with the client. The parent/guardian should also be notified, if clinically appropriate.
4. Based on the determined risk level, the clinician will discuss clinical recommendations with facility/school staff and parent/guardian (if applicable), such as psychiatric hospitalization, supervision/monitoring, or any other recommendation that is deemed appropriate by the clinician.
5. The clinician should thoroughly document contact with client, report of threat made by client, actions taken upon discovery of threat, and name/title of facility/school staff who was notified of the report prior to leaving the facility. This should be filed with other TCS documentation or left with point person. It is recommended that the clinician use the handwritten Progress Note, which should be located in the field kit. A copy of the note should be retained for your records.
6. The clinician should thoroughly document contact with client, report of threat made by client, actions taken upon discovery of threat, and name/title of facility/school staff who was notified of the report in Doc Tracker as soon as possible.
7. When deemed clinically appropriate, the clinician should attempt follow-up with facility/school staff and client or parent/guardian (if applicable) to ensure client safety and for ongoing assessment. All follow-up efforts should be documented in Doc Tracker.

For non-nursing facility/non-residential or non school-based clients:

1. Upon discovery of threat, each clinician will assess risk level through the clinical interview process or through the use of the *Brief Risk Assessment.*
2. If a threat is reported and clinician is concerned for client safety/welfare, the clinician should always ensure client safety first and foremost and should not leave the client unattended until client is deemed to be safe.
3. The clinician should consider the following course of action:
   (a) If appropriate, recommend hospitalization and encourage client to go to the emergency room, if appropriate.
   (b) Contact a family member, friend, or trusted member of client's support system to discuss report of threat and recommendations. If appropriate, the clinician should ask this person for assistance in transporting client to the emergency room.
   (c) If risk is imminent and the client is refusing to go to the hospital and does not agree to not harm himself/herself, the clinician will call the police or 911 for assistance in transporting

the client to the hospital and will not leave the client unattended until under appropriate police or medical supervision.

4. The clinician should thoroughly document contact with client in Doc Tracker as soon as possible, noting report of threat made by client, actions taken upon discovery of threat, and name/title of facility/school staff who was notified of the report.
5. When deemed clinically appropriate, the clinician should attempt follow-up with the client to ensure client safety and for ongoing assessment. All follow-up efforts should be documented in Doc Tracker.

EFFECTIVE DATE: May 2017

REVIEWED: March 2018