



COOL Program – Domestic Violence

1225 EAST 5TH STREET, WS NC 27101 | 336-776-0322

FORMAT SHEET

Participant Name: _____

Group Assigned: _____ Time: _____ Start Date: _____

1. Format Sheet

- 1.2 Demographics Page
- 1.3 – 1.7 IPVP Assessment
- 1.8 Program Rules - Participant Agreement
- 1.9 Focus Treatment Sheet
- 1.10 Participant Consent-HIPAA
- 1.11 Two Way Consent for Release
- 1.12 Criminal Background (If available)
- 1.13 Domestic Violence Quiz
- 1.14 Copy of participant identification
- 1.15 Program Rules with group assigned (Give a copy to participant after signed)
- 1.16 Participant attendance Sheet (To be filed in the attendance book)

OFFICE USE ONLY		
Recorded on	Date	Staff Initials
Therapy Note		
Participant Group Attendance Sheet		
P.O and CS Report Log		
Scanned in Database		



COOL Program — Domestic Violence

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SECTION ONE: YOUR INFORMATION			
Name:		Date of Birth:	Age:
Address:			Apt#:
City:		State:	Zip Code:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		E-mail address:	
Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Multi Racial <input type="checkbox"/> Native American			
Phone Numbers:	Home:	Cell:	Work:
Employer:		Email address:	
Person to contact for Emergency:		Relationship to you:	Phone #:
Referral Source: <input type="checkbox"/> Criminal Court <input type="checkbox"/> Civil Court <input type="checkbox"/> Probation/Parole <input type="checkbox"/> DSS <input type="checkbox"/> Voluntary <input type="checkbox"/> Other			
County: <input type="checkbox"/> Forsyth <input type="checkbox"/> Davie <input type="checkbox"/> Davidson <input type="checkbox"/> Guilford <input type="checkbox"/> Montgomery <input type="checkbox"/> Stokes <input type="checkbox"/> Surry <input type="checkbox"/> Other			
Probation: <input type="checkbox"/> Supervised <input type="checkbox"/> Unsupervised <input type="checkbox"/> PJC <input type="checkbox"/> Deferred Prosecution <input type="checkbox"/> Not Applicable			
Probation / Court Officer:		DSS Case Worker:	
SECTION TWO: CURRENT PARTNER INFORMATION			
Name:		Date of Birth:	Age:
What is this person's relationship to you?:			
Address:			Apt#:
City:		State:	Zip Code:
Phone Numbers:	Home:	Cell:	Work:
Employer:			
SECTION THREE: VICTIM INFORMATION			
Name:		Date of Birth:	Age:
What is this person's relationship to you?:			
Address:			Apt#:
City:		State:	Zip Code:
Phone Numbers:	Home:	Cell:	Work:
Employer:			
Does the victim have a protective order (50B or 50C) against you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you living with the victim now?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, how long?		If no when stop dating / separate:	



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INTIMATE PARTNER VIOLENCE PREVENTION ASSESSMENT

Participants Name:	Participant ID#:
Interviewer Name:	Date:

Directions: The questions below provide us with information to better serve you. Please answer each one as completely as possible. It takes most people 30 to 45 minutes to complete. If a question does not apply to your situation, please write "N/A" beside of it. All of your answers will be reviewed by a case manager reviewing the questionnaire; the case manager will ask you additional questions. If you do not understand a question, please ask your case manager interviewer to assist you.

FAMILY/RELATIONSHIP HISTORY

What is the name of the person you are accused of abusing?:

What is your relationship with this person?
 Spouse Girlfriend Mother Father Co-Worker Intimate Partner

Current contact with victim:
 Living with Daily Several times a week Weekly Monthly Occasionally None

Are you currently in a relationship with the victim? Yes No

Does this person intend to leave or break up with you? Yes No

How has your relationship with the victim changed?

Relationship Status:
 Single Dating Engaged Living with Married Separated Divorced Widower

Name of Current Intimate Partner: _____ How long have you been together? _____

How would you describe your current relationship?

If you are separated from your victim, was the separation due to violence? Yes No

Do you have any children? Yes No

First/Last Name	Date of Birth	Residence	Relationship to Children

Please list the names of all people that you have had serious relationships with and the dates that you were with them:

First/Last Name	Started	Ended	Relationship Status (dated, lived together, married, separated, divorced)

EDUCATIONAL HISTORY

What is the highest level of education that you have finished?

Elementary School: 1 2 3 4 5

Junior High: 6 7 8

High School: 9 10 11 12 GED

College/Vocational: _____
 Number of years: _____ Graduated: Yes No
 Major: _____

Graduate: _____
 Number of years: _____ Graduated: Yes No
 Major: _____

Are you enrolled in any schools at this time? Yes No Other Training: _____

If yes where?

What is your schedule?	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday



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EMPLOYMENT HISTORY

Current Employer:

Currently: Full Time Part Time Laid-Off Disabled Retired Student Other

What is your schedule?	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Adjustable (list day of week schedule is received)

How many jobs have you had in the past 5 years?

If you are not currently employed; when were you last employed?

MILITARY SERVICE

Military Experience: Yes No

Discharge Date:

Branch of Service:

Type of Discharge:

Date enlisted or drafted:

Rank at Discharge:

Are you currently in the Reserves? Yes No

If yes, what Branch?

PSYCHIATRIC HISTORY

Are you receiving counseling services at present? Yes No

If yes, please briefly describe:

Have you received counseling in the past? Yes No

If yes, please briefly describe:

Have you ever been hospitalized for mental health reasons before? Yes No

Where	When	How long	What were you treated for?

Have you ever participated in domestic violence counseling before? Yes No

Where?	When?
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Did you complete? Yes No

Has depression or anxiety been an issue in the past? Yes No If yes, please briefly describe:

Are you currently under a doctor's care for depression/anxiety or any other mental health problem? Yes No

If yes, please briefly describe:

Have you experienced life stressors such as: divorce chronic illness death of a loved one unemployment

other stressors in the past year? If yes, please briefly describe:

MEDICAL HISTORY

Name of your primary care physician?

Location:

Phone Number:

Are you currently taking any prescription medications? Yes No

Drug	Dosage	Frequency	Duration	Reason	Prescribing MD

Have you ever been knocked unconscious, suffered from a concussion, or been hospitalized for a head injury? Yes No

When:	Treatment received:	Diagnosis:
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Do you have any medical conditions such as: <input type="checkbox"/> seizures <input type="checkbox"/> heart disease <input type="checkbox"/> high blood pressure <input type="checkbox"/> diabetes <input type="checkbox"/> other chronic conditions? If yes, please describe:		
List any allergies:		
In the event of a Medical Emergency, who should we contact?		
Name:	Relationship to you:	
Daytime phone #:	Evening phone #:	
Address:	Apt #	Evening phone #:
City:	State:	Zip Code:
LEGAL HISTORY		
Do you have an Order of Protection against you by the Victim (50B) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you involved in any pending cases civil or criminal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you now have, or have you ever had an Order of Protection (50B) placed on you by another person: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your current intimate partner ever pressed charges against you for assault? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please briefly describe:		
Has law enforcement ever come to your home to investigate abuse allegations? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Where you ever arrested, charged, or convicted of domestic violence or assault charges? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please briefly describe:		
Have you ever been charged with a crime prior to this incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list all charges, convictions and dates of offenses:		
Do you have any pending charges for violation of a court order or violation of conditions of probation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please briefly describe:		
Do you have an attorney for these charges? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who?	
SUBSTANCE ABUSE HISTORY		
Have you ever used alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when was the last time:	
If you are not using, how long have you been alcohol-free?		
How often do you drink alcoholic beverages? <input type="checkbox"/> Daily <input type="checkbox"/> 4 to 5 x/week <input type="checkbox"/> 2 to 3 x/week <input type="checkbox"/> 1 x/week <input type="checkbox"/> 2 x/month <input type="checkbox"/> ____ # x/year		
Have you ever used drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when was the last time?	
If you are not using, how long have you been drug-free?		
How many times have you tried to quit using alcohol or drugs?		
In your life, which of the following controlled substances have you used? <input type="checkbox"/> Marijuana <input type="checkbox"/> Powder Cocaine <input type="checkbox"/> IV Cocaine <input type="checkbox"/> Crack Cocaine <input type="checkbox"/> Speed (amphetamines) <input type="checkbox"/> Downers/Quaaludes/Barbiturates <input type="checkbox"/> Angel Dust/PCP <input type="checkbox"/> Acid/LSD <input type="checkbox"/> Pain pills (Vicodine, Demoral, Codeine, Oxycotine, etc.) <input type="checkbox"/> Valium/Xanax (without a prescription) <input type="checkbox"/> Inhalants (Gasoline, Whippets, Glue, etc.) <input type="checkbox"/> Hallucinogens (Mushrooms, Peyote, Mescaline) <input type="checkbox"/> Heroin/Opium <input type="checkbox"/> Ecstasy <input type="checkbox"/> Ruffies (Rohipnol)		
In the past 6 months, which controlled substances have you used?		
How regularly do you use them <input type="checkbox"/> Daily <input type="checkbox"/> 4 to 5 x/week <input type="checkbox"/> 2 to 3 x/week <input type="checkbox"/> 1 x/week <input type="checkbox"/> 2 x/month <input type="checkbox"/> ____ # x/year		
On average, how much do you use?		
Have you had legal consequences as a result of your drug and/or alcohol abuse? (e.g. DWI, charged with other crimes while using, stealing to support habit) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please describe:		
Has anyone close to you every expressed concern about your drinking or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who?		
How many times in the last year have you been late to work because you had been using drugs or alcohol?		
Please describe how it affected your work?		



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How did/does your drug or alcohol use affect your home life?			
Out of the number of times you have been charged with a crime, how many times were you under the influence of drugs or alcohol?			
In the last year, have you ever experienced withdrawal symptoms, such as, the shakes, black outs, or seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you currently in a 12-step program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, where and how often do you attend per month?		Name of sponsor:	
Have you ever been through a chemical dependency outpatient treatment program, including DWI classes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been through a chemical dependency inpatient or residential treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
HOUSING/COMMUNITY NEEDS			
Are you currently in danger of being evicted from your home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you need a referral to other agencies in the community? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason:			
RELIGIOUS/ETHICAL ISSUES			
Are you affiliated with a spiritual or religious group <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, with whom?			
How important to you are spiritual matters? <input type="checkbox"/> Not <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Much			
SUICIDAL/HOMICIDAL RISK			
Have you noted and increase in depression? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you been involved in more risk-taking behaviors in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Have you had serious and persistent thoughts regarding suicide or hurting yourself in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Are you currently feeling suicidal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Have you had serious or continuous thoughts of harming or killing another person? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
Do you have intentions of harming or killing another person? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please describe:			
TRAUMA/ABUSE HISTORY			
What circumstance(s) affected your life as a child? <input type="checkbox"/> Abuse <input type="checkbox"/> Violence <input type="checkbox"/> Poverty <input type="checkbox"/> Parental death <input type="checkbox"/> Other, specify:			
Were you ever mistreated as a child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were you abused: (Check all that apply) <input type="checkbox"/> verbally <input type="checkbox"/> emotionally <input type="checkbox"/> physically <input type="checkbox"/> sexually			
By whom:	Frequency:	Severity:	Duration:
Was physical violence part of your parent(s)'s, guardian(s)'s relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Between whom:		Please describe:	
How long have you been in a relationship with your partner?			
What do you and your partner do when you disagree?			
What do you do when you become angry?			
What was the last incident of any other kind of mental, emotional, or psychological abuse toward your partner?			
Date:	Please describe:		



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Please check which of the following behaviors you have done to your present intimate partner or any partner in the past:					
<input type="checkbox"/> Argued with her/him	<input type="checkbox"/> Criticized her/him	<input type="checkbox"/> Called her/him ugly names			
<input type="checkbox"/> Threatened to leave her/him	<input type="checkbox"/> Threatened to take the children	<input type="checkbox"/> Threatened to have an affair			
<input type="checkbox"/> Kept track of her/his time	<input type="checkbox"/> Threatened to harm pets	<input type="checkbox"/> Threatened to harm others			
<input type="checkbox"/> Threatened to harm her/him	<input type="checkbox"/> Threatened with a weapon	<input type="checkbox"/> Driven recklessly			
<input type="checkbox"/> Thrown or broken things	<input type="checkbox"/> Harmed pets	<input type="checkbox"/> Held captive against her/his will			
<input type="checkbox"/> Harassed by phone/email	<input type="checkbox"/> Monitored email or phone messages	<input type="checkbox"/> Grabbed her/him			
<input type="checkbox"/> Accused her/him of being unfaithful	<input type="checkbox"/> Restrained her/him	<input type="checkbox"/> Pulled her/his hair			
<input type="checkbox"/> Carried or picked up against her/his will	<input type="checkbox"/> Spit at or on her/him	<input type="checkbox"/> Pushed her/him			
<input type="checkbox"/> Slapped/Hit/Punched her/him	<input type="checkbox"/> Kicked or stomped on her/him	<input type="checkbox"/> Forced her/him to have sex			
<input type="checkbox"/> Hit her/him with something	<input type="checkbox"/> Strangled her/him	<input type="checkbox"/> Stabbed her/him			
<input type="checkbox"/> Followed her/him	<input type="checkbox"/> Done surveillance her/him	<input type="checkbox"/> Threatened to burn down the residence			
<input type="checkbox"/> Other:					
Has your intimate partner(s) ever sought medical attention for injuries after a fight with you? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What were her/his injuries?					
Has domestic violence occurred between you and other intimate partners? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How many relationships and how many times?					
What is the worst injury you have ever caused to anyone?					
Do you have access to firearms? <input type="checkbox"/> Yes <input type="checkbox"/> No List any weapons that you own:					
As an adult, have you been physically violent to any of the following? <input type="checkbox"/> Parents <input type="checkbox"/> Friends <input type="checkbox"/> Cops <input type="checkbox"/> In-Laws <input type="checkbox"/> Strangers <input type="checkbox"/> Siblings <input type="checkbox"/> Health Care Providers <input type="checkbox"/> Children					
If yes, please describe:					
Do you and your intimate partner have disagreements about sex? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please describe:					
Have you forced your intimate partner to have sex or perform sexual acts against her/his will? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please describe:					
Please describe the incident which led you to contact us:					
Do you associate with other friends or co-workers, who encourage or endorse abuse to their intimate partners? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you ever intentionally inflicted injury or killed a pet? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:					
How would you describe your relationship with your children? (Put N/A if not applicable):					
Do you think the children are impacted when they see or hear you and your intimate partner arguing or fighting? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe their reaction:					
Have your children ever had to come between you and your partner during an argument or fight? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe what happened:					
How do you discipline your children?		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Put in a corner	<input type="checkbox"/> Time Out	<input type="checkbox"/> Restrict phone
<input type="checkbox"/> Restrict to house	<input type="checkbox"/> Talk & explain rule	<input type="checkbox"/> Shaking	<input type="checkbox"/> Take away toys/TV/games	<input type="checkbox"/> Scold	<input type="checkbox"/> Yell
<input type="checkbox"/> Restrict friends	<input type="checkbox"/> Slapping	<input type="checkbox"/> Hitting/Punching	<input type="checkbox"/> Kicking	<input type="checkbox"/> Hit with objects	<input type="checkbox"/> Spanking
<input type="checkbox"/> Other:					
Is the Department of Social Services or Child Protective Services (CPS) currently involved in your family? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, for what reason:					
CPS worker:		County:		Phone:	
Has CPS been involved with your family in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain when and for what reason:					



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INTIMATE PARTNER VIOLENCE PREVENTION PROGRAM

The IPVP program is approved by the North Carolina Department of Administration to provide psycho-educational services to domestic violence offenders. The program is designed to hold offenders accountable: challenging their beliefs, teach new skills to help offenders change their behavior, provide role models while educating offenders about non-controlling behaviors, and confront collusion, and victim blaming by offenders and others. Community Intervention and Educational Services heightens public awareness by making information available in the community and coordinating services including referrals to other agencies for needed services.

BY SIGNING THE LINE, THE PARTICIPANT IN THE COOL PROGRAM AGREE TO THE FOLLOWING POLICIES:

PROGRAM FEE POLICIES	
A	The INTAKE ASSESSMENT FEE must be paid by participant at the time of interview. It is non-refundable \$40.00
B	Pay \$20 per session due at the beginning of each session group.
C	No participant will be allowed to carry a balance greater than \$45 . Participants will not be allowed to attend the group session and will be counted absent if their participation would cause a balance greater than \$45.
D	There must be a ZERO BALANCE at the last group or participants will not be allowed to attend and will be counted absent
E	If you are convicted of a new domestic violence charge or have been absent for 90 or more days , you must start all over again. (Which means paying fee over again)!!!! No exemption will be made
PROGRAM ATTENDANCE POLICY	
A	ONLY 3 ABSENCES will be allowed a 4th missed class will result in staffing to determine participant status in the program
B	Participants arriving after their group start time will not be allowed to disrupt group and will be counted absent
C	Participants must complete 26 weekly group sessions lasting 90 minutes per session and an exit interview. This does not include the intake assessment. All sessions must be completed to gain credit for completion of the program.
PROGRAM PARTICIPATION POLICIES	
A	I, _____ will talk about my use of violence and/or abusive behaviors, and accept responsibility for my actions
B	Participate in discussions and satisfactorily complete all assignments
C	Be respectful and considerate of all participants and staf, turn off all electronic devices. No dark sunglasses (RX only). No weapons of any kind.
D	Participants will not be allowed to attend any program sessions under the influence of drugs/alcohol. If substance abuse is suspected to be a problem then a staff person will recommend that a substance abuse evaluation be completed. The participant must comply with all treatment recommendations.
E	I, _____ agree not to be violent, intimidate, stalk, or harass any person while the program and advise program staff of any further police contact, service of a protection order, or any new or pending charges. I understand and agree that I will be terminated immediately from the program.
F	Circumstances and behaviors that elevate risk to the victim may result in offenders bring discharged from the ipvp program.
G	Advise the group facilitator of any change of address, telephone number, and employment.
H	Respect confidentiality-participants must not share information about ipvp program participant outside the group setting
I	Comply with all recomnedations, which may include mental health and/or substance treatment. Medical referrals will be made as needed.
REPORTING POLICIES	
A	The State of North Carolina requires that the program make an effort to contact the participant's partner and/or victim to gather a history of abuse, and to offer services to him or her.
B	Relevant officials from various community systems (e.g. the court, the district attorney's office, pre-trial/day reporting program, community service, probation/parole, department of social services, step one, etc) will be informed whether or not I am complying with the IPVP program expectations.
C	Any charges with these terms must first be discussed with ipvp program staff community interention and environmental services has the right to suspend or drop anyone from the program who is not complying with all terms of this agreement.

Signature of Participant: _____ Date: _____



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GOALS/INTERVENTION

1. Clarifications of goals and development of a focused treatment plan.
 - Rapport building
2. Recognize cause and effect of behavior
 - Examine and assume responsibility for behavior
 - Identify Abusive behaviors
 - Breaking through denial of responsibility
 - Be accountable for behavior
 - Decrease denying, blaming, and justification of statements and beliefs
3. Demonstrate understanding the cycle of abuse and abusive behaviors
4. Recognize the difference between comfortable and uncomfortable feelings
 - Identify the source of uncomfortable feelings, and how to avoid them
 - Recognize escalating behaviors
 - Demonstrate the appropriate expression of uncomfortable feelings, and avoiding them
5. Learn pro-social attitudes about men and women
 - Recognize the harmful impact of sex role stereotypes
6. Demonstrate the understanding of drug and alcohol use in relationships
 - Examine the physical effects of drugs and alcohol
 - Devise ways to resist peer pressure
 - Recognize safe vs. unsafe substances
7. Adapt beliefs and value systems that lead to choosing non-abusive behavior
 - Practice dealing with conflict and getting along with other people
 - Learn appropriate responses to criticism
8. Explore how different choices are made
 - Strive for solutions to problems
 - Demonstrate effective use of time, effort, and resources when making effective decisions
9. Demonstrate the understanding the effect of Domestic Violence have on children
 - Learn to practice new problem-solving skills with children
 - Work on non-violent relationships with partner
 - Learn methods of non-violent discipline
10. Develop or improve support system
 - Acknowledge that change is unavoidable and prepare for it
 - Set realistic, educational, and personal goals
 - Learn how to cope with personal loss
 - Learn how to manage stress appropriately
 - Identify interest and skills that you would like to pursue
11. Recognize and show respect for individual differences
 - Demonstrate assertive communication skills
12. Practice dealing with conflict, and getting along with other people
 - Stop any further acts of Domestic Violence

Client Name _____

Therapist _____

Focus of Treatment _____

Client Signature _____ Date _____

Therapist/Case Manager Signature _____ Date _____



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PARTICIPANT HIPAA CONSENT FORM

I give my consent for Community Intervention and Educational Services to complete an evaluation/assessment and provide appropriate treatment services. I reserve the right to withdraw the consent for evaluation/assessment, or refuse treatment at any time. I give permission to secure emergency medical treatment if necessary. I understand that my signature does not waive my legal rights, including the release of the agency or its agent for negligence liability. _____

My rights as a Participant were explained to me and a written copy of these rights was given to me on this date. Additionally, my health information rights were explained to me and a written copy of these rights was given to me on this date. _____

It is the policy of Community Intervention and Educational Services that the Participants receive appropriate treatment and continuity of care. In order to fulfill this, information may be shared between Community Intervention and Educational Services agency programs. This data is contained in a record system for statistical and program planning purposes. North Carolina statutes and current precedent prohibit certain types of information from remaining confidential and impose a duty on the recipient of such information to report it to the appropriate authorities. _____

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected under federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless the patient consents in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of federal law and regulation by a program is a crime. Suspected violations may be reported to the appropriate authorities in accordance with federal regulations. _____

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 USC 290dd-3 and 42 USC290ee-3 for federal laws and 42 CFR Pan 2 for federal regulations). _____

As a participant in the Intimate Partner Violence Prevention Program, it is necessary that limited information be exchanged between PSS and the party(s) which referred you to CIES. This information may include, but is not limited to:

1. Assessment information
2. Attendance in program sessions
3. Balance information
4. Expected completion date

I realize that I am not required to give my consent to release this information, but that without this information, the service provided by Community Intervention will be limited. This agreement may be withdrawn, (preferably through a written request from the Participant), but that any information already released will not be affected. These limitations have been explained to me and I understand them fully. _____

As a participant in the COOL program I give my consent to release information to the below named referring body _____

As a participant in the COOL program I give my consent to release information regarding my participation to _____ who is listed as the victim in my court referred case. _____

The purpose of this information exchange is to ensure compliance with the orders of your referring body as well as the treatment recommendations of Piedmont Support Services. _____

Referring Body: _____

The above information has been fully explained to me and I certify that I understand its contents.

Participant Name (Print or type)

Participant Signature

Date



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TWO WAY CONSENT FOR RELEASE

Information to be released by:

Agency/School/Persons: _____

Address: _____

Telephone: _____ Fax: _____

Name/Position: _____

Information to be released to:

Agency/School/Persons: _____

Address: _____

Telephone: _____ Fax: _____

Name/Position: _____

I also give my permission for the exchange of information (oral and/or written) between the above named agencies/schools/persons.

Print Name: _____

Signature of Participant: _____ Date: _____

CIES Caseworker Name (print): _____

CIES Caseworker Name (Signature): _____ Date: _____



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DOMESTIC VIOLENCE QUIZ

True/False: Test your dating violence knowledge by answering the **True/False** questions below (check one)

1. **Dating violence is rare among high school students, college students, and other educated people.** True False
2. **When someone decides to leave an abusive relationship, the abuse usually ends.** True False
3. **Drug and/or alcohol abuse is often a factor in dating violence incidents.** True False
4. **The best way to get a friend to leave an abusive relationship is to “cut ties” with them.** True False
5. **If violence occurs once in a dating relationship is it likely to happen again.** True False
6. **Police hardly make arrests in dating violence situations.** True False

Multiple Choice: You can have more than one correct answer (check all that apply)

7. **What kind of behavior would be considered a sign of relationship abuse?**
 - Your partner decides to take a nap while you're talking about something important
 - Your partner tells you that you are fat and / or ugly
 - Your partner lets you know that he / she doesn't like it when you “flirt” with other people
 - You're considered a vegetarian and your partner makes you eat at a restaurant without a veggie menu
8. **What is a good way to help a friend in an abusive relationship?**
 - Offer to beat up your friend's partner
 - Offer to burn down your friend's partner house
 - Listen when your friend wants to talk about the relationship
9. **True love is**
 - Never having to say “I'm sorry”
 - Feeling that your partner needs are just as important as your own
 - When your partner is jealous and possessive proves that he / she loves you
 - When you and your partner spend all your time together
10. **Why do people abuse their partners?**
 - The abuser drink too much alcohol, and can't control him/herself when drunk
 - The partner makes the abuser so angry
 - The abuser wants to control the partner
 - They don't have much money, which causes stress in the relationship
11. **Which of the behaviors would be considered a sign of dating violence?**
 - You and your partner are arguing, and they keep swerving into oncoming traffic until you agree
 - When you decide to leave the relationship and your partner threatens to commit suicide, because they can't live without you
 - You have an argument about what to do on a Friday night, so you decide to spend the evening alone without speaking until the next day
 - After going out with your friend on a Friday night your partner accuses you of cheating



COOL Program – Domestic Violence

1225 EAST 5TH STREET, WS NC 27101 | 336-776-0322

GROUP RULE FOR DOMESTIC VIOLENCE CLASSES

Today's Date: _____ **YOUR COPY!! (Give to client)**

1. Must complete 26 sessions. **STATE RULES! NOT OURS!**
2. Only allowed to **miss 3 Sessions** (please use this wisely!). **ALL MISSED SESSIONS MUST BE MADE UP.**
3. You can only attend **one session per week.**
4. You are **NOT ALLOWED TO SWITCH** from group to group.
5. Please arrive at least **10 minutes prior to class time.** If you arrive late, you will not be allowed to attend the group and will be marked absent.
6. **Fee is \$20 per class.** Total for 26 classes is \$520. Payments may be made in advance or in increments at the time of each class.
7. **Assessment fee is \$40. (It is non-refundable)**
8. **You cannot go over owing \$45** and must be caught up before continuing attending to the group. We accept cash, credit / debit and check.
9. Each class lasts one hour and 30 minutes. **You must stay for the entire class.**
10. Cell phones must be turned off and put away. **No texting!**
11. Come to class **free of the influence of alcohol or illegal drugs.**
12. Do not use racist or sexist language, or wear clothing with disregarding messages during class.
13. You must remain non-violent and must not use threats while involved with DAIP.
14. **You must participate** in class discussions and cooperate with DAIP staff.
15. You should refer to your partner or ex-partner by his / her first name.
16. **You will accept responsibility for your actions,** and focus on yourself.
17. **You will be respectful** to staff and other participants.
18. **Remember confidentiality!** Anything that is said or done in class must stay in class!!!
19. If you are **convicted of a new domestic violence charge** or **have been absent for 90 days or more,** you **MUST START ALL OVER AGAIN (WHICH MEANS PAYING FEES OVER AGAIN)! No exemptions.**
20. Please let us know if your probation officer or any contact information have changed so reporting can be done. It is your responsibility!!!
21. **You are here to address your issues in regard to domestic violence, not your partner's!!!**
22. **ATTENDANCE:** You are responsible for signing in at each class.
23. Any individual conversations between staff and yourself, does not need to be shared with others in the group!

Main Office Line: 336-776-0322

Website: www.PSSofNC.com

Men Group Option

Tuesday: 6 p.m. – 7:30 p.m.

Thursday: 10 – 11:30 a.m.

Thursday: 6 p.m. – 7:30 p.m.

Saturday: 11 a.m. – 12:30 p.m.

Women Group Option

Monday: 12 Noon – 1:30 p.m.

Thursday: 5:30 – 7 p.m.

Saturday: 9:30 – 11 a.m.

Group Day: _____ Start Date: _____ Time: _____



COOL Program – Domestic Violence

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PARTICIPANT SIGN-IN SHEET

Start Date: _____ Group _____ Time: _____

Client Name: _____ Phone: (_____) _____

Email Address: _____

P.O. C.S. DSS Attorney Name: _____

	Date of Session	Present ?	Amount Paid	Notes	Staff Initials
Intake		<input type="checkbox"/> Yes <input type="checkbox"/> No			
1		<input type="checkbox"/> Yes <input type="checkbox"/> No			
2		<input type="checkbox"/> Yes <input type="checkbox"/> No			
3		<input type="checkbox"/> Yes <input type="checkbox"/> No			
4		<input type="checkbox"/> Yes <input type="checkbox"/> No			
5		<input type="checkbox"/> Yes <input type="checkbox"/> No			
6		<input type="checkbox"/> Yes <input type="checkbox"/> No			
7		<input type="checkbox"/> Yes <input type="checkbox"/> No			
8		<input type="checkbox"/> Yes <input type="checkbox"/> No			
9		<input type="checkbox"/> Yes <input type="checkbox"/> No			
10		<input type="checkbox"/> Yes <input type="checkbox"/> No			
11		<input type="checkbox"/> Yes <input type="checkbox"/> No			
12		<input type="checkbox"/> Yes <input type="checkbox"/> No			
13		<input type="checkbox"/> Yes <input type="checkbox"/> No			
14		<input type="checkbox"/> Yes <input type="checkbox"/> No			
15		<input type="checkbox"/> Yes <input type="checkbox"/> No			
16		<input type="checkbox"/> Yes <input type="checkbox"/> No			
17		<input type="checkbox"/> Yes <input type="checkbox"/> No			
18		<input type="checkbox"/> Yes <input type="checkbox"/> No			
19		<input type="checkbox"/> Yes <input type="checkbox"/> No			
20		<input type="checkbox"/> Yes <input type="checkbox"/> No			
21		<input type="checkbox"/> Yes <input type="checkbox"/> No			
22		<input type="checkbox"/> Yes <input type="checkbox"/> No			
23		<input type="checkbox"/> Yes <input type="checkbox"/> No			
24		<input type="checkbox"/> Yes <input type="checkbox"/> No			
25		<input type="checkbox"/> Yes <input type="checkbox"/> No			
26		<input type="checkbox"/> Yes <input type="checkbox"/> No		LAST SESSION IF NO ABSENCES	
Total Attended:		Total Paid:		Exit Interview Date:	

Program Requirement = Assessment Interview + 26 Group Sessions

Program Name: DV/COOL Facilitator Name: _____