Please complete the enclosed packet completely; a Center for Mental Health representative is available to assist with completion of the application packet upon your request. Also, be prepared upon return of the completed application packet by bringing a picture identification card (driver’s license), social security card, and any insurance cards. If you do not have any type of insurance (private, Medicare, Medicaid, etc.), please bring in proof of your income for your household.

Again, please feel free to ask for assistance if you have any questions regarding the application packet and/or services offered by the Center. We are pleased to assist you in any way possible.

Thank you.

CENTER FOR MENTAL HEALTH
Application for Services

This application is a part of your Center record and the information provided will be treated as confidential. This information is required in order for us to assign you a therapist and bill you and/or your insurance company. Please complete the questions as thoroughly as possible. The Center for Mental Health provides services and benefits to its clients without regard to race, color, national origin, handicap, age, sex, marital status, religion or political beliefs.

Please complete this application specific to the person seeking services

Name: ___________________________ Date of Birth: ___________ SEX: ___________________________
       (Last)            (First)            (M I)             Age: ___________

☐ M ☐ F

Address: ___________________________ (Street or P O Box) ___________________________ (City) ___________________________ (County) ___________________________ (State) ___________________________ (Zip Code) ___________________________

Social Security #: ___________________________ Maiden/Previous Names: ___________________________

Home #: ___________________________ Cell #: ___________________________ Work #: ___________________________

☐ 1) SSI due to Mental
☐ 2) SSI not due to Mental Illness
☐ 3) SSDI due to Mental Illness
☐ 4) SSDI not due to Mental Illness
☐ 5) Does not apply

Complete only if applicant is under the age of 18:

Name of Parent/Guardian: ___________________________ SSN: ___________________________

Address: ___________________________ (Street/P O Box) ___________________________ (City) ___________________________ (State) ___________________________ (Zip Code) ___________________________

DOB: ___________________________

Home #: ___________________________ Cell #: ___________________________ Work #: ___________________________

Source of Referral

☐ 01 Self/Family/Friend
☐ 02 Clergy
☐ 03 Other Mental Health Provider
☐ 04 Medical Doctor/Non-Psychiatric
☐ 05 Montana State Hospital
☐ 06 Residential Facility
☐ 07 Other Mental Health Center
☐ 08 Crisis Center
☐ 09 Courts
☐ 10 Schools
☐ 11 Hospital Emergency Room
☐ 12 Law Enforcement
☐ 13 Other/Unknown
☐ 14 Native American Agency
☐ 15 Veteran’s Administration
☐ 16 Homeless Shelter
☐ 17 Alcohol/Drug Treatment Center
☐ 18 Employer/EAP
☐ 19 Agency for the Elderly
☐ 20 Agency for Children
☐ 21 Developmental Disability Services

Why are you seeking services at the Center for Mental Health?


**CONTACT INFORMATION: IN CASE OF AN EMERGENCY**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
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**FOR STATISTICAL PURPOSES, THE FOLLOWING INFORMATION IS REQUESTED** (V OR X APPROPRIATE BOXES FOR EACH CATEGORY)

### RACE / ETHNICITY

(You may check up to three boxes)

- [ ] 1 Caucasian
- [ ] 2 African American
- [ ] 3 American Indian / Alaskan
- [ ] 4 Asian
- [ ] 5 Native Hawaiian or other Pacific Islander
- [ ] 6 More than one race
- [ ] 7 Unknown
- [ ] 8 Hispanic, Latino: [ ] Yes [ ] No

### MILITARY STATUS

- [ ] (M) Married
- [ ] (D) Divorced
- [ ] (W) Widowed
- [ ] (S) Separated
- [ ] (N) Never Married

### MARITAL STATUS

- [ ] 01 Full Time
- [ ] 02 Part Time
- [ ] 03 Unemployed But Desiring and Able to Work
- [ ] 04 Student / Preschool
- [ ] 05 Homemaker
- [ ] 06 Retired
- [ ] 07 Disabled
- [ ] 08 Supported/Sheltered/Transitional Employment
- [ ] 09 No Interest in Work
- [ ] 10 Non-Paid Work/Volunteer
- [ ] 11 Other
- [ ] 12 Unknown

### EMPLOYMENT STATUS

- [ ] 13 Unknown

### CURRENT EDUCATIONAL STATUS (please circle one)

1. No formal education
2. Adult Education Classes (GED)
3. Attends Vocational School
4. College part-time
5. College full-time
6. Other:
7. Home Schooled
8. Public School K-12
9. Private School

_____ Last grade completed

### LIVING SITUATION – (last six months)

- [ ] 03 Hospitalization
- [ ] 04 Nursing Home
- [ ] 05 SRO Transient / Hotel
- [ ] 06 Shelter / Mission
- [ ] 07 Personal Care Home
- [ ] 08 Mental Health Group Home

- [ ] 09 Non-Mental Health Group Home
- [ ] 10 Foster Home
- [ ] 11 Living With Others (in their care)
- [ ] 12 Supported Independent living
- [ ] 13 Living Independently With Others
- [ ] 14 Living Independently (alone)

- [ ] 15 Other:
- [ ] 16 Therapeutic Foster Care
- [ ] 17 Residential Treatment Facility (Psychiatric)
- [ ] 18 Homeless
- [ ] 19 Jail/Pre-Release Center
- [ ] 20 Unknown

### LEGAL STATUS

Have you been on probation or parole in the last three (3) months? [ ] Yes [ ] No

Juvenile Justice Adjudication in the last three (3) months? [ ] Yes [ ] No

Are you coming here voluntarily or have you been Court Ordered to receive services?

- [ ] 1 Voluntary
- [ ] 2 Civil – Involuntary
- [ ] 3 Criminal - Involuntary
**LEGAL CUSTODY**

Who has *legal Custody* of you, the applicant?:  ✔ or ✗ appropriate boxes

- S = Self
- P = Parent / Grandparent
- G = Guardian
- D = Department of Family Services
- C = Department of Corrections or Juvenile Justice
- B = Bureau of Indian Affairs / Tribal Court
- F = Other Family
- O = Other  *(please specify):* ____________

**FAMILY INFORMATION** *(List everyone, including applicant, currently residing in the home)*

<table>
<thead>
<tr>
<th>COMPLETE NAME:</th>
<th>RELATIONSHIP</th>
<th>DATE OF BIRTH</th>
<th>SOCIAL SECURITY #</th>
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**FAMILY INCOME**

List all income and benefits you, your spouse, dependents, or other family members receive from any source *(including employment, Social Security, SSI, SSDI, Pensions, VA, Child Support, BIA, etc.)*

<table>
<thead>
<tr>
<th>COMPLETE NAME (include middle initial)</th>
<th>SOURCE OF INCOME</th>
<th>GROSS INCOME</th>
<th>WK</th>
<th>MO</th>
<th>OTHER</th>
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</table>

**ZERO INCOME:**  ✔ *Check this box* if your total household income is *ZERO*:  ✔
MEDICAL HISTORY: Please answer all questions below pertaining to applicant.

1. Do you have any medical problems you are now being treated for?  
   Yes  No
   If yes, please explain:

2. Do you have any chronic medical problems?  
   Yes  No

3. When did you last see a physician?  For what reason?

4. Have you had surgery or an illness in the last 5 years?  
   Yes  No
   If yes, please explain:

5. Current height:  Current Weight:  

6. What MEDICAL PROVIDERS are you CURRENTLY seeing?  
   1.  3.  2.  4.  

7. Please list all current medications and Prescriber. Please include dosage, if known.  
   1.  3.  5.  2.  4.  6.  

8. Have you ever had trouble with any medications prescribed for you?  
   Yes  No
   Are you allergic to any medications?  Yes  No  Unknown
   If yes to either question, please explain:

9. Has there been an important change in your overall health in the last year?  
   Yes  No
   If yes, please explain:

10. In the past five years, have you ever been hospitalized for more than one week?  
    Yes  No
    If yes, please explain:

11. Do you take any non-prescribed medications or drugs?  
    Yes  No
    If yes, please specify:
    Pharmacy Name:  Location:

12. Do you have now, or have you ever had: (check all that apply)

<table>
<thead>
<tr>
<th>✓  CONDITION</th>
<th>DATE(S)</th>
<th>✓  CONDITION</th>
<th>DATE(S)</th>
</tr>
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<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td>High or Low Blood Pressure</td>
<td></td>
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<tr>
<td>Anemia or Blood Disorder</td>
<td></td>
<td>Kidney Problems</td>
<td></td>
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<tr>
<td>Been Unconscious</td>
<td></td>
<td>Problem w/Coordination or Balance</td>
<td></td>
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<tr>
<td>Bleeding Problems</td>
<td></td>
<td>Radiation Therapy or Treatment</td>
<td></td>
</tr>
<tr>
<td>Cancer or Tumor</td>
<td></td>
<td>Rheumatic Fever</td>
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<tr>
<td>Chest pains</td>
<td></td>
<td>Seizures</td>
<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
<td>Sinus Problems</td>
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<tr>
<td>Frequent Headaches</td>
<td></td>
<td>Stomach or Digestive Problems</td>
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<td>Glaucoma</td>
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<td>Stroke</td>
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<td>Head Injuries</td>
<td></td>
<td>Substance Abuse</td>
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<tr>
<td>Hearing Problems</td>
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<td>Tuberculosis (TB)</td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td>Venereal Disease</td>
<td></td>
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</tbody>
</table>
- Yes  
- No  
- Unknown

14. Have you had a Medical Exam in the past year?  
- Yes  
- No  
- Unknown

15. Have you had a Dental Exam in the past year?  
- Yes  
- No  
- Unknown

16. Have you had a Vision Exam in the past year?  
- Yes  
- No  
- Unknown

17. Is there any disease or condition we should know about?  
- Yes  
- No

If yes, please explain:

18. **FEMALES ONLY**  Did you have difficulties (physical /mental) after giving birth?  
- Yes  
- No

If yes, please explain:

Are you currently pregnant?  
- Yes  
- No

### HISTORY OF MENTAL HEALTH SERVICES

- 1 Montana State Hospital  
- 2 Other Inpatient Care  
- 3 Partial Hospitalization  
- 4 Outpatient Care  
- 5 No prior services  
- 6 Unknown  
- 7 This facility
INSURANCE INFORMATION

Do you have Medicaid? □ Yes □ No  ID #: ____________________________  Do you have Medicare? □ Yes □ No  ID#: ______________

Do you have private insurance?  □ Yes □ No  
If yes, what is the name of the insurance company? ________________________________

Do you have BCBS HELP PLAN?  □ Yes □ No

**Please bring the appropriate insurance cards with you when returning this packet.**

A. PERSON RESPONSIBLE FOR PAYMENT:

Name: ___________________________________________  SEX: □ Female  □ Male

Cell Phone: ___________________________  Home Phone: ___________________________  Work Phone: ___________________________

Address: ___________________________ ___________________________ ___________________________ ___________________________
  (Street or P O Box)  (City)  (State)  (Zip Code)

Sponsor Name, if Military: ___________________________________________  Marital Status: □ Single  □ Married  □ Other

Branch of Military Service: ___________________________  Rank: ___________________________

B. HEALTH INSURANCE INFORMATION:

Insured / Policyholder’s Name: ___________________________________________

Sex: □ Female  □ Male  Insured’s Birth Date: ___________________________  Insured’s SSN: ___________________________

Address: ___________________________ ___________________________ ___________________________ ___________________________
  (Street or P O Box)  (City)  (State)  (Zip Code)

Employer’s Name: ___________________________  Phone: ( )

Insurance Company: ___________________________  Phone: ( )

Address: ___________________________ ___________________________ ___________________________ ___________________________
  (Street or P O Box)  (City)  (State)  (Zip Code)

Group / Policy #: ___________________________  Certificate / ID#: ___________________________

Patient’s Relationship to Insured: □ Self  □ Spouse  □ Child  □ Other  Marital Status: □ Single  □ Married  □ Other
C. **ADDITIONAL HEALTH INSURANCE INFORMATION: (if applicable)**

<table>
<thead>
<tr>
<th>Insured / Policyholder’s Name:</th>
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<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td>☐ Female ☐ Male</td>
</tr>
<tr>
<td>Insured’s Birth Date:</td>
<td></td>
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<tr>
<td><strong>Address:</strong></td>
<td></td>
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<td>(Street or P O Box)</td>
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<td>Employer’s Name:</td>
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<td>Insurance Company:</td>
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<td><strong>Address:</strong></td>
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<td>Group / Policy #:</td>
<td>Certificate / ID#:</td>
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<tr>
<td>Patient’s Relationship to Insured:</td>
<td>☐ Self ☐ Spouse ☐ Child ☐ Other</td>
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<tr>
<td>Marital Status:</td>
<td>☐ Single ☐ Married</td>
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<tr>
<td>► Is patient’s condition related to:</td>
<td>☐ Employment ☐ Auto Accident ☐ Other Accident ☐ Other:</td>
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<tr>
<td>► Hospitalization Dates Related to Current Services:</td>
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**Assignment & Release:**

This authorization and assignment shall be valid for the duration of the claim.

I further agree that a photocopy of this authorization and assignment shall be valid as the original.

CLIENT / AUTHORIZED SIGNATURE: X  ___________________________ DATE: ___________________________
Thank you allowing The Center for Mental Health to provide your care. If you have any questions concerning the care you are receiving, please do not hesitate to ask our staff. We are happy to assist you throughout your treatment.

The Center for Mental Health, in conjunction with the State of Montana, may assist you with the cost of your services through the Mental Health Services Plan (MHSP) or the Health Economic Livelihood Partnership Plan (HELP), of which will have a set of clinical eligibility criteria that need to be met prior to authorization. It is important that you provide the necessary documentation and financial information. **If you do not follow through with the application process or you do not qualify for the assistance programs, you will be responsible for the cost of all mental health services you receive.**

Our Center’s policy is to bill your primary insurance carrier for covered services before billing you for the balance due. In fact, before billing MHSP, Medicaid, or HELP, as a final payer, your primary insurance carrier must be billed. If there is another agency responsible for payment of your services, make sure that information is given at the time of application.

**If it is determined you do not qualify for the above services, and/or there is a balance due after your insurance carrier has been billed for covered services, you will be billed the Center’s regular, full-fee rate for services.** You may qualify for the sliding fee scale which is based on the total family income and the number of individuals in the household, with your personal fee rate determined when you provide the proof of income documentation. Other assistance may be offered based on your individual case, such as maximum amount billed for services and/or financial plan based on what you can afford to pay monthly on your SELF-pay balance. You will receive a monthly billing statement from us indicating your balance due and if you are unable to make full payment, please contact our billing department regarding the Center’s financial policy and payment plan at (406)771-8648.

____________________________  ____________________
Signature                      Date

____________________________  ____________________
Witness                        Date
AGGRESSIVE BEHAVIOR POLICY

The CENTER FOR MENTAL HEALTH is designed to be a safe place. Aggressive behavior does not go along with this philosophy. Aggressive behavior is defined as: physical fighting, pushing, throwing objects, yelling, swearing, or threatening harm. These behaviors are not acceptable at the CENTER FOR MENTAL HEALTH.

The FIRST time you violate this policy, you will be asked to leave the program/office for 24 HOURS. During these 24 hours, you may keep scheduled appointments and you may have community contacts with your case manager. Before returning to the program/office, you must meet with your case manager and the Program Manager(s).

The SECOND time you violate this policy, you will be asked to leave the program/office for 48 HOURS. During these 48 hours, you may keep scheduled appointments, and you may have community contact with your case manager. Before returning to the program/office, you must meet with your case manager and the program Manager(s).

The THIRD time you violate this policy you will be asked to leave the program/office until a meeting is arranged with the Incident Review Board to discuss whether you are benefitting from services at the CENTER FOR MENTAL HEALTH.

The reason for this policy is to keep the CENTER FOR MENTAL HEALTH a pleasant environment to be in, and to be sure all members and staff are safe.

Signature: ___________________________________________ Date: ____________

(Client/Authorized Signature)
YOUR MENTAL HEALTH RIGHTS IN MONTANA

1. You have the right to be treated in a non-discriminatory manner with dignity and respect while receiving mental health services at any Montana Mental Health facility.

2. You have the right to participate in the development of an individual treatment plan and any ongoing planning of your mental health services. You have a right to receive a reasonable explanation in terms you can understand of your general condition, treatment objectives, the nature and significant possible adverse effects of recommended treatment, reasons this treatment is considered appropriate and what, if any, alternative treatment services and types of mental health providers are appropriate and available.

3. You have the right to be free from excessive or unnecessary medication. You have the right to give informed consent to take or not take antipsychotic or other medications if they are prescribed to you unless the court has ordered differently or an emergency situation exists where your life or the lives of others are in danger.

4. You have the right to confidential records. Although you must give written approval to allow your records to be released to most others, there are some exceptions to this rule under Montana law. The Center will not disclose your record to others unless you direct us to do so, or unless the law compels us to do so.

5. You have a right to review your records at the Center. You may ask to have your records corrected. You may see your records or get more information about it from your Therapist, Case Manager or Program Manager.

6. You are entitled to the maximum amount of privacy consistent with the effective delivery of services to you.

7. You have a right to appropriate treatment and related services under conditions that are supportive of your personal liberty.

8. You have the right not to be subjected to experimental research or other experimentation without your informed voluntary and written consent.

9. You have a right to be free from abuse and neglect or threats of abuse and neglect while receiving services at any mental health facility in Montana.

10. You have the right to a humane psychological and physical environment while you are in the mental health facility.

11. You have the right to receive information about the Center’s client grievance procedure and to file complaints. You must be allowed to exercise this right and other rights without reprisal, including reprisal in the form of denying you appropriate available treatment. The Center recognizes that some clients may need assistance and/or support in filing their grievance. If clients request assistance in this respect the Center will provide a referral to a local client support group, a family members support group or a state designated advocacy agency.

12. You may have additional rights listed in Montana Statute, most of which apply to inpatient settings and right during an involuntary commitment process. Your primary therapist or case manager will explain those rights to you if you have concerns in these areas.

By signing below, you are stating that you hereby understand your rights.

Name _____________________________________________________ Date ______________________

(Client/Authorized Signature)
Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Options.

I understand that as a part of my health care, the Center for Mental Health (C4MH) receives, originates, maintains, discloses and uses individually identifiable health information including, but not limited to, health records and other health information describing my health history, symptoms, examinations and test results, diagnoses, treatment plans, and billing and health insurance information. I understand that the C4MH and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

1. Diagnose any medical/psychiatric condition.
3. Communicate with other health professionals concerning my care.
4. Document services for payment/reimbursement.
5. Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided.) And peer review (the process of monitoring the effectiveness of health care personnel.)

I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that the C4MH will make with respect to my individually identifiable health information. I understand that I have the right to review the Notice before signing this consent. The C4MH has afforded me sufficient time to review this Notice and has answered any questions that I have to my satisfaction. I also understand that the C4MH cannot use or disclose my individually identifiable health information other than as specified on the Notice. I also understand, however; that the C4MH reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

I understand that I do not have to consent the use or disclosure of my individually identifiable health information for treatment, payment, and health care options, but that if I do not consent, C4MH may refuse to provide my health care services unless applicable state or federal law requires the C4MH to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that the C4MH is not required to agree to the requested restriction but that, if it does agree, it must honor the restrictions unless I request that it stop doing so or the C4MH notifies me that it is no longer going to honor the request.

I request the following restrictions on the use or disclosure of my individually identifiable health information:

I understand that I have the right to request restriction as to the method of communications to me. For example, I might request that all medical bills be mailed to a certain post office box rather than to my home. I further understand that the C4MH may not ask me why I want the alternate method of communication.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for the facility directories and to family members.

I object to uses and disclosures as follows:

I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that the Center for Mental Health has already taken action in reliance on my earlier effective consent.

Signature of Patient or Legal Representative

Date

Witness/Center for Mental Health Representative

Date
I consent to mental health treatment. Treatment shall be rendered by professional staff of the Center for Mental Health.

In most circumstances, information will not be released to persons not employed by the Center for Mental Health without written permission. Information may be released in an emergency to protect my life or that of another person. The courts may subpoena records from the Center for Mental Health.

I understand I may revoke this consent to treatment at any time, if I have admitted to treatment voluntarily.

Dated this _____________________ day of __________________________, 20_______

__________________________________________________________

Client Signature

__________________________________________________________

Witness
Mental Health Ombudsman

The Ombudsman represents the interest of consumers and families involved in the public mental health system. The position educates consumers about the system including information about eligibility and covered costs. The Ombudsman assists when disagreements arise regarding coverage and eligibility. The Ombudsman acts as an advocate for consumers in dealing with state staff, providers and managed care organization’s case managers.

Mental Health Ombudsman
Mental Disabilities Board of Visitors

P. O. Box 200804 (59620-0804)

1412 ½ - 8th Street
Helena, MT  59601
1-406-444-9669
Or
1-888-444-9669
(Toll Free Number)
**Mental Illness Drug and Alcohol Screening (MIDAS)**

**Case #:______________**

**Name:________________________________**

**Date:________________**

**Each question refers to the past six months**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you feel that you have a problem with your use of drugs and/or alcohol and/or gambling?</td>
<td></td>
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</tr>
<tr>
<td>2. Do you use drugs, alcohol or gambling even though your doctor or other treaters recommend that you do not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is your family concerned about your drugs and/or alcohol or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are your treaters concerned about your drugs and/or alcohol or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you had legal problems or engaged in illegal activity (other than using drugs) due to drugs and/or alcohol or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you had medical problems related to, or worsened by, drugs and/or alcohol or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use drugs and alcohol or gambling to relieve mental health symptoms?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do you find that using drugs and/or alcohol or gambling worsens your mental health symptoms?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you have problems taking your psychiatric medication as prescribed because of drug and/or alcohol use or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you gotten in trouble, including getting in trouble at a mental health treatment program, because of drug and/or alcohol use or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Have you had ER visits or psychiatric hospitalizations that were connected to drug and/or alcohol use or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you ever feel guilty about your drug and/or alcohol use or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you experienced withdrawal symptoms or intense cravings to use drugs or alcohol or to gamble?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you attended self-help (e.g., 12 Step) meetings relating to drug and/or alcohol addiction or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Have you received any addiction treatment, including detoxification?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Have you felt unable to control your use of any drug or alcohol or gambling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Do you consider yourself to be an alcoholic or drug addict or gambling addict?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you engage in the use of alcohol, drugs, or gambling activity three times a week or more?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Zero Income Verification

Case #: _____________

I, ___________________________ , on this day of ___________________________ (Today’s Date)

verify that ___________________________________ receives $ ___________ income

Applicant Name

per month.

Present Living Arrangement:

☐ Homeless  ☐ Alone  ☐ Shelter/Mission
☐ Hospital  ☐ With Family  Other Sources of Income
☐ Nursing Home  ☐ With Friends

☐ Homeless  ☐ Alone  ☐ Shelter/Mission
☐ Hospital  ☐ With Family  Other Sources of Income
☐ Nursing Home  ☐ With Friends

Does anyone provide food or clothing for you?  ☐ Yes  ☐ No

Can anyone claim you on his or her income taxes?  ☐ Yes  ☐ No

Will you, or have you applied for:  ☐ Yes, will or have applied for:  ☐ No, have not applied

☐ Unemployment  ☐ Employment  ☐ School
☐ Medicaid  ☐ Medicare  ☐ None

Please explain how you are paying for your housing, food, and other necessities:

________________________________________________________________________
________________________________________________________________________

If you receive public assistance, provide verification of the type and amount of assistance you receive. Public assistance may include financial assistance, Medicaid, food stamps, subsidized housing, etc.

I hereby declare that all information provided by me on this form is complete and true to the best of my knowledge and belief. I agree to notify the Center for Mental Health at 1-888-718-2100 of any changes in the above information as soon as possible, but within 30 days of my knowledge of the change.

Applicant’s Signature: _______________________________ Date: ____________

Applicant’s Address: _______________________________ Soc. Sec. #: ____________

Witness Signature: _________________________________
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Privacy Notice, please contact our Privacy Officer at (406) 761-2100, PO Box 3089, Great Falls, Montana 59403.

I. Introduction - This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your health information.

Protected health information means health information (including identifying information about you) we have collected from you or received from any other source. It may include information about your past, present or future physical or mental health condition, the provision of your health care, and payment for your health care services.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are also required to comply with the terms of our current Notice of Privacy Practices.

II. How We Will Use and Disclose Your Health Information

Our use & disclosure of your health information is described below. For each category, we will explain what we mean in general, but we will not describe all specific uses or disclosures of health information.

Uses and Disclosures for Treatment, Payment and Health Care Operations

We will use and disclose your health information:

- To provide your health care and related services and to coordinate your health care and related services. For example, we may need to disclose information to a case manager who is responsible for coordinating your care.
- Among staff who work at the Center for Mental Health. For example, our staff may discuss your care at an internal case conference.
- To another health care provider (e.g., your primary care physician or a laboratory) working outside of the Center for Mental Health for purposes of your treatment.

For Payment - We may use and disclose your health information in order to bill and collect payment from your health plan or other third party payer. For example, we may disclose your health information to permit your health plan to approve or pay for your services. These actions may include:

- making a determination of eligibility or coverage for health insurance;
- reviewing your services to determine if they were medically necessary;
- reviewing your services to determine if they were appropriately authorized or certified in advance of your care;
- reviewing your services for purposes of utilization management, to ensure the appropriateness of your care, or to justify the charges for your care.
- in order to determine if the plan will approve additional visits to your therapist.
- disclosing your health information to another health care provider so that provider can bill you for services they provided to you, such as home health care services.

Uses & Disclosures That May be Made Without Your Authorization, But For Which You Will Have an Opportunity to Object.

Facility Directory - We do not maintain a patient directory at any of our outpatient or residential facilities. If asked, we will not confirm orally, in writing or through any other medium that you are our current or former patient, with the exceptions listed below under Persons Involved in an Individual’s Care.

For Health Care Operations - These uses and disclosures are necessary to operate our organization and make sure that our patients receive quality care. These activities may include quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training students in clinical activities, licensing, accreditation, business planning and development, and general administrative activities. We may combine health information of our patients for research and to make decisions about additional services we may offer.

We may also provide your health information to other health care providers or to your health plan to assist them in performing their health care operations. We will do so only if you have or have had a relationship with the other provider or health plan. For example, we may provide information about you to your health plan to assist them in their quality assurance activities. We may contact you to provide appointment reminders.

Health-Related Benefits & Services - We may use and disclose your health information to tell you about health-related benefits or services that may be of interest to you. If you do not want us to provide you with information about health-related benefits or services, you must notify the Center for Mental Health Privacy Officer. Please state clearly that you do not want to receive materials about health-related benefits or services.

Fundraising Activities - We will generally not use or disclose your health information for the purpose of contacting you about raising money for our programs, services, or operations. If in the event we would wish to use or disclose your health information for the purpose of contacting you or others about raising money for our programs, services, or Persons Involved in Your Care.

We may use and disclose your health information:

- To an entity assisting in disaster relief efforts and to coordinate uses and disclosures for this purpose to family or other individuals involved in your health care.
- In limited circumstances, to a friend or family member who is involved in your care. If you are physically present and have the capacity to make health care decisions, your health information may only be disclosed with your agreement to persons you designate to be involved in your care. If you are in an emergency situation, we may
disclose your health information to a spouse, a family member, or a friend so that such person may assist in your care. In this case we will determine whether the disclosure is in your best interest and, if so, only disclose information that is directly relevant to participation in your care.

And, if you are not in an emergency situation but are unable to make health care decisions, we will disclose your health information to:

- A person designated to participate in your care in accordance with an advance directive validly executed under state law,
- your guardian or other fiduciary if one has been appointed by a court, or
- If applicable, the state agency responsible for consenting to your care.

We May Use and Disclose Your Health Information Without Your Authorization or Opportunity to Object for:

Emergency Treatment Situations - for example, we may provide necessary health information to a paramedic who is transporting you in an ambulance. If a clinician is required by law to treat you and your treating clinician has attempted to obtain your authorization but is unable to do so, the treating clinician may nevertheless use or disclose your health information as required or allowed by law.

Communication Barriers - for example, if one of our clinicians attempts to obtain consent from you, but is unable to do so due to substantial communication barriers. However, we will only use or disclose your health information if the clinician determines in their professional judgment that, absent the communication barriers, you likely would have consented to use or disclose information under the circumstances.

Research - to researchers when their research has been approved by our Institutional Review Board or a similar privacy board following their review of the research proposal and established protocols to protect the privacy of your health information.

Legal Requirements - we will disclose health information about you when required to do so by federal, state or local law.

Averting a Serious Threat to Health or Safety - when necessary to prevent a serious and imminent threat to your health or safety or to the health or safety of the public or another person. Under these circumstances, we will only disclose health information as permitted and required by Montana law.

Organ and Tissue Donation - if you are an organ donor, we may release your health information to an entity that conducts organ, eye or tissue transplantation or serves as an organ donation bank, as necessary to facilitate organ, eye or tissue donation and transplantation.

Public Health Activities - including disclosures to:

- report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
- report vital events such as birth or death;
- conduct public health surveillance or investigations;
- report child abuse or neglect;
- report certain events to the Food and Drug Administration (FDA) or to a person subject to the jurisdiction of the FDA, including information about defective products or problems with medications;
- notify patients about FDA-initiated product recalls;
- notify a person who may have been exposed to a communicable disease or who is at risk of contracting or spreading a disease or condition;
- notify the appropriate government agency if we believe you have been a victim of abuse, neglect or domestic violence.
- we will only notify an agency to report such abuse, neglect or domestic violence if we obtain your agreement or if we are required or authorized by law

Health Oversight Activities - To a health oversight agency for activities authorized by law. Oversight agencies include government agencies that oversee the health care system, government benefit programs such as Medicare or Medicaid, and other government programs regulating health care, and civil rights laws.

Disclosures in Legal Proceedings - To a court or administrative agency when a judge or administrative agency gives us a valid order to do so. We also may disclose health information about you in legal proceedings without your permission when we receive a valid investigative subpoena for your health care information. We will not provide this information in response to a subpoena without your authorization if the request is for records of a federally assisted substance abuse program.

Law Enforcement Activities - To a law enforcement official for law enforcement purposes when:

- the disclosure is required by law, such as a valid investigative subpoena, a search warrant, a summons issued by a court, or a grand jury subpoena, or information about the general physical condition of a patient if injured by a gunshot or stab wound, in a motor vehicle accident, or injury in a possible criminal act.

Medical Examiners or Funeral Directors - Medical examiners & County Coroners are appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances. We may also disclose health information about our patients to funeral directors as necessary to carry out their duties.

Military and Veterans - If you a member of the armed forces, we may disclose your health information as required by military command authorities. We may also disclose your health information for the purpose of determining your eligibility for benefits provided by the Department of Veterans Affairs. If you are a member of a foreign military service, we may disclose your health information to that foreign military authority.

National Security and Protective Services for the President and Others - To authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so they may conduct special investigations.

Inmates - to a correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of law enforcement official and the information is needed for the health or safety of the inmate, other inmates, or the staff.

Worker’s Compensation - to comply with state Worker’s Compensation Laws.

Business Associates - There are some services provided in our organization through contacts with business associates, such as transcription services, auditing services, information (computer) services, foster care, and collection agencies. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have asked them to do and bill you or your insurance company for the services provided. To protect your health information, we require the business associate to certify that they are taking appropriate measures to safeguard your information.

III. Uses & Disclosures of Your Health Information With Your Permission.
Uses and disclosures not described in Section II of this Notice of Privacy Practices will generally only be made with your written permission, called an authorization. You have the right to revoke an authorization at any time. If you revoke your authorization we will not make any further uses or disclosures of your health information under that authorization, unless we have already taken an action relying upon the uses or disclosures you have previously authorized.

IV. Your Rights Regarding Your Health Information.

Right to Inspect and Copy - You have the right to request an opportunity to inspect or copy health information used to make decisions about your care, whether they are decisions about your treatment or payment of your care. You must submit your request in writing. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, and supplies associated with your request. We may deny your request to inspect or copy your health information in certain limited circumstances. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request may be reviewed. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer.

Right to Amend - For as long as we keep records about you, you have the right to request us to amend any health information used to make decisions about your care, whether they are decisions about your treatment or payment of your care. To request an amendment, you must submit a written document and tell us why you believe the information is incorrect or inaccurate.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if we ask us to amend health information that:

• was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;
• is not part of the health information we maintain to make decisions about your care;
• is not part of the health information that you would be permitted to inspect or copy; or
• is accurate and complete.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request.

If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the health information that is the subject of your request.

Right to an Accounting of Disclosures - You have the right to request that we provide you with an accounting of disclosures we have made of your health information. An accounting is a list of disclosures. But this list will not include certain disclosures of your health information such as those we have made for purposes of treatment, payment, and health care operations.

To request an accounting of disclosures, you must submit your request in writing to the local Center for Mental Health office. For your convenience, you may submit your request on a form called a Request for Accounting, which you may obtain from the local Center for Mental Health office. The request should state the time period for which you wish to receive an accounting. This time period should not be longer than six (6) years and not include dates before April 14, 2003.

The first accounting you request within a 12-month period will be free. For additional requests during the same 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge and you may choose to withdraw or modify your request before we incur any costs.

Right to Request Restrictions - You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. To request a restriction, you must submit this in writing addressed to the local Center for Mental Health office who will ask you to sign a request for restriction form, which you should complete and return to us. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment.

Right to Request Confidential Communications - You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only by work or by e-mail. To request such a confidential communication, you must make your request in writing. We will accommodate all reasonable requests. You do not need to give us a reason for the request; but your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice - You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice of Privacy Practices electronically, you may still obtain a paper copy. To obtain a paper copy, contact any of our offices.

V. Complaints

If you believe your privacy rights have been violated, you may file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. To file a complaint, contact the address available on our form titled “Fact Sheet for Filing Privacy, Transaction & Code Set, and Security Complaints” which you may request from our staff. Our Privacy Officer will assist you with writing your complaint. If you request such assistance. The Center for Mental Health Privacy Officer can be contacted at the Center for Mental Health, 915 First Avenue South, Great Falls, Montana 59403, 406-761-2100, extension 1587. We will not retaliate against you for filing a complaint.

VI. Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at our main office and at each site where we provide care.

You may also obtain a copy of the current Notice of Privacy Practices by accessing our website at www.center4mh.org or by calling us at 1-406-761-2100 or 1-888-718-2100 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday to request that a copy be sent to you in the mail or by asking for one any time you are at one of our offices.
CSCT PAYMENT POLICY

Case #:

<table>
<thead>
<tr>
<th>Client Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Parent / Guardian:</td>
<td></td>
</tr>
<tr>
<td>Relationship:</td>
<td></td>
</tr>
</tbody>
</table>

1. If your child is eligible for Medicaid, CSCT services will be billed to Medicaid, and family will owe nothing.

2. If your child is eligible for other insurance, appropriate CSCT services will be billed to that insurance, and family will owe amount in accordance with the attached monthly maximum fee schedule.

3. If your child is not eligible for any insurance, family will owe amount in accordance with the attached monthly maximum fee schedule.

4. If there are any changes in your child’s insurance eligibility, we will need to adjust the fees in accordance with the attached monthly maximum fee schedule.

5. All signed agreements are subject to change at any time due to modifications of State statutes.

MONTHLY MAXIMUM PAYMENT: $___________________________________

I hereby authorize the Center for Mental Health to release appropriate financial information to other agencies to assist in the collection of my bill if I do not pay as agreed. It is my responsibility to notify the Center of any changes in income so that my amount can be adjusted.

X

__________________________   ____________________________

(Authorized Signature)        (Date)

X

__________________________   ____________________________

(Signature of CMH Representative)  (Date)
CENTER FOR MENTAL HEALTH

SLIDING FEE SCHEDULE – UNINSURED/UNDERINSURED/SERVICES NOT COVERED BY INSURANCE, MHSP, MDCD, MDCR
BASED ON POVERTY GUIDELINES PUBLISHED IN THE FEDERAL REGISTER/NOTICE
ON JANUARY 22, 2015
EFFECTIVE FEBRUARY 27, 2015

PERCENTAGE OF FEE TO BE CHARGED FOR SERVICES

Note: Persons at or below 100% of the Federal Poverty Guidelines are eligible for the minimum rate of 10% of the Center’s Full Fee or may be eligible for Charity Care.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>10% From</th>
<th>10% To</th>
<th>25% From</th>
<th>25% To</th>
<th>50% From</th>
<th>50% To</th>
<th>75% From</th>
<th>75% To</th>
<th>100% From</th>
<th>100% To</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>$11,771</td>
<td>$14,713</td>
<td>$14,714</td>
<td>$17,655</td>
<td>$17,656</td>
<td>$20,598</td>
<td>$20,599</td>
<td>and over</td>
</tr>
<tr>
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<tr>
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<tr>
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<td>and over</td>
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<tr>
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<td>$45,913</td>
<td>$45,914</td>
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<tr>
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<td>$51,113</td>
<td>$51,114</td>
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<td>$71,558</td>
<td>$71,559</td>
<td>and over</td>
</tr>
</tbody>
</table>
ADDITIONAL RIGHTS OF PERSONS ADMITTED TO A CENTER FOR MENTAL HEALTH FACILITY

Patients admitted to a mental health facility, whether voluntarily or involuntarily, shall have the following rights:

1. Patients have a right to privacy and dignity.

2. Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment. Patients must be accorded the right to appropriate treatment and related services in a setting and under conditions that:
   (a) are the most supportive of the patient's personal liberty, and
   (b) restrict the patient's liberty only to the extent necessary and consistent with the patient's treatment needs, applicable requirements of law, and judicial orders.

3. Patients shall have the same right to visitation, reasonable access to telephone communications, including the right to converse with others privately, except to the extent that the professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be reviewed after each periodic review of the treatment plan if any restrictions are to be continued. Patients shall have an unrestricted right to visitation with attorneys, with spiritual counselors, and with private physicians and other professional persons.

4. Patients shall have an unrestricted right to send and receive mail. Patients shall have an unrestricted right to receive mail from their attorneys, private physicians and other professional persons, the mental health board of visitors, courts, and government officials. Patients shall have a right to receive mail from others except to the extent that a professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of mail. The written order must be reviewed after each periodic review of the treatment plan if any restrictions are to be continued.

5. Patients have the right to access to letter-writing materials, including postage, and have a right to have staff members of the facility assist persons who are unable to write, prepare, and mail correspondence.

6. Patients have the right to wear their own clothes and to keep and use their own personal possessions, including toilet articles, except that as such clothes or personal possessions may be determined by the professional person in charge of the patient's treatment plan to be dangerous or otherwise inappropriate to the treatment regimen. The facility has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and serviceable clothing. Such clothing shall be considered the patient's throughout his stay at the facility. The facility shall make provision for the laundering of patient clothing.

7. Patients have the right to keep and be allowed to spend a reasonable sum of their own money.

8. Patients have the right to religious worship. Provisions for such worship shall be made available to all patients on a non-discriminatory basis. No individual shall be required to engage in any religious activities.

9. Patients have the right to regular physical exercise several times a week. Moreover, it shall be the duty of the facility to provide facilities and equipment for such exercise. Patients have a right to be outdoors at regular and frequent intervals in the absence of contrary medical considerations.

10. Patients have the right to be provided, with adequate supervision, suitable opportunities for interaction with members of the opposite sex except to the extent that a professional person in charge of the patient's treatment plan writes an order stating that such interaction is inappropriate to the treatment regimen.

11. Patients have the right to receive prompt and adequate medical treatment for any physical ailments. In providing medical care, the mental health facility shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

12. Patients have the right to a diet that will provide at a minimum the recommended daily dietary allowances as developed by the national academy of sciences. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient or the friend of respondent in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.
(13) Patients have a right to a humane psychological and physical environment within the mental health facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the efficient attainment of the treatment goals set for the patient. In order to assure the accomplishment of this goal:
(a) regular housekeeping and maintenance procedures which will ensure that the facility is maintained in a safe, clean, and attractive condition shall be developed and implemented;
(b) there must be special provision made for geriatric and other nonambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory patients to communicate their needs to the facility staff;
(c) pursuant to an established routine maintenance and repair program, the physical plant of every facility shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety, and well-being of the patients;
(d) every facility must meet all fire and safety standards established by the state and locality. In addition, any hospital shall meet such provisions of the life safety code of the national fire protection association as are applicable to hospitals. Any hospital shall meet all standards established by the state for general hospitals insofar as they are relevant to psychiatric facilities.

(14) A patient at a facility has the right:
(a) to be informed of the rights described in this section at the time of his admission and periodically thereafter, in language and terms appropriate to the patient's condition and ability to understand;
(b) to assert grievances with respect to infringement of the rights described in this section, including the right to have a grievance considered in a fair and timely manner according to an impartial grievance procedure that must be provided for by the facility; and
(c) to exercise the rights described in this section without reprisal and may not be denied admission to the facility as reprisal for the exercise of the rights described in this section.

(15) In order to assist a person admitted to a program or facility in the exercise or protection of the patient's rights, the patient's attorney, advocate, or legal representative shall have reasonable access to:
(a) the patient;
(b) the program or facility areas where the patient has received treatment or has resided or the areas to which he has had access; and
(c) pursuant to the written authorization of the patient, records and information pertaining to the patient's diagnosis, treatment, and related services.

(16) A person admitted to a facility shall have access to any available individual or service that provides advocacy for the protection of the person's rights and that assists the person in understanding, exercising, and protecting his rights as described in this section.

(17) This section may not:
(a) obligate a professional person to administer treatment contrary to the professional judgment;
(b) prevent a facility from discharging a patient for whom appropriate treatment, consistent with the clinical judgment of a professional responsible for the patient's treatment, is or has become impossible to administer because of the patient's refusal to consent to the treatment;
(c) require a facility to admit a person who has, on prior occasions, repeatedly withheld consent to appropriate treatment; or
(d) obligate a facility to treat a person admitted to the facility solely for diagnostic evaluation.

I have read this list of rights and responsibilities or had them read to me. I understand and agree to them.

PRINTED of Patient / Guardian

Patient Signature / Guardian

Date