Client's Name: ___________________________

Projected Length of Stay with Milhous: _________________________

REFERRAL TO: Milhous Children's Services, Sub-Acute Treatment

☐ Nevada City location
☐ Sacramento location

PRESENTING PROBLEMS:

This client has been admitted to Milhous Children's Services in order to address the following issues:

1. ____
2. ____
3. ____

The placement agency agrees to provide a **clothing allowance,** available no later than ____/____/______
Does child have adequate clothing? ☐ Yes ☐ No _______ *(Initial)*

If the child's clothing becomes damaged or out grown, what would you like done with the items?
☐Sent back to me ☐Give to Charity ☐ Discarded _______ *(Initial)*

The placement agency **must** provide **Medi-Cal card, Medi-Cal eligibility and/or proof of other insurance,** if applicable, with all necessary claim forms. **All uncovered medical costs will be the responsibility of the placement agency, parent, and/or guardian**.
This requirement has been provided: ☐Yes ☐No _______ *(Initial)*

The placement agency will provide a record of **immunizations**.
This requirement has been provided: ☐Yes ☐No _______ *(Initial)*

If the resident is currently on psychotropic medications, the placement agency has provided **at least** seven days supply of all such **medications**.
This requirement has been provided: ☐Yes ☐No _______ *(Initial)*

Licensing requires placement agency to provide Milhous with a copy of the child's Level 14 certificate within 30 days of placement.
Certificate has been provided: ☐Yes ☐No _______ *(Initial)*

Milhous must have a signed consent for the child to continue taking each medication he/she is prescribed at the time of admission. Please list the names of the person(s) who can give medical consent.

____
____

Specific medication consent for existing prescriptions (JV-220) is provided: ☐ Yes ☐ No ____ *(Initial)*

Name and phone number of the **person in charge of psychiatric hospitalization arrangement**, if other than the placement worker.

____

Name and Address of **hospital to be used,** if other then local hospital:

____
____

The placement agency understands that Milhous Children's Services may not provide transportation for home visits or court appearances and that funding these costs will be the responsibility of the placement agency or parent as negotiated between them.

The placement agency also agrees to facilitate transition from our program to independent living or adult care for those clients who attain the age of eighteen while at Milhous Children's Services.

If any of these critical items are not available or acceptable at the time of placement, placement may be delayed or denied. Space below is provided to indicate any agreement made regarding this information.

____

This agreement is to operate in addition to and in full concert with the California Health and Welfare Agency- Group Home Agreement.

X____ Date____/____/______
Placement Worker /Parent

X____ Date____/____/______
Milhous Children's Services Representative

Please ensure the completion of each of the items contained in this 33 page packet; please complete all signatures prior to intake:

- INTAKE PACKET PAGES 1 -2
- FACE SHEET PAGE 3-4
- AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR
- AUTHORIZATION TO CONTINUE MEDICATIONS AT TIME OF ADMISSION
- NOTICE TO GUARDIANS OF CHILDREN PLACED IN NEVADA CITY AND SACRAMENTO,
- REGARDING MEDICAL INSURANCE
- DEVELOPMENTAL HISTORY
- MEDICAL HISTORY
- DANGEROUS PROPENSITIES
- INFORMATION RELEASE AUTHORIZATION
- AUTHORIZATION TO PARTICIPATE IN OFF GROUNDS OUTINGS
- DISCHARGE POLICY
- "DISCIPLINE" POLICY
- RESIDENT COMPLAINT PROCEDURE
- PERSONAL RIGHTS
- VISITATION POLICY
- THERAPEUTIC BEHAVIORAL SERVICES (TBS)
- AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
- NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT
- PRE – ADMISSION PROFILE
- NOTICE OF PRIVACY PRACTICES - MENTAL HEALTH

FACE SHEET: Client Identification / Emergency Information

I.D.#	Name (first, middle, last): Error! Reference source not found.	D.O.B:	D.O.P:

Ethnicity:	Height:	Weight:	Eyes:	Hair:

Identifying Marks:	Social Security Number:

*Allergies: ☐Yes ☐No *If yes, list:* ____

Legal Status (Source of Income): ☐ 300 ☐600 ☐ ERMH ☐ Other: ______________________

Medi-CAL #:	Private Carrier or HMO:	
Eligibility Worker Name:	Group#:	ID#:
Phone:	Name of Insured:	
Name of Medi-CAL/HMO:	Name of Guarantor:	
Claims Phone #:	Claims Phone #:	
	Prescriptions Covered? ☐Yes ☐No	

In Case of Emergency Contact:	☐ Mother	☐ Father	☐ Placement Worker
	☐ Step-Mother	☐ Step-Father	☐ Other:

PLACEMENT WORKER / AUTHORIZED REPRESENTATIVE

Name:

Agency:

Street/ PO Box:

City: Zip:

Phone: Fax:

Cell: Email:

24 Hour Contact:

CASA, EMQ or WRAP WORKER

Name:

Agency:

Street/ PO Box:

City: Zip:

Phone: Fax:

Cell: Email:

24 Hour Contact:

MENTAL HEALTH WORKER / REPRESENTATIVE

Name:

Agency:

Street/ PO Box:

City: Zip:

Phone: Fax:

Cell: Email:

24 Hour Contact:

ATTORNEY or OTHER

Name:

Agency:

Street/ PO Box:

City: Zip:

Phone: Fax:

Cell: Email:

24 Hour Contact:

FACE SHEET: Family and Contact Information

FAMILY/ CONTACT #1		**FAMILY/ CONTACT #2**	
Name:		Name:	
Relation to Child:		Relation to Child:	
Street/ PO Box:		Street/ PO Box:	
City, ST:	Zip:	City, ST:	Zip:
Phone:	Fax:	Phone:	Fax:
Cell:	Email:	Cell:	Email:
Level of Parental Involvement:		Level of Parental Involvement:	

Persons Authorized to remove child from placement

Name	Relationship	Conditions

Persons Authorized to have phone contact and/ or on ground visits with child

Name	Relationship	Conditions

DO NOT ALLOW these Persons to remove child from Placement

Name	Relationship	Conditions

Persons NOT AUTHORIZED to have phone contact and/ or on ground visits with child

Name	Relationship	Conditions

Additional Comments:

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

The undersigned parent(s) or guardian of __________________________, a minor child, do hereby authorize Milhous Children's Services as an agent for the undersigned to consent to an X-ray examination, anesthetic, medication, medical or surgical diagnosis, treatment and hospital care or mental health treatment which is deemed advisable by, and is rendered under the general supervision of any physician, surgeon, and psychiatrist licensed under the provisions of the Medical Practice Act or the medical and mental health staff of any accredited hospital whether such diagnosis is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our agent, Milhous Children's Services, to give specific consent to any and all such diagnosis, treatment, or hospital care in the exercise of best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This Authorization shall remain in effect until terminated, unless sooner revoked in a written form, which is delivered to Milhous Children's Services.

Signature Relationship Date

X____

X____

Copy/Fax to Nurse/Med Office

AUTHORIZATION TO CONTINUE MEDICATIONS AT TIME OF ADMISSION

NOTE: A MILHOUS PHYSICIAN MUST OBTAIN SEPARATE INFORMED CONSENT BEFORE FURTHER MEDICATIONS CAN BE SUPPLIED

On admission to Milhous Children's Services, this child, Error! Reference source not found.*, is taking the following medications:*

Medication Name	Dosage
____________________________	______________________
____________________________	______________________
____________________________	______________________
____________________________	______________________
____________________________	______________________

We must have a signed authorization for the child to continue on the above medications.

Does the above mentioned child have any **Allergies** (Medication, food, seasonal, etc.)? ☐Yes ☐No
If yes, please specify:

The undersigned parent(s) or guardian of__________________________, *a minor child, do hereby authorize Milhous Children's Services to continue to dispense the medications listed above.*

Signature *Relationship* *Date*

*X*____

*X*____

Copy/Fax to Nurse/Med Office

NOTICE TO GUARDIANS OF CHILDREN PLACED IN NEVADA CITY AND SACRAMENTO, REGARDING MEDICAL INSURANCE

If your child has **Private Health Insurance**, or **Dual Insurance** through both Private *and* Medi-Cal, please contact your child's health insurance company to change his Primary Care Provider **AS SOON AS POSSIBLE.**

This process can take a few weeks, so it is important to start right away. By doing so, you will ensure your child receives proper health care.

Primary Care Provider, **Ranch location**, is:
Sierra Family Medical Clinic
15301 Tyler Foote Rd.
Nevada City, CA 95959
(530) 292-3478

Dental Provider, **Ranch Location**, is:
Sierra Family Medical Clinic
Bozhidar P. Popov, D.M.D.
15301 Tyler Foote Rd.
Nevada City, CA 95959
(530) 292-3478

Primary Care Provider, **Sacramento location**, is:
Health For All
923 V Street
Sacramento, CA 95818
(916) 448-6553

Dental Provider, **Sacramento location**, is:
Western Dental
4401 Florin Road
Sacramento, CA 95833
(916) 428-4000

GUARANTOR FOR CO-PAYMENTS, DEDUCTIBLES, and NON-COVERED HEALTH COSTS: Parent/County agrees to pay for **anything** not covered under Medi-Cal/Private Insurance.

Name of Client: Error! Reference source not found.

Guarantor Signature: ____ Date: ____/____/______

Guarantor Mailing Address: ____

City, ST: ___________________________________ Zip : _____________________

____ Initial Notice to Kaiser Patients: Kaiser will no longer accept checks. Payment must either be made payable by cash or credit card at the time of pick up. If payment is made by credit card, the card holder must be present at the time of pick up. Payment arrangements may also be made ahead of time with our Billing Department.

____ Initial Please note that if you do not have Dental Insurance, that all bills related to dental care will be billed directly to the responsible party. At a minimum, this will include a dental cleaning once every 6 months.

A copy will be provided for your records, but a signed copy of this agreement must be maintained in Milhous Children's Services files for billing purposes.

DEVELOPMENTAL HISTORY

FAMILY-
Marital status of parents at birth:
☐ Married ☐ Living Together ☐ Not Living Together ☐ Unknown

Length of stay in biological family: ___________________________________

Siblings:

Name	Age	Date & reason for removal from home:

MAJOR MILESTONES:

Please indicate any known information regarding major milestones, (Ex: birth complications, age began walking, talking, toilet trained, etc.):

PRIOR PLACEMENT HISTORY

Name of Placement	Dates of Placement	
a) ______________________________	From ________	To ________
b) ______________________________	From ________	To ________
c) ______________________________	From ________	To ________
d) ______________________________	From ________	To ________

MEDICAL HISTORY

History of Major Illness, Injuries and Surgeries:

Does the child require visual or hearing aids? ☐Yes ☐No If Yes, type: ______________________

Does the child require orthodontia aid(s)? ☐Yes ☐No If Yes, type: ______________________

Does the child have any ALLERGIES? ☐Yes ☐No
If Yes, please list:

Does the child have a history of substance abuse? ☐Yes ☐No
If Yes, please describe:

Does the child have a history of sexual abuse? ☐Yes ☐No
If Yes, please describe:

Admission DSM – IV Diagnoses

Code Description

Axis I

Axis II

Axis III

Axis IV ☐ Problems with primary support group ☐ Problems related to the social environment
☐ Educational Problems ☐ Occupational Problems ☐ Housing Problems ☐ Economic Problems
☐ Problems with access to health care ☐ Legal Problems ☐ Other Problems

Axis V **Current (GAF):** ________ **Highest (GAF) Past 24 Months:** _____________

Most Recent Attending Physician: Phone:

Most Recent Attending Dentist: Phone:

Most Recently Attended School: Phone:

District: Phone:

Please attach all pertinent court orders, custody orders, or placement agency orders for the above information.

____ ____/____/______

Signature of Person Completing Form and Verifying Above Information Date

DANGEROUS PROPENSITIES

In compliance with the Department of Health's regulation that those who care for children are to be informed of any known or suspected dangerous propensities of each child placed within a residential group home setting, we are advising you that this child has displayed the following aggressive or dangerous behaviors:

(**Rating Scale 1-5, with 1 being mild or infrequent and 5 being uncontrolled danger to self and/or others. If not applicable, do not rate.**)

RATING					BEHAVIOR
1	2	3	4	5	
☐	☐	☐	☐	☐	Uncontrollable Assault
☐	☐	☐	☐	☐	Arson
☐	☐	☐	☐	☐	Suicidal Gesture or Attempt
☐	☐	☐	☐	☐	Other (Specify):

Please describe the circumstances and provide copies of incident reports if available.

The above represents a full disclosure of client named above potential for danger to the best of my knowledge. I understand I will be asked to discuss this information further at the time of intake review.

Name of Child: Error! Reference source not found.

X____ ______/____/______

Signed Title Date

INFORMATION RELEASE AUTHORIZATION

Name: ____

Date of Birth: Error! Reference source not found.

To: ____
Physician, Clinic, Hospital, School, Residential Facility

____
Address, State, Zip

I hereby authorize Milhous Children's Services and Milhous School, Inc. to request and/or exchange information concerning the past or present medical, psychological, and academic history of the student named above.

(California Administrative Code, Title 5, Sections 435, 438,: Access to Confidential Records)

I hereby authorize you to release any or all information contained in the record of the minor named above to:

Milhous Children's Services and Milhous School
24077 State Highway 49
Nevada City, CA 95959

This information is required to assist the above named agency in determining the type of care needed.

____________________________________ X____
Name (Please Print) Signature

____
Relationship to person on whom information is requested.

AUTHORIZATION TO PARTICIPATE IN OFF GROUNDS OUTINGS

Residents at Milhous will have frequent opportunities to participate in off grounds outings that are outside the geographic boundaries of the Nevada County/Sacramento County. Some examples include: ski trips in Placer County and professional baseball games in Oakland.

Often, because of our non-profit status, these opportunities are the result of donations from businesses or community members. As a result, we do not always have substantial advance notice time. However, we must always have your permission to transport your child outside of the boundaries of Nevada County/Sacramento County.

The undersigned parent(s) or guardian of Error! Reference source not found.**,** a minor child, do hereby authorize Milhous Children's Services to take this child on off grounds outings that require transportation outside of Nevada County/Sacramento County.

This Authorization shall remain in effect until terminated, unless sooner revoked in a written form which is delivered to Milhous Children's Services.

Signature Relationship Date

*X*____ ____/____/______

*X*____ ____/____/______

DISCHARGE POLICY

Milhous will maintain close contact with the placement worker and/or mental health liaison on a regular basis. The Milhous Clinical Licensed Practitioner of the Healing Arts (LPHA) will notify the placement worker in writing of any concern which might precipitate a discharge before treatment is completed. Milhous will then provide a 7-day notice. If a situation requires a more immediate discharge, Milhous will issue a 3-day notice.

Concerns that would precipitate a discharge prior to completion of treatment are:

1) Uncontrollable level of aggression, in which safety of client and/or others cannot be maintained in a community licensed setting.

2) Determination after placement that history and needs are significantly different from that presented and that there are problems which cannot be appropriately addressed in this environment (e.g. substance abuse as the primary diagnosis).

3) Dangerous or extremely detrimental effect on other clients' progress, through continued intentional peer provocation or manipulation that is not responsive to treatment.

4) Commission of a crime that results in change of status from a 300 to 600 or indicates that a 600 client is escalating criminal behavior toward felony crime, and criminal behavior that is beyond our safety capacity.

5) Continued or pervasive inability or refusal by client or parents to cooperate with program.

6) Suicidal threats, gestures or attempts which are judged to be lethal, and in which client's safety cannot be maintained in a community licensed setting.

7) Unmanageable level of psychosis, which cannot be maintained safely in a community licensed program and/or is unresponsive to psychiatric intervention.

8) A continuing concern regarding client's lack of progress/regression over an extended period of time.

The placement agency or parent may also choose to terminate the placement prior to completion of treatment. In that instance, Milhous Children's Services would expect to receive a written 7 day notice with a statement outlining the reason(s) for the termination. Clients may also be recommended for discharge because they have completed their treatment goals more quickly than the time frame indicated in this contract. It is the goal of Milhous Children's Services to graduate clients to the least restrictive setting that is able to meet their needs.

X____ Date____/____/______
☐Parent ☐Placement Worker Signature

X____ Date____/____/______
Milhous Children's Services Representative

"DISCIPLINE" POLICY

INTERVENTION

Milhous Children's Services supports a philosophy of rational and humanistic, behaviorally oriented intervention. In keeping with that philosophy, the program has established clear rules and behavioral expectations for residents. There are clear consequences for both appropriate and inappropriate behaviors by residents. Staff is expected to adhere to consistent application of rules and consequences among all residents. The rules have been established to insure a safe and healthy environment in which our residents may live and attend school.

Punishment of any resident or group of residents by any staff person is PROHIBITED. Punishment is defined as the misuse of the power of staff toward residents. CORPORAL AND PSYCHOLOGICAL PUNISHMENT ARE STRICTLY PROHIBITED. Corporal punishments include but are not limited to: striking a youth directly or with any physical object, shaking, spanking, etc. Allowing another youth or group of youths to physically attack a resident will be viewed as corporal punishment performed by the staff person on duty. Psychological punishment includes, but is not limited to: harsh, humiliating or degrading responses; extensive withholding of emotional response or stimulation.

RESPONSE COST SYSTEM and PARTICIPATION PROGRAM

Milhous Children's Services utilizes a response cost system to decrease or eliminate inappropriate behaviors on the part of the resident. We also incorporate a participation and behavioral contract system to increase or develop appropriate behaviors.

Resident's behavior is monitored through a color coded behavior system called the Milhous Level of Trust. Each color represents the number of days of safe behavior. The length of time on a particular level is designed to provide a challenge but still attainable to reach. This is not designed as a gauge of readiness to complete the program, but as a visual tool representing a resident's safe behavior. The levels of trust are outlined below:

- **Red** – STOP (Serious or Dangerous Behavior) – engaged in seriously dangerous and/or unpredictable behavior. Residents are placed on level red supervision for **3 days.** Activities may be modified.
- **Yellow** – CAUTION – At the end of the 3 days of level Red supervision, the Resident is then placed on Yellow Level for the following **4 days**. May still need additional staff attention and support in order to choose more appropriate responses.
- **Green** – GO –cooperative in the program and supportive of fellow residents and staff while refraining from serious and/or dangerous behavior. This resent has demonstrated safe and predictable behavior. Residents on Green Level are eligible to attend any activity that they have earned based on their level.

Clients that are placed on Red are scheduled a Serious Safety Behavioral Plan (SSBP) meeting. This meeting is designed to work with the client on formulating immediate intervention plans that the resident agrees to work on. The assignment of "T-Time" (Thinking Time) and restitution are also determined as a consequence for their negative behaviors.

Resident's *participation* is monitored through the use of participation cards. When a resident is engaged in program for the specified period of time, the resident receives a staff signature. During a specified time of the day, residents can use these points to purchase items in the program store. Typical items are candy, soda, popcorn, books, art supplies, cards, etc. All items have a point price.

TIME OUT / TIME AWAY

Residents may be directed to a time out or time away. Time outs are a time limited exclusion from program and extraneous stimuli as a consequence of behaviors which are targeted for extinction. Time out is always supervised although supervision may be visually screened from the resident.

Time Aways can be requested by the resident or directed by staff. When the resident escalates or displays behaviors that indicate the beginning of an escalation, they are encouraged or directed to a time away. The length of a time away is dependent upon the resident's behavior. Often times resident's behavior is threatening towards self or others and until the resident displays behaviors that are non-threatening, they may remain on a time away or be moved into program but separate from others until which time they appear safe to be around others.

Time Aways are often times used following the display of a dangerous behavior and a resulting physical intervention. Again, the purpose is to provide an environment where the resident can safely de-escalate.

When a resident appears calm, he or she will be "processed" back into program. Processing is the interaction between the resident and staff member to discuss what may have motivated the resident to act out and to discuss possible solutions to prevent future occurrences. Also, consequences are discussed during this period of time. Time Aways are supervised and charted by staff.

CRISIS INTERVENTION

Milhous Children's Services embraces a pro-active crisis intervention strategy. Resident's are encouraged to initiate Time Aways if they begin to feel frustrated or angry. Time Aways provides the resident with an open ended time in which he or she can remove themselves from the situation which he or she find difficult and reduce potentially irritating stimuli by being away from peers in a quiet area. Time Aways are visually supervised by staff. Time Away is used to avert or reduce crisis before a resident has become potentially dangerous to self or others. If a resident engages in potentially dangerous behaviors, he/she will be directed to or escorted to a safe area by staff. If the resident is unable to regain control and becomes more escalated and physically violent, staff may initiate one of the following interventions: basket restraint, use of exclusionary room, standing escort, and in instances where these interventions are not able be done safely due to the client's violence, a floor assisted restraint may be used. All these interventions are documented with an incident report and reported to Community Care Licensing where applicable.

I have read the "Discipline" Policy or it has been read to me and I understand the policies at Milhous Children's Services.

x_____________________________________ ____/____/______

☐Parent ☐Placement Worker Signature Date

x_____________________________________ ____/____/______

Resident's Signature Date

I have witnessed the reading of this document by or to my resident and I understand the policies and affirm that my resident also understands the policies.

x_____________________________________ ____/____/______

MCS LPHA/Therapist Date

RESIDENT COMPLAINT PROCEDURE

1. Any resident who feels or believes that their personal rights have been violated in any way may file a complaint.

2. Residents are encouraged to state their complaints openly and directly. You may make a verbal complaint regarding another resident or any staff person during group meetings.

3. If you feel that your complaint cannot be resolved in the group meeting or are afraid for any reason that making a public complaint would lead to retaliation or do not wish to wait until the group meeting to make your complaint, you may approach any staff person with your complaint.

4. Some locations are equipped with a Grievance/Complaint Box that you can write down your complaint and put in the box. You can identify yourself or remain anonymous.

5. If your complaint deals with any concern regarding your physical safety, staff will write your complaint down on an incident report form and will give that form to the supervisor. If you are complaining about the supervisor on duty, the complaint will be given to the Program Director. You will then be given the opportunity to meet the either the supervisor or the Program Director and the person against whom you are filing a complaint. During that meeting, you will be given the opportunity to describe your complaint and name any witnesses to the incident. You will also be allowed to hear the response of the other person involved. You and the other person will be given support in coming to agreement regarding what actually happened and how things could be handled more appropriately between you in the future.

   A. If you complain that you have been physically assaulted or injured and we find that there is evidence to support your complaint, we will do the following:
      1. We will report the incident by phone and in writing to licensing along with our knowledge of the facts.
      2. The Program Director or supervisor will give consequences to the person involved.
      3. All staff are expected to cooperate completely with any investigating personnel from within Milhous Children's Services or any authorized outside agency in their investigation of a complaint.
      4. You will have the opportunity to tell the licensing investigator what you believe happened and the other person involved will also have the opportunity to tell the licensing investigator what they believe happened.

   B. If there is substantial doubt that what you are complaining about has actually occurred:
      1. We will report the incident by phone and in writing to licensing along with our thoughts and questions regarding the incident based on our investigation.
      2. The Program Director or supervisor will decide what is necessary to keep you safe until we determine what actually happened.
      3. The Program Director or supervisor will continue to investigate your complaint to try and find out what really happened.
      4. All staff are expected to cooperate fully with any investigating personnel from within Milhous Children's Services or any authorized outside agency in their investigation of a complaint.
      5. You will have the opportunity to tell the licensing investigator what you believe happened and the other person involved will also have the opportunity to tell the licensing investigator what they believe happened.

6. If the supervisor or the Program Director review your complaint but feel that there is no evidence to support your complaint, we will:
      1. Tell you so.
      2. File a written report documenting our findings.

   You may phone licensing and report the complaint yourself directly.

7. You will not be punished for filing a complaint with any staff person or with licensing. However, it is important for you to be aware that if you intentionally file false complaints that they create many unnecessary difficulties for you and the other person involved. Do not use false complaints as a means of getting another individual in trouble. We take the complaint procedure very seriously, and we expect you to do the same.

8. You will be informed of the outcome of any licensing investigation involving your complaint.

I have read the complaint procedure or it has been read to me and I understand how to file a complaint at Milhous Children Services.

X____ ____________________

☐ Parent ☐ Placement Worker's Signature Date

X____ ____________________

Resident Signature Date

I witnessed the reading of this document by or to my resident and I understand the procedure and affirm that my resident also understands the procedure.

x_______________________________________ ____________

MCS LPHA/Therapist Date

PERSONAL RIGHTS

Community Care Facilities and Child Day Care Facilities

PERSONAL RIGHTS. See 86072 for waiver conditions applicable to rehabilitation facilities. See 101223 for waiver conditions applicable to Child Day Care Facilities.

(a) ALL FACILITIES. Each person receiving services from a community care facility and/or a child day care facility shall have rights which include, but are not limited to, the following:

The Right:

(1) To be accorded dignity in his/her personal relationship with staff and other persons.
(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with the daily living functions, including eating, sleeping, or toileting, or withholding of shelter, clothing, medication or aids to physical functioning.
(4) To be informed, and to have the authorized representative informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the licensing agency's complaint receiving unit, and of information regarding confidentiality.
(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. (In child day care facilities, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parents or guardians of the child.
(6) To leave or depart the facility at any time, except for house rules for the protection of the clients or for minors and others from whom legal authority has been established. (Pertains to Community Care facilities only)
(7) Not to be locked in any room, building, or facility premises by day or nights.
(8) Not to be placed in restraining devices without advance approval by the licensing agency.

(b) RESIDENTIAL FACILITIES. See 86072 for waiver conditions applicable to rehabilitation facilities. In addition to (a) above, each person provided services by a residential facility should have and may exercise the following rights:

The Right:

(1) To visit the facility with his/her relatives or authorized representative prior to admission.
(2) To have his/her relatives or authorized representative regularly informed by the facility of activities related to care and supervision including but not limited to modifications to needs and services plan.
(3) To have communication to the facility from his/her relatives or authorized representatives answered promptly and completely.
(4) To be informed to the facility's policy concerning family visits and other communication with clients. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.
(5) To have visitors, including advocacy representatives, visit privately during waking hours provided such visitations do not infringe upon the rights of other clients, unless prohibited by court order or the authorized representative.
(6) To wear his or her own clothes, to possess and control his/her personal cash resources, to possess and use his/her own personal items, including his/her own toilet articles.
(7) To have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of telephone in emergencies.
(8) To have access to individual storage space for his/her private use.
(9) To mail and receive unopened correspondence unless prohibited by court order or by the authorized representative and for children to have ready access to letter writing materials and stamps.
(10) To receive assistance in exercising the right to vote.
(11) To receive or reject medical care or health-related services, except for minors and others from whom legal authority has been established.
(12) To move from the facility in accordance with the terms of he admission agreement.

Section 80072, and 1012233, Title 22, California Administrative Code. Also Sections 83072, Small Family Homes, 84072 Group Homes, 85072 Adult Residential Homes, 87072 Foster Family Homes, 87144 Residential Facilities for the Elderly, 102423 Family Day Care Homes. To be reviewed with the client and/or parent/guardian at the time of admission.

As mentioned above, the client and/or parent(s)/guardian has the right to be informed of the licensing agency to contact regarding complaints. Clients should contact the agency stated below:

Licensing Agency to Contact for Complaints
Community Care Licensing
2400 Glendale Lane, Suite C
Sacramento, CA 95825
(916) 973-3846

ACKNOWLEDGMENT: I have been personally advised and have received a copy of these rights at the time of my admission to Milhous Children's Services.

X___________________________________ __________________
Client's Signature Date

I, as designated representative and/or parent/guardian of this child have been personally advised and have received a copy of these rights at the time of his/her admission to Milhous Children's Services.

X___________________________________ __________________
☐Parent ☐Placement Worker Signature Date

VISITATION POLICY

Milhous Children's Services recognizes the importance for our children of continued contact with the significant support persons in their lives. We accomplish this goal through family therapy and scheduled on-site and off-site visits. However, children are placed with our agency due to serious treatment issues, and it is vital to maintain a consistent structure of school, day treatment, and milieu therapy.

Visits are approved in collaborative communication between the Milhous Treatment Team, the County Workers, and the Family. We strive to schedule on-site and off-site visits after the completion of the Monday-Friday school and day treatment program and during school holidays. Visits generally begin after 4:30 p.m. on Friday, and the resident returns by Sunday evening. This allows the resident to participate fully in the therapeutic program, maintain progress towards academic credits and stabilize the milieu community.

In addition, visits may be scheduled based on the safety of the resident's behavior and his/her compliance with the Milhous program. Visitation decisions are made only upon careful consideration by the support team and are based on the individual needs of the resident and his/her family.

Please request the current school schedule from our education department to remain updated on up coming holidays/breaks. We depend on our interagency partners, as well as the resident's family, to comply with the demands of our intensive therapeutic and school program.

I have read the visitation procedure or it has been read to me and I understand the visitation policy at Milhous Children Services.

X____ ___________________
Resident Signature Date

X____ ___________________
Placement Worker Signature Date

X____ ___________________
Parent Signature Date

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Therapeutic Behavioral Services (TBS) is a short-term one-to-one behavior intervention service provided by Milhous Children's Services for eligible Medi-CAL clients with serious emotional problems who are at risk for losing their placement due to severe behavioral difficulties; or who need additional support to successfully transition to a lower level of placement, including family reunification.

TBS is intended to be an additional mental health service which supplements the child/youth's current specialty mental health service by addressing the target behavior(s) or symptoms(s) that are jeopardizing the child/youth's current living situation or planned transition to a lower level of placement. TBS is intended to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that is the barrier to achieving residence in the lowest appropriate level. TBS treatment goals are developed collaboratively with the Milhous treatment team, county agencies, and families (when available). TBS is decreased when indicated by reduction in target behaviors and discontinued when the identified behavioral benchmarks have been achieved or are not reasonably expected in the clinical judgment of the TBS provider to be achieved.

The Milhous Children's Services TBS Department is comprised of both professional and paraprofessional personnel. Professional staff have a master's or doctorate in the mental health field and may be licensed, working toward licensure, or license waivered. Paraprofessional staff have a variety of education and experiential backgrounds working with young people with special needs. All staff participate in ongoing staff development to assure they are current with best practices and techniques.
Information disclosed by you, your child, and your family while participating in the Therapeutic Behavioral Services program is generally confidential. However, there are exceptions to confidentiality, including, but not limited to, reporting suspected child abuse, expressed threats of violence towards an identifiable victim, danger to self or others, and in certain legal proceedings.

To provide integrated and comprehensive services, verbal and written information may be exchanged about your child and family within the collaborative treatment team on a need to know basis, and for supervision and consultation purposes. This team is comprised of Milhous Children's Services staff and may also include participants from designated partner agencies who are involved in delivering these comprehensive services, as indicated on the Authorization for Use or Disclosure of Health Information included in this packet.

If ______________________________(child/youth) is found eligible for TBS and the service is authorized, in order to provide the service as quickly and effectively as possible, we ask that you indicate your acceptance and understanding of TBS by signing below.

____ ___________________

Legal Guardian Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETION OF THIS DOCUMENT AUTHORIZES THE DISCLOSURE AND/OR USE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, AS SET FORTH BELOW, CONSISTENT WITH CALIFORNIA AND FEDERAL LAW CONCERNING THE PRIVACY OF SUCH INFORMATION. **FAILURE TO PROVIDE *ALL* INFORMATION REQUESTED MAY INVALIDATE THIS AUTHORIZATION.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Client Name: Error! Reference source not found.

Persons/Organizations authorized to *use or disclose* the information:

Milhous Children's Services

Persons/Organizations authorized to *receive* the information: *Medical, Dental and Psychiatric Service Providers*

Purpose of requested use or disclosure: *Medical Treatment*

This Authorization applies to the following information (select *only one* of the following):

☐ All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: ______________________________

☐ Only the following records or types of health information (including any dates): ______________________________

EXPIRATION

This Authorization expires: ________________________

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: **Milhous Children's Services , 24077 State Highway 49 ,*Nevada City, CA 95959***

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: ___________________________ Time:_________________ am/pm

Signature: ____ Relationship to client: ___________________________

(client/representative/spouse/financially responsible party)

Witness: ____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Milhous Children's Services. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our *Notice* or if you have any questions regarding our *Notice* you may obtain a copy of the revised *Notice* by contacting:
Quality Assurance Department
24077 State Highway 49
Nevada City, CA 95959

I acknowledge receipt of the *Notice of Privacy Practices* from Milhous Children's Services.

Signature: ____ Date: _________________

Relationship to client: ____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Name of person attempting to obtain acknowledgement:

____ Signature: _______________________Date:________________

Please document attempt(s) to obtain signature and reason(s) why no signature was obtained:

Milhous Children's Services Confidential Pre-Admission Profile

DATE OF REFERRAL: ____

CHILD'S NAME: ____

D.O.B.: _______________ AGE: ______________ CHILD'S GENDER: ☐M ☐F

HEIGHT: ________________ WEIGHT:_________________

CHILD'S CURRENT LOCATION: ____________________________________

REFERRING AGENCY: ____________________________________

REFERRING PARTY: ____________________________________

RELATIONSHIP TO CHILD: ____________________________________

REFERRING PARTY PHONE: _______________________ FAX:________________________

Check which type of program this child needs.

☐Adoption Services
☐CTF
☐Drug & Alcohol Rehabilitation Program
☐Foster Family Care
☐Intensive Therapeutic Foster Care
☐Shelter Care Services
☐Wraparound Services Program
☐Group Home / Residential Treatment Services
☐Hospital
☐Foster Family Care
☐Intensive Therapeutic Foster Care
☐Residential Treatment With Locked Unit Capability

If you have selected Group Home /Residential Treatment Services please indicate the California Rate Classification Level (RCL). RCL levels can range 1 thru 14 .You may enter a single level or a range . (example: level 9 or range 8 thru 12) Single level __________ or range _________ thru ___________

Check the services your child will need.

☐After Care
☐Bilingual
☐Bicultural
☐Drug & Alcohol Prevention Counseling
☐Day Treatment/ Certified
☐Developmentally Disabled Program
☐Family Preservation / Reunification
☐Family Support
☐Foster Care For Special Needs Children
☐Gang Intervention
☐In-Home Services
☐Independent Living Skills
☐Wraparound Services
☐Wilderness / Ranch / Animals
☐Rural Location
☐Parenting Classes
☐Pregnant/Parenting Teens
☐Psychiatric Assessment/Diagnostics
☐Psychiatric Medication Prescribed /Monitored
☐Sexual Offenders Comprehensive Program
☐Sexual Offenders Counseling
☐Sexual Abuse Counseling
☐Special Medical Needs
☐Therapy- Individual / Group / Family
☐Vocational Training

Check the child's Placement status

- ☐ Mental Health
- ☐ M.H. / Education 26.5 / 36.32
- ☐ 300 W&I Health & Human Services / C.P.S.
- ☐ 600 series / Probation
- ☐ Aid to Adoptive Parents
- ☐ Private

Check any health issues that apply

- ☐ Significant Physical Limitations
- ☐ Non-Ambulatory
- ☐ Pregnancy
- ☐ Special Diet
- ☐ Infectious Disease
- ☐ Significant Visual Impairment
- ☐ Eating Disorder
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Asthma
- ☐ Other Significant Medical Needs
- ☐ Significant Hearing Impairment

If the answer to any of the above are checked yes, please briefly note the severity of the condition if known:

Is there a possibility that this child may require manual restraint?

- ☐ Yes
- ☐ No

Does the child have need of psychotropic medication?

- ☐ Yes
- ☐ No
- ☐ Unknown

Education

Last School Attended:
City:
State:

Child qualifies for:

- ☐ Regular Ed
- ☐ Special Ed
- ☐ Unknown
- ☐ Other: ___________________________________

Type of special education class if needed:

- ☐ Emotionally Disturbed (Ed)
- ☐ Developmentally Disturbed (DD)
- ☐ Learning Disabled (LD)
- ☐ Special Day Class (SDC)
- ☐ Unknown

Juvenile justice involvement:

- ☐ Child is a current ward of the juvenile justice court
- ☐ Has Past Or Pending Charges
- ☐ No Involvement
- ☐ Unknown

Check any known citation or arrest for the following:

- ☐ Offense against People
- ☐ Offense against Property
- ☐ Drug Or Alcohol Related
- ☐ Truancy
- ☐ Runaway
- ☐ Use Of Weapons
- ☐ Arson
- ☐ Sexual Offenses
- ☐ Gang Activity

Drug & Alcohol or other substance abuse

- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Dependent
- ☐ Heavy

Check any significant behavioral issues

- ☐ Non-compliance
- ☐ Excessively influenced by peers
- ☐ Chronic tantrums
- ☐ Verbal abusiveness
- ☐ Physically assaultive
- ☐ Property destruction
- ☐ Hyperactivity
- ☐ Poor Impulse Control
- ☐ Self-Injury
- ☐ Suicide Attempt
- ☐ Habitual Encopresis
- ☐ Habitual Enuresis
- ☐ Recurrent running away
- ☐ Cruel to animals
- ☐ Fire setting
- ☐ Theft
- ☐ Inappropriate sexual behavior
- ☐ Refusal to take medication
- ☐ Refusal to participate in therapy
- ☐ School Refusal

Check any significant psychological problems of this child.

- ☐ Anxiety
- ☐ Attention-Deficit / Hyperactivity Disorder
- ☐ Autism / Pervasive Developmental Disorder
- ☐ Chemical Dependence
- ☐ Conduct Disorder / Delinquency
- ☐ Depression
- ☐ Eating Disorder
- ☐ Enuresis / Encopresis
- ☐ Fire Setting
- ☐ Gender Identity Disorder
- ☐ Grief / Loss Unresolved
- ☐ Learning Disorder / Underachievement
- ☐ Low self-esteem
- ☐ Mania / Hypomania
- ☐ Suicidal Ideation / Attempt
- ☐ Mental Retardation
- ☐ Oppositional Defiant
- ☐ Peer / Sibling Conflict
- ☐ Phobia-Panic / Agoraphobia
- ☐ Physical Abuse Victim
- ☐ Psychoticism
- ☐ Runaway
- ☐ Separation Anxiety
- ☐ Sexual Abuse Perpetrator
- ☐ Sexual Victim
- ☐ Sleep Disturbance
- ☐ Social Phobia / Shyness
- ☐ Speech / Language Disorder
- ☐ Other:

____

Signature of Placement Worker Date

MILHOUS CHILDREN'S SERVICES

NOTICE OF PRIVACY PRACTICES - MENTAL HEALTH

1. ***SIGN AND RETURN THE ATTACHED "ACKNOWLEDGEMENT OF RECEIPT"***

2. ***KEEP "NOTICE OF PRIVACY PRACTICES" FOR YOUR RECORDS.***

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

If you have any questions about this notice, please contact our Quality Assurance Department at (530) 265-9057.

WHO WILL FOLLOW THIS NOTICE

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

- Any health care professional authorized to enter information into your chart.
- All departments and units of the agency.
- Any member of a volunteer group we allow to help you while you are a client of the agency.
- All employees, staff and other personnel.

All sites and locations of Milhous Children's Services follow the terms of this notice. In addition, these sites and locations may share medical/mental health information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING MENTAL HEALTH INFORMATION

We understand that information about your mental health treatment and related health care services (mental health information) is personal. We are committed to protecting mental health information about you. We create a record of the care and services you receive at the agency. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to your mental health information generated by the agency, whether made by agency personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your mental health information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose mental health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your mental health information.

We are required by law to:

make sure that mental health information that identifies you is kept confidential (with certain exceptions);
give you this notice of our legal duties and privacy practices with respect to mental health information about you; and
follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MENTAL HEALTH INFORMATION ABOUT YOU

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

DISCLOSURE AT YOUR REQUEST
We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

FOR TREATMENT
We may use mental health information about you to provide you with medical or mental health treatment or services. We may disclose mental health information about you to doctors, nurses, aides or other agency personnel who are involved in taking care of you at the agency. For example, a doctor treating you for a medical condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed for you. In addition, the doctor may need to tell the agency's food service if you are taking certain medications so that we can arrange for appropriate meals that will not interfere or improperly interact with your medication. Different departments of the agency also may share mental health information about you in order to coordinate the different things you need. We also may disclose mental health information about you to people outside the agency who may be involved in your medical or mental health treatment after you leave the agency. For example, we may give your physician access to your health information to assist your physician in treating you.

FOR PAYMENT
We may use and disclose mental health information about you so that the treatment and services you receive at the agency may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at the agency so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

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

Appointment Reminders
We may use and disclose mental health information to contact you as a reminder that you have an appointment for treatment or care at the agency.

Health-Related Products and Services
We may use and disclose mental health information to tell you about our health-related products or services that may be of interest to you.

Family Members or Others You Designate
Upon request of a family member and with your consent, we may give the family member notification of your diagnosis, prognosis, medications prescribed and their side effects and progress.

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

To Avert a Serious Threat to Health or Safety

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

SPECIAL SITUATIONS

Public Health Activities

We may disclose mental health information about you for public health activities. These activities may include, without limitation, the following:

to prevent or control disease, injury or disability;
to report births and deaths;
to report regarding the abuse or neglect of children.
to report reactions to medications or problems with products;
to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Health Oversight Activities

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

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose mental health information about you in response to a court or administrative order. We may also disclose mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested. We may disclose mental health information to courts, attorneys and court employees in the course of conservatorship, and certain other judicial or administrative proceedings.

Law Enforcement

We may release mental health information if asked to do so by a law enforcement official:

In response to a court order, subpoena, warrant, summons or similar process;

To identify or locate a suspect, fugitive, material witness, certain escapes and certain missing person;

About a death we believe may be the result of criminal conduct;

About criminal conduct at the agency;

When requested by an officer who lodges a warrant with the facility, and

When requested at the time of a patient’s involuntary hospitalization.

Coroners and Medical Examiners
We may be required by law to report the death of a patient to a coroner or medical examiner.

Protection of Elective Constitutional Officers
We may disclose mental health information about you to government law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families

Advocacy Groups
We may release mental health information to the County Patients' Rights Office with a patient or patient representative's authorization, or for investigations resulting from reports required by law to be submitted to the Director of Mental Health.

Department of Justice
We may disclose limited information to the California Department of Justice for movement and identification purposes about certain criminal patients, or regarding persons who may not purchase, possess or control a firearm or deadly weapon.

Multidisciplinary Personnel Teams
We may disclose mental health information to a multidisciplinary personnel team relevant to the prevention, identification, management, or treatment of an abused child, the child's parents, or an abused elder or dependent adult.

Senate and Assembly Rules Committees
We may disclose your mental health information to the Senate or Assembly Rules Committee for purpose of legislative investigation.

Other Special Categories of Information

Special legal requirements may apply to the use or disclosure of certain categories of information —*e.g.,* tests for the human immunodeficiency virus (HIV) or treatment and services for alcohol and drug abuse. In addition, somewhat different rules may apply to the use and disclosure of medical information related to any general medical (non-mental health) care you receive.

Psychotherapy Notes

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

- We may use or disclose your psychotherapy notes, as required by law, or:
- for use by the originator of the notes
- in supervised mental health training programs for students, trainees, or practitioners
- by the covered entity to defend a legal action or other proceeding brought by the individual
- to prevent or lessen a serious and imminent threat to the health or safety of a person or the public
- for the health oversight of the originator of the psychotherapy notes
- for use or disclosure to coroner or medical examiner to report a patient's death.
- for use or disclosure necessary to prevent or lessen a serous and imminent threat to the health or safety of a person or the public
- for use or disclosure to the Secretary of DHHS in the course of an investigation

YOUR RIGHTS REGARDING MENTAL HEALTH INFORMATION ABOUT YOU

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

Right to Inspect and Copy

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

To inspect and copy mental health information that may be used to make decisions about you, you must submit your request in writing to Quality Assurance Department, 24077 State Highway 49, Nevada City, CA 95959. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to mental health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the agency will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend

If you feel that mental health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the agency.

To request an amendment, your request must be made in writing and submitted to Quality Assurance Department, 24077 State Highway 49, Nevada City, CA 95959. In addition, you must provide a reason that supports your request.

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

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

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your mental health record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures

You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of mental health information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to Quality Assurance Department, 24077 State Highway 49, Nevada City, CA 95959. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the mental health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the mental health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a type of therapy you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Quality Assurance Department, 24077 State Highway 49, Nevada City, CA 95959. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about mental health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to . We will not ask you the reason for your request. We will accommodate all reasonable requests. 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 a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice: Quality Assurance Department, State Highway 49, Nevada City, CA 95959.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for mental health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the agency. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register at or are admitted to the agency for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the agency or with the Secretary of the Department of Health and Human Services. To file a complaint with the agency, contact Quality Assurance Department, State Highway 49, Nevada City, CA 95959, (530-265-9057). All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MENTAL HEALTH INFORMATION

Other uses and disclosures of mental health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose mental health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your mental health information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

----------INTAKE / MHC USE ONLY ----------

MENTAL HEALTH COORDINATION CHECKLIST

INTAKE / MHC, Please verify the completion of the packet, ensuring all signatures are obtained and questions answered:

- ☐ INTAKE PACKET PAGES 1 -2
- ☐ FACE SHEET PAGE 3-4
- ☐ AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR
- ☐ AUTHORIZATION TO CONTINUE MEDICATIONS AT TIME OF ADMISSION
- ☐ NOTICE TO GUARDIANS OF CHILDREN PLACED IN NEVADA CITY AND SACRAMENTO,
- ☐ REGARDING MEDICAL INSURANCE
- ☐ DEVELOPMENTAL HISTORY
- ☐ MEDICAL HISTORY
- ☐ DANGEROUS PROPENSITIES
- ☐ INFORMATION RELEASE AUTHORIZATION
- ☐ AUTHORIZATION TO PARTICIPATE IN OFF GROUNDS OUTINGS
- ☐ DISCHARGE POLICY
- ☐ "DISCIPLINE" POLICY
- ☐ RESIDENT COMPLAINT PROCEDURE
- ☐ PERSONAL RIGHTS
- ☐ VISITATION POLICY
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (TBS)
- ☐ AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
- ☐ NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT
- ☐ PRE – ADMISSION PROFILE
- ☐ NOTICE OF PRIVACY PRACTICES - MENTAL HEALTH

ADDITIONAL PAPERWORK REQUIRED FOR INTAKE COMPLETION

- ☐ CHILD HEALTH QUESTIONAIRE (CHQ)
- ☐ NEEDS AND SERVICES FORM