RECORD OF ACCESS

Name:

Date	Staff/ Contractor Accessing File	Reason for Access	Staff/Contractor's Signature

Name: DOB:

Member Name: Member DOB: Member ID #:

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member Information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from one provider unless my health plan makes an exception. I may change providers if I am not satisfied with the services. If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. **Aetna:** https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711
2. **Amerihealth Caritas Louisiana**: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call 1-888-756-0004; TTY 1-866-428-7588
3. **Healthy Blue**: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)
4. **Louisiana Healthcare Connections**: https://providersearch.louisianahealthconnect.com/ or call 1-866-595- 8133 Hearing Loss: 711)
5. **United Healthcare Community**: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514

The provider that I have freely selected to deliver MHR services to me, or my child is:

Provider Name:	The Gift Mental Health Clinic, LLC
Provider Phone Number:	504-644-2575
Provider Contact Name:	Will Bell
Provider Address:	3301 Canal Street #1 New Orleans, La 70119

By signing the form below, I understand that I have chosen to receive services from this MHR provider, and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

Member/Legal Guardian Signature Date

Printed Legal Guardian Name (if applicable) Date

Providers Information: A Member Choice form is required prior to receiving any mental health rehabilitation services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

W. Bell
Provider Signature Date

Name: DOB:

Client Data/Intake Form

Date:

Name: DOB: Age:

Grade: Gender:

……

Race: Marital Status: Ethnicity: not specified

Medicaid Number: Social Security Number:

Primary Language used: Interpreter Needed:

Phone Number: Alternate Phone:

Address:

City: State: Zip Code:

Mailing Address (If different): _____

Client's School/Employer: _____

Medical History: ____Refer to Assessment_____
Current Health needs: _____
List any current medications: _____
Any known allergies? _____
Are you currently receiving services from another agency? ___Y ___N
Have you previously received mental/behavioral health in the past? ___Y ___N
If yes, please provide name of agency/individual, reason for services and dates of service:
_____
Primary Care Physician: _____Phone#: _____
Referral Source**:** _____Phone#: _____
Eligible: Yes/No If no list reason: _____
Indicate community referral source: _____
Date Referral Source was notified: _____ Appt date & time: _____

EMERGENCY CONTACT INFORMATION

Name	Relationship to client	Phone#
Name	Relationship to client	Phone#

_____ Electronic Signature) _____

Recipient or Legally Responsible Person / Date — The Gift Representative/Date

Name: DOB:

Presenting Problems:

Anxiety
Criminal Behavior (stealing, vandalism, ect)
Constant restlessness
Homicidal
Forgetfulness
Defiance/Oppositional
Destructiveness (destroying property)
Hurting animals (pets)
Change appetite
Gravely impaired
Hallucinations (visual, auditory, ect)
Obsessions/compulsions
Impulsiveness
Insomnia or Hypersomnia
Obsession with firearms
Lying
Bullying
Delusional
Fidgety
Fighting-setting
Cutting Self
Disrespectfulness
Self-Injuries behaviors
Difficulty concentrating
Temper tantrums
Withdraw/Isolation
Excessive energy

Crying Spells
Phobias
Running Away
Suicidal
Depression
Low-Self-esteem
Hyperactive
Excessive talking

OTHER:

If suicidal, homicidal, gravely impaired, dangerous behaviors or need further clinical guidance contact a licensed clinician to further assess for triage! Document clinical disposition when applicable. Indicate, whether urgent, emergent or routine care is needed.

LMHP's Signature & Credentials, when applicable Date:

Name: DOB:

Client's/Member's Rights and Responsibilities

CLIENT/MEMBER RIGHTS:

1. To be informed of the client's rights and responsibilities at the time of admission or within 24 hours of admission.
2. To have a family member, chosen representative and/or his or her own physician notified of admission to the BHS provider at the request of the client.
3. To receive treatment and medical services without discrimination based on race, age, religion, national origin, gender, sexual orientation, or disability.
4. To maintain the personal dignity and respect of each client.
5. To be free from physical, chemical mental abuse, neglect, exploitation, harassment, retaliation and humiliation.
6. To receive care in a safe setting.
7. To receive the services of a translator or interpreter, if applicable, to facilitate communication between the clients and the staff.
8. To be informed of the client's own health status and to participate in the development, implementation and updating of the client's treatment plan.
9. To make informed decisions regarding the client's care by the client or the client's parent or guardian, if applicable, in accordance with federal and state laws and regulations.
10. To participate or refuse to participate in experimental research when the client gives informed, written consent to such participation, or when a client's parent or legal guardian provides such consent, when applicable, in accordance with federal and state laws and regulations.
11. To be informed, in writing, of the policies and procedures for filing a grievance and their review and resolution.
12. To submit complaints or grievances without fear of reprisal.
13. To have the client's information and medical records, including all computerized medical information, kept confidential in accordance with federal and state statutes and rules/regulations.
14. To be given a copy of the program's rules and regulations upon admission.
15. To receive treatment in the least restrictive environment that meets the client's needs.
16. To not be restrained or secluded in violation of federal and state laws, rules and regulations.
17. To be informed in advance of all estimated charges and any limitations on the length of services at the time of admission or within 72 hours;
18. To receive an explanation of treatment or rights while in treatment.
19. To be informed of the:
    a. Nature and purpose of any services rendered.
    b. The title of personnel providing that service.
    c. The risks, benefits, and side effects of all proposed treatment and medications.
    d. The probable health and mental health consequences of refusing treatment; and
    e. Other available treatments which may be appropriate.

20. To accept or refuse all or part of treatment, unless prohibited by court order or a physician deems the client to be a danger to self or others or gravely disabled;

Name: DOB:

CLIENT/MEMBER RESPONSIBILITIES:

Your part is to take responsibility for the following:

1. Follow agency rules, policies and procedures.
2. Follow the steps described in this handbook if you wish to file a grievance or appeal with our agency.
3. Keep scheduled appointments and call to cancel or reschedule if you cannot make your scheduled appointment.
4. Ask questions when you don't understand or when you want more information.
5. Provide any information to your worker that is necessary for your treatment.
6. Participate actively to create goals that will help you in your recovery.
7. Follow the treatment plans that you and your providers have agreed upon.
8. Take medications as they are prescribed for you.
9. Tell your doctor if you are having unpleasant side effects from your medications, or if your medications do not seem to be working to help you feel better.
10. Seek out additional support services in the community.
11. Invite the people (family, friends, etc.) who will be helpful and supportive to you to be included in your treatment.
12. Understand your rights and the grievance process.
13. Treat staff, as you would expect to be treated.

Client and/or Parent/Guardian's Signature **Date**

W. Bell
The Gift Representative's Signature **Date**

Name: DOB:

CONSENT FOR TREATMENT

I, give my permission to receive counseling/therapy services from **The Gift**. I understand that by giving my permission to receive services***, I have the right to withdraw my consent at any time***. Withdrawal of my consent will result in my file being closed immediately. By giving my permission to receive services, I understand that I, as a client, have the right to confidentiality, the right to privileged communication, responsibilities I must uphold as a client and the right to refuse service at any time. I understand that I, as a client, have the right to give informed consent to individuals, agencies, and/or organizations to view my file. I understand that I, as a client, have the right to request, in writing, information in my file at any time.

By signing below, I am agreeing that I have read and understand the above information and agree to the following services:

Assessment	Group Counseling
Education	Family Counseling
Couples Counseling	Psychiatric Evaluation
Medication Management	Other *CPST & PSR*

Signature of Recipient or Parent/Legal Guardian Date

Signature of **The Gift** Authorized Representative Date

Consent to Treatment will expire (annual update):

Name: DOB:

AUTHORIZATION FOR SCHOOL VISITS

I, the parent/ guardian of _____ give **The Gift** representative(s) permission to visit my child at school.

My child attends _____ and the schools address/ phone number is _____

_____.

The school counselor/social worker name is _____. My child is in the _____ grade and his/ her teacher name is _____.

Place a check below if you decline services to be provided at school.

_____ **I do not give The Gift representative(s) permission to visit my child at school.**

Recipient/ Legally Responsible Person Date

The Gift Representative Signature Date

School Consent will expire on (annual update):

Name: DOB:

EMERGENCY PREPAREDNESS

Please provide us with emergency contact information in the event that you are asked to evacuate the area.

CLIENT NAME:	**EMERGENCY CONTACT NAME:**
Phone Number: _____ Email: _____ Facebook: _____ Instagram: _____	Phone Number: _____ Email: _____

Do you have somewhere to evacuate? ___ **Yes** **No**
If so, where? _____

Do you plan to evacuate? **Yes** **No**
If so, when? _____

Do you plan to return? **Yes** **No**

Who will evacuate with you?
_____

Do you have the necessities to evacuate? ___**Yes** **No**

What is the best way to contact you? **Phone** **Text** **Email (**Circle All That Apply)

In the event that refills are needed, what pharmacy do you use? _____Contact #_____

Any additional information/ comments:
_____

Recipient or Legally Responsible Person / The Gift Representative's Signature / Date

Name: DOB:

Advance Directives Acknowledgement Form

It is your right to have a written direction about their mental/health treatment, known as an advance directive, if you ever lose your ability to make decisions. This plan basically describes how you want to be cared for in case you ever become unable to decide or speak for yourself. You also have the right to revoke the consent at any time.

You may also include a "health-Care Proxy". This lets you name another person to make decisions about your care if you become unable to do so.

For assistance preparing these plans, we recommend that you speak to someone you trust. For example, one of our agency staff, a family member or a minister. If you choose one of our staff your plan can be made known to the LMHP conducting your mental health assessment and it will be incorporated into your assessment.

You may also contact any of the advocacy agencies attached to this form for help completing an advance directive.

The agency has explained what advance directive is and its purpose. I understand the plan and at this time I am signing this acknowledgement form and also choose:

I do not have an advance directive at this time and not interested; therefore "I Refuse."
(If refusal is indicated, NO ADDITIONAL INFORMATION IS NEEDED)

I wish to speak to the agency staff about an advance directive plan.

I wish to speak to other advocacy agencies or family members about my advance directive plan.

Recipient or Legally Responsible Person Date

The Gift Representative's Signature Date

Name: DOB:

Client Orientation Checklist

Each client, parent, or legal guardian of a client will be instructed and given written information regarding the following, upon admission to **The Gift** program:

- Informed Consent/Freedom of Choice
- Non-discrimination provisions
- family involvement;
- safety;
- the rules governing individual conduct;
- authorization to provide treatment;
- adverse reactions to treatment;
- the general nature and goals of the program; staff providing services
- proposed treatment to include treatment methodology, duration, goals and services;
- risks and consequences of non-compliance;
- treatment alternatives;
- client's rights and responsibilities; refusal of services; right to revoke;
- all other pertinent information, including fees and consequences of non-payment of fees;

Additional information will be provided throughout the intake process, including but not limited to:

1. Grievance and Appeal Procedures
2. Communication/input policies regarding:
   a. Quality of Care
   b. Outcome Achievement and Strategic planning efforts
   c. Client Satisfaction
3. Explanation of the agency's
   - Mission/Philosophy/General nature and goals of the program
   - Services, activities, and therapeutic interventions
   - Family Participation/Involvement
   - Hours of Operation
   - 24-Hour On- Call Policy
   - Ethical Code of Conduct
   - Confidentiality Policy and HIPPA Privacy Rights
   - Requirements for follow-up for mandated clients, regardless of his/her discharge outcome.
4. Explanation of any and all financial obligations, fees, and arrangements for services provided by the organization.
5. Orientation with the agency facilities, including emergency exits, fire suppression equipment, and first aid kits.
6. The agency policies regarding safety and:
   a. Seclusion, restraints or physical holds
   b. Smoking and Tabaco
   c. Illicit or licit drugs
   d. Weapons
   e. Abuse and neglect
7. Identification of direct care worker.

Name: DOB:

8. Program rules that identify:
    a. Any restrictions the program may place on clients.
    b. Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the client.
    c. Means by which the client may regain rights or privileges that have been restricted.
9. Identification of the purpose and process of assessment.
    a. Smoking and Tabaco
    b. Illicit or licit drugs
    c. Weapons
10. Abuse and neglect and exploitation
11. Family Involvement
12. Program rules governing individual conduct, risk and consequences of non-compliance
13. Education regarding Advanced Directives, where appropriate.
14. Authorization to provide treatment and adverse reactions to treatment.
15. A description of how the Treatment Plan will be developed, treatment methodology, duration, goals and services
16. Information regarding transition, transfer and discharge criteria and procedures.
17. Treatment alternatives/Treatment approaches.
18. Non- payment fee, all client must maintain Medicaid eligible to avoid disruption of services.
19. Health and Safety concerns inclusive of physical and Environmental safety, Waste Management and Infection Control Factors.

By signing this acknowledgement, I agree to the terms of all contents of the Client Orientation/Intake Process and have received a copy of the Client Handbook.

Client's Signature Date

Parent/Guardian's Signature (If applicable) Date

The Gift Representative Signature Date