FOUNDATION X

ACCEPTANCE OF MENTAL HEALTH SERVICES

_____1. I certify that I am freely choosing mental health services.

_____2. I understand that I have the right to choose a provider of my choice.

_____3. I understand that I have the right to change service providers.

_____4. I certify that I have read the Client's Rights and Confidentiality and Security of files information.

_____5. I certify that I have read the list of providers in my area and freely chosen.

_____Agency to provide services.

_____6. Plan of Care Services Options: (check all that apply) ___Med Mgt.;___PSR.

____CPST;____Psychological Evaluation; ____Family Therapy; _____Individual Therapy; _____ MST

Consumer's Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Administrative/Staff: _____ Date: _____

FOUNDATION X

3084 Westfork Drive, Suite C
Baton Rouge, La 70816
Tel : 225- 960-1813 Fax : 225-227-2502

(Please Write your name exactly as it appears on your insurance ID Card)

Last: _____ First: _____ Ml: _____
Address: _____City: _____State: _____
Zip Code: _____ Email: _____

Home Phone: _____Work Phone: _____Other Phone _____
Date of Birth: _____ SS# _____Sex: _____ Male _____ Female

Legal Status: ____Minor/Child _____Adult _____Adult with Legal Guardian _____DCFS

Race: ____Caucasian ____Black/African American ____Asian/Pacific ____Amer IndianAlaskan ___Other

Ethnicity: _____No Hispanic _____Hispanic Primary Language: _____
Parent/Guardian Name: _____ Relationship: _____

Primary Care Physician: _____
Address and Phone: _____

- Medical Conditions or Allergies: Yes: _____ No _____
- Use of medications or tools/equipment used to assist with daily living? ____ Yes _____No
- Any special needs we need to be aware of as we begin to provide services? ___Yes ___No

Who Referred to You? _____School_____Work _____Friend/Family _____Other

Education: _____ Last grade completed: Current School: _____

Insurance Information: (Please provide a copy of your insurance cards)

Medicaid ID# _____ Medicaid Provider _____

I CONSENT TO TREATMENT BY FOUNDATION X. TO OBATIN EMERGENCY MEDICAL CARE IF NEEDED.

_____ _____

Client's Signature **Date**

_____ _____

Parent Signature/ Guardian Signature **Date**

_____ _____

Staff Signature **Date**

FOUNDATION X

Client Medical Emergency Information Form

Client's Name: _____

In case of a medical emergency involving the above client please contact:

1. Name: _____

   Phone: _____ Cell: _____

2. Name: _____

   Phone: _____ Cell: _____

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

FOUNDATION X

INFORMED CONSENT TO MENTAL BEHAVIORAL HEALTH TREATMENT

Please read carefully before signing this form. The Mental Health treatment that are available to you must be explained prior to signing.

1, _____ client receiving services, hereby consent to receive Mental Behavioral Health treatment from Foundation X for the purpose of addressing mental health concerns/ symptoms. I understand that additional information about the purpose, side effects, and potential risks and benefits as well as information.

By signing below, I understand that I consent to treatment currently:

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

FOUNDATION X

IDEMNIFICATION, HOLD HARMLESS, AND RELEASE AGREEMENT

The undersigned and/or client, parents/legal guardian of _____ a recipient of Community Psychiatric Treatment Support/ Psychosocial Rehabilitation (hereinafter referred to as "CPST/PSR") through Foundation X, hereby indemnifies and holds harmless Foundation X, its personnel and any and all related corporate entities which may be affiliated with the provider of said CPST/PSR services. This indemnity and hold harmless agreement releases Foundation X, and any of its affiliates from any claims of any kind whatsoever or of any nature whatsoever or of any nature for injury to the person or his/her parents or siblings or any individual claiming damages in association with CPST/PSR services. This indemnity and hold harmless agreement shall be considered a complete and total waiver of all liability on the part of Foundation X, and any corporate entity or person associated with same.

Client's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

FOUNDATION X

3084 Westfork Drive Suite C, Baton Rouge, La 70816
Telephone (225) Facsimile (225)

Grievance

Each consumer of Foundation X is provided with a written grievance procedure, which is designed to allow consumers to make complaints without fear of retaliation.

Foundation X recommends open and productive communication among clients and staff. However, Foundation X recognizes that miscommunication and misunderstandings may occur at times. Each client and/or family has the right to express his/her opinion and air any perceived or actual grievance through a formal grievance procedure.

Upon admission to the program, the grievance procedure is discussed with the client. The signed original document will be placed in the client's file with a copy given Foundation X recommends that every attempt be made to solve the complaint at the lower level.

Procedure

1. Clients should request a meeting with the staff member's supervisor to discuss the problem. The supervisor should document the complaint, the results of the discussion and the results of the meeting. An original is to be placed in the client's file, a copy given to the client and the original placed in the main office file.
2. If there is no resolution at the first step, the Program Manager should be notified. The Program Manager will conduct a meeting with all parties and the Program Manager will issue a report including what actions will be taken. The original will be placed in the client's file with copies given to all parties.
3. If the client is dissatisfied with the results of the second step, the client may appeal in writing to the Program Manager to investigate the complaint.

The Program Manager will review all information and may make a written decision at that point or call a meeting to investigate further. The Grievance Committee will be comprised of the Program Manager, one member of the Board of Directors and one consumer. The Grievance committee will issue a formal report within (7) working days of the meeting. The Committee, upon finding a valid complaint, may recommend changes in policies and procedures or sanction the staff member(s).

4. If the client remains dissatisfied with the findings of the Grievance Committee, he/she may file a formal complaint with the Regional Director of Mental Health, Department of Health, and Hospitals.

The internal grievance procedures are not to be construed as a limitation of the rights of the individual but provide an additional remedy, which can be pursued. While the complaint process specified above has been developed to cooperatively resolve complaints, you may at any time register your complaint with an outside Behavioral Health Agency and request their assistance in achieving resolutions.

The Grievance Procedure and Client's Right has been explained to me.

_____ _____ _____ _____

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

_____ _____

Staff Signature **Date**

FOUNDATION X

Family On-Call Information Sheet

What do I do if there is a crisis? Foundation X has a 24-hour emergency call system. Families may call_____ and wait for someone or a voice mail to pick up the line. State that there is a crisis problem, leave your name, number, and the on-call staff professional will contact you (usually within 15-20 minutes). If you do not hear from someone within 15-20 minutes, call the service again.

What happens when the on-call professional contacts me? Professional staff member will help you talk through the problem, suggest interventions to use, and explore options. The Professional staff will usually ask to talk to your child or the client to assist in calming that person and giving assistance in regaining control. If necessary, professional staff will meet with you face to face or may send a mental health tech to help through the situation.

When I call will I get the professional staff that works with my child? Professional staff rotate, or take turns being on call, so it is likely your regular staff person will not respond to your calls, however, all professional and crisis staff are trained and will have a copy of your treatment plan/service plan.

Should my child be in the hospital? In a large majority of situations, we are able to help you through the situation without resorting to the hospital. A major goal of out- programs is to avoid hospitalization. There are risks involved when using hospitals, such as: making behaviors worse, picking up other inappropriate behaviors, or developing a dependency on the hospital. Hospitals should only be used as a last resort, and that usually means there is a grave safety risk. Our staff will help you with other alternatives or get further guidance as needed.

What if I have a problem, but it's not a crisis? If you are worried that a problem may grow worse and become a crisis or need some direction in handling a situation, it is appropriate to call for assistance over the telephone. However, for routine matters or questions about appointments, you can leave a message with the operator to be forwarded the next business day.

May I call on the staff at home? We request that you do not call staff at their homes. We rotate on call that staff may get the needed rest and recuperation they need to be at optimal level when they are working with you and your family. This is to better take care of everyone's needs.

What if I have a problem with an on-call situation? Please let your Clinical Manager know if there is a problem on the next business day. We are here to assist you and cannot address any problems or difficulties if we are not informed or aware of the situation.

_____

Client's Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Staff Signature: _____ Date: _____

FOUNDATION X

Client Acknowledgement of 24 Hour on Call Services

By signing below, I acknowledge that I have read and understand Foundation X 24-Hour Crisis Response Plan.

IF THE CLIENT IS NOT 18 YEARS OF AGE OR OLDER, THIS ACKNOWLEDGEMENT MUST ALSO BE SIGNED BY THE CLIENT'S PARENT (S) OR LEGAL GUARDIAN.

_____

Client's Name

_____ _____

Client's Signature or Parent/Guardian Signature Date

_____ _____

Staff Signature Date

FOUNDATION X

MENTAL HEALTH SERVICES-NO SHOW POLICY CONTRACT

I, _____, as the client, biological parent, legal, or temporary guardian of client: _____ in Foundation X mental health services program do understand that there are specific requirements regarding to my participation in the program and do the following:

1. Make and keep a doctor's appointment with agency Medial Director at least once every 2 months, whether I am taking medication or not.
2. I am required to attend 90% of sessions with therapist or LMHP.
3. I am required to cancel appointments with therapist 24 hours in advance if unable to meet.
4. I am required to attend I CPS T session and I PSR session per week.
5. I am required to be instrumental in the development of and implementation of treatment plans.
6. If a client misses more than I month of services, the client is required to have an appointment with therapist and program director to identify barriers to sessions.
7. If no contact has been made with the client in 1 week, a letter of contact will be mailed to the client's home.
8. If we do not hear back from the client within 2 weeks, after the letter was sent out the agency will assume that client no longer wants our services and will be discharged from program.
9. Discharge summary will be mailed to client's home.
10. If client is a non-voluntarily client letter stated, no show and copy of discharge summary will be mailed to referral source.

ll. In cases of extreme non-compliance with treatment such as over 50% of appointments missed or over 4 appointments missed in a 12-month period; misuse /abuse of medications; or Doctor-Shopping, the Medical Director may close the case and discharge the clients permanently form Foundation X per the discharge policy and procedure.

I understand that it is important for me to fully participate in the program so I can improve and reach goals I set for myself. I further understand that if I do not fully participate, this will indicate that I do not need this level of treatment, and I will be dropped to a lower level of need and transitioned out of mental health services program more quickly.

If I have any problems with staff or program or just have questions, I understand that I need to call the Program Director (225) 960- 1813 to let them know what problems I am having.

I agree to be a full partner with Foundation X, in my treatment so we can get the best possible results.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

TELEHEALTH CONSENT FORM

FOUNDATION X

I, _____hereby consent to engage in Telehealth with _____ (LPC, Psychiatrist, Therapist, Staff).

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g., Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a client's care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person sessions.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am
5. I understand that in some instances Telehealth may not be as effective or provide the same results as inperson therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
6. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
7. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_____ _____

Client's Signature Date

_____ _____

Staff Signature Date

Therapist reviewed Telehealth Consent Form with client, client understands and agrees to the above advisements, and client has consented to receiving sessions form staff via Telehealth.

FOUNDATION X

Person Served Orientation Checklist

The following items, which are contained in the person served handbook and other program materials, have been reviewed with the person served as part of the Foundation X. intake and orientation to services process. A check of the items below, and the signatures that follow indicate that each area of orientation has been fully reviewed and is understood by the person served.

- ☐ Services provided
- ☐ Behavioral expectations of person served
- ☐ Access to after-hours and emergency services
- ☐ Right & responsibilities of person served
- ☐ Confidentiality policy
- ☐ Methods and opportunities to provide input
- ☐ Standards of professional conduct
- ☐ Safety, evacuation & emergency procedures
- ☐ The use of seclusion or restraint
- ☐ The use of tobacco products
- ☐ Weapons brought to the program
- ☐ Staff responsible for service coordination
- ☐ Days and hours of operation
- ☐ Intent/ consent to treat
- ☐ Expectations for family involvement
- ☐ Grievance/ complaint procedures
- ☐ Limits of confidentiality
- ☐ Staff responsible for service coordination
- ☐ Financial obligations, fees, and billing procedures
- ☐ Fire suppression & first aid kits
- ☐ Prescription brought to program
- ☐ Policy on legal or illegal substances in program
- ☐ Restrictions
- ☐ Events, behaviors, attitudes & consequences
- ☐ Response to identification of potential risk to person served
- ☐ The loss and regaining of privileges
- ☐ Discharge/Transition criteria and procedures
- ☐ Purpose and process of the assessment
- ☐ Purpose and process of the person-centered planning
- ☐ Participation in goal setting & achievement
- ☐ Use of motivational incentives
- ☐ Expectations for legally required appointments, sanctions, or court notifications, if applicable
- ☐ Reporting and follow-up if treatment mandated, regardless of discharge outcome
- ☐ Advance directives education as indicated

My signature below indicates I was given opportunity to ask questions and I fully understand all items checked on this form.

_____ _____

Client signature **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Staff Signature **Date**

FOUNDATION X

3084 Westfork Drive Suite C, Baton Rouge, La 70816
Telephone (225) ● Facsimile (225)

Authorization to Release or Obtain Health Information (including paper, oral, and electronic information)	
Recipient's Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security #:

Foundation X
Mental Health Rehabilitation Agency

☐ RELEASE information TO or ☐ OBTAIN information FROM
(Place an "X" in the box that indicated if the information is being released OR requested)

Relationship: **Psychiatrist _____** Telephone: _____
Relationship: **School_____** Telephone: _____
Relationship: **PCP _____** Telephone: _____
Relationship: **Emergency Contact _____** Telephone: _____

The Purpose of this Authorization is to gather information needed to obtain and provide Mental Health Rehabilitation services.

In compliance with state and federal laws which require special permission to release otherwise privileged information, please release the following records: *(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*

☐ Discharge summary ☐ Psychiatric/ Psychological Evaluations ☐ Medical History, Examination, Reports
☐ Psychotherapy Needs ☐ Prescriptions ☐ Alcoholism
☐ Drug Abuse ☐ HIV (AIDS) ☐ Sexually Transmitted diseases
☐ Genetics ☐ Vocational Rehabilitation ☐ Laboratory Reports and X-Ray Reports
☐ School Records (Including: Attendance, progress reports, grades, IEP, and behavioral problems/plan)
☐ Other:_____

This authorization shall expire on _____ (date or event). I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

_____ _____
Signature of Individual or person Representative authorized by law Date

For Foundation X Use When Requesting Records

I am authorized to receive this disclosure. Documentation of the above Personal representative has been obtained.

_____ _____
Signature of Individual or person Representative authorized by law Date

You have the right to revoke this authorization at any time. To revoke, send a written statement to: Foundation X. Attn: Records Office 3084 Westfork Drive Suite C, Baton Rouge La, 70816 Your request will become valid when the Records Office receives it.

FOUNDATION X

Member Name (First, Last 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:	Foundation X
Provider Phone Number:	
Provider Contact Name:	
Provider Address:	3084 Westfork Drive Suite C, Baton Rouge La 70816

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)

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.

_____ _____

Provider Signature Date


FOUNDATION X