Mid-Plains Center for Behavioral Healthcare Services, Inc.

ADMISSION FORM

First Name:	MI:	Last Name:	Gender M F
Address City State Zip			
County	Phone: (including area code)	Birth Date	Age
Preferred Method of Contact: Any Home Phone Mobile Phone Fax Mail		SS#	
Insurance # (if applicable)	Medicaid # (if applicable)	Medicare # (if applicable)	

State Ward *(if client is a minor)*
Yes No

Disabled? (Receiving SSDI?)
Yes No
Type of Disability _____

Check all that apply:
- ☐ I am a woman who is pregnant and uses drugs.
- ☐ I am a woman who is pregnant and uses IV drugs.
- ☐ I am a woman who uses drugs and I have dependent children.
- ☐ I am a woman who uses drugs and I am trying to regain custody of my children.
- ☐ I have a Mental Health Board Commitment

Veteran?
Yes No

Work Comp?
Yes No

Race
1. American Indian or Alaska Native
2. Native Hawaiian or Other Pacific Islander
3. Asian
4. Black/African Am.
5. White/Caucasian
6. Hispanic/Latino
7. Other
8. Refused

Ethnic Background
1. Mexican
2. Puerto Rican
3. Cuban
4. Other Hispanic
5. Dominican Rep
6. Not Hispanic/Latino
7. Refused

Primary Language Spoken in Home:
1. English
2. Spanish
3. Other
4. Vietnamese
5. Sudanese
6. Refused

Religion:
1. Catholic
2. Jewish
3. Other
4. Protestant
5. Muslim
6. Refused
7. None

Highest Grade Completed
Pre-school K 1 2 3 4 5 6 7 8 9 10 11
12-No Diploma High School Grad GED
Grad Degree Prof Degree Refused

Marital Status
Single Married Divorced
Widowed Separated Refused

Employment
Employed Full Time Employed Part Time
Retired Student Not Employed Refused

Annual Household Income ☐Self ☐Spouse ☐Parent ☐Other (check all that apply)

☐ $ Less than 5,000	☐ $ 5,000 - 9,999	☐ $ 10,000 – 14,999
☐ $ 15,000 – 24,999	☐ $ 25,000 – 34,999	☐ $ 35,000 or more

Referral Source
- ☐ Self Referred
- ☐ School
- ☐ HHS
- ☐ OJS
- ☐ Probation – Diversion
- ☐ ICCU
- ☐ Region III
- ☐ Court Ordered
- ☐ Mental Health Board
- ☐ Other Third Party _____

Residential Arrangement
- ☐ Family Home
- ☐ Relative's Home
- ☐ Independent Living
- ☐ Foster Care
- ☐ Group Home
- ☐ Residential Treatment Center
- ☐ Hospital
- ☐ Youth Rehab and Treatment Center
- ☐ Emergency Shelter
- ☐ Homeless
- ☐ Unknown
- ☐ Refused

Person to notify in case of an emergency:

Name: _____Relationship: _____

Phone:(home)_____(mobile) _____work) _____

Family Physician_____Phone:_____
Have you had a physical within the last 12 months? Y / N Year and month last seen?_____
Number of days within the last 30 days your physical heath was not good? _____
Number of days within the last 30 days your mental health was not good? _____

Mid-Plains Center for Behavioral Healthcare Services, Inc.

Today's Date: _____

☐ **NEW** ☐ **READMIT**

Appointment Date: _____

Appointment Time: _____

Therapist/Medical Staff:_____

Please check service(s) you would like to receive:
☐ **Outpatient counseling** ☐ **Dual Diagnosis counseling** ☐ **Medical Management** ☐ **Opioid Clinic**

Please briefly explain why you are seeking our services:

_____

_____

_____

_____

Consent to Receive Text Messages about Appointment Reminders:

Clients in our practice may be contacted via text messaging to remind them of an appointment.

Please Initial: _____ I consent to receive text messages from Mid-Plains center for Behavioral Healthcare Services, Inc. on my cell phone and any number forwarded or transferred to that number to receive appointment reminder. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

The cell phone number that I authorize to receive text messages for appointment reminders is:

_____

Mid-Plains Center for Behavioral Healthcare Services, Inc. Does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Client Signature:_____Date:_____

Mid-Plains Center for Behavioral Healthcare Services, Inc.

INITIAL SCREENING FOR SELF-HARM POTENTIAL

Consumer Name: _____ ID#: _____

Instructions: To be completed by the Intake Coordinator at admission. Please check 'yes' or 'no' for each question.

Was there a potentially lethal suicide attempt in the past 24 hours?	❑ Yes	❑ No
Are there statements of intent to self-harm?	❑ Yes	❑ No
Is there a plan for self-harm?	❑ Yes	❑ No
Is the patient unwilling and unable to contract NOT to harm oneself?	❑ Yes	❑ No
Is the patient experiencing auditory hallucinations that command self-harm?	❑ Yes	❑ No

A YES on any of the above questions dictates the need for crisis intervention.

Employee Name: _____

Employee Signature: _____ Date: _____

(Consumer accepted at Triage by: _____ Date: _____)

SELF-ADMINISTERED SCREEN FOR INFECTIOUS DISEASES

• Have you ever had a positive HIV test?	☐ Yes	☐ No
• Have you ever had a positive Hepatitis B test?	☐ Yes	☐ No
• Have you ever had a positive Hepatitis C test?	☐ Yes	☐ No
• (Women) Is it possible that you could be pregnant?	☐ Yes	☐ No
• Have you ever had a positive skin test for TB?	☐ Yes	☐ No
• Have you ever been told you have TB?	☐ Yes	☐ No
• Has anybody you've been around been diagnosed with TB in the past year?	☐ Yes	☐ No

TOTAL QUESTIONS ANSWERED "YES": _____

GAMBLING QUICK SCREEN

• Has gambling ever made your home life unhappy?	☐ Yes	☐ No
• Do your friends gamble a lot?	☐ Yes	☐ No
• Do you often gamble with money you originally intended to use for other things?	☐ Yes	☐ No
• Do you ever lie about your gambling?	☐ Yes	☐ No
• Does one of more family members do a lot of gambling?	☐ Yes	☐ No

RESULTS – STAFF USE ONLY
☐ Not considered an issue at this time
☐ Consumer needs further assessment in this area

Mid-Plains Center for Behavioral Healthcare Services, Inc.

SELF ADMINISTERED SCREEN FOR AOD ABUSE

The questions below are about your use of alcohol or other drugs (AOD).
Your answers will be kept confidential.

During the last twelve months…

☐ **Yes** ☐ **No** 1. Have you used any alcohol or other drugs?

☐ **Yes** ☐ **No** 2. Do you feel you've used too much alcohol or other drugs?

☐ **Yes** ☐ **No** 3. Have you tried to cut down or quit using alcohol or other drugs?

☐ **Yes** ☐ **No** 4. Have you gone for help because of your drinking or drug use?
(Such as AA, Narcotics Anonymous, other counselors or a treatment program?)

☐ **Yes** ☐ **No** 5. Have you had any health problems from alcohol or other drugs?

☐ **Yes** ☐ **No** 6. Have you ever: (check any of these that apply to you)

☐ Had blackouts or other periods of memory loss?
☐ Injured yourself after drinking or using drugs?
☐ Had convulsions or delirium tremens (DT's)?
☐ Had hepatitis or other liver problems?
☐ Felt sick, shaky or depressed when you stopped using?
☐ Felt "coke bugs" or a crawling feeling under your skin after you stopped using?
☐ Used needles to shoot drugs?

☐ **Yes** ☐ **No** 7. Has your drinking or other drug use caused problems at school or work?

☐ **Yes** ☐ **No** 8. Have you been arrested or had other legal problems? (Such as bouncing checks, DUI, theft or drug possession charges?)

☐ **Yes** ☐ **No** 9. Have you lost your temper, gotten into arguments or fights while drinking or using drugs?

☐ **Yes** ☐ **No** 10. Do you need to drink or use more alcohol or drugs to get the effect you want?

☐ **Yes** ☐ **No** 11. Do you spend a lot of time thinking about how to get alcohol or other drugs?

☐ **Yes** ☐ **No** 12. When drinking or using drugs, are you more likely to do something you wouldn't normally do? (Like break the law, sell possessions that are important to you, or have unprotected sex?)

☐ **Yes** ☐ **No** 13. Do you feel bad or guilty about your drinking or drug use?

The next questions are about your experience over your whole lifetime…

☐ **Yes** ☐ **No** 14. Have you ever had a drinking or other drug problem?

☐ **Yes** ☐ **No** 15. Have any of your family members ever had a drinking or drug problem?

☐ **Yes** ☐ **No** 16. Do you feel bad or guilty about your drinking or drug use?

Your therapist will complete this section.

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 5	___ 8	___ 11	___ 14
___ 3	___ 6	___ 9	___ 12	___ 16
___ 4	___ 7	___ 10	___ 13	___ Total Score (score range 0-14)

Score	Degree of Risk for AOD Abuse (Preliminary Interpretation of Responses)				
0-1	none to low	2-3	Minimal	4 & >	Moderate to high possible need for further assessment

DATE: _____

Mid-Plains Center for Behavioral Healthcare Services, Inc.

SELF REPORT ON SUBSTANCE USE (Continued)

Thank you for filling out this form. Please fill it out as honestly and completely as possible. Your answers are confidential. Here are instructions and an example of how to fill it out. **If you have questions, please ask for help.**

- ☐ Start at the column on the left. If you have never used a substance, write none on that line and go to the next substance listed. Please write an answer for any drug you have tried, even once.

1. If you have ever tried a substance, go to the right and write in that space when the last time you used it was. Then move to the next column, to the right.

- ☐ If you have used in the last month, how long ago did you use? How many times did you use this month?
- ☐ Then go to the next column. How old were you when you first drank or used the drug?
- ☐ Then go to the next column. How did you use it? Did you drink, or smoke, or inhale, or shoot the drug IV?
- ☐ Move on to the next column. What is the average amount you used? What is the most you ever used?
- ☐ Did you ever have any problems because of using? Problems with the law, your job, your health or relationships?
- ☐ Then move down to the next substance and answer the same questions for it.

SUBSTANCE (DRUG)	LAST TIME YOU USED IT	USED IN THE PAST MONTH? WHEN?	AGE WHEN FIRST USED	HOW USED? (SMOKE, ORAL, IV?)	AVERAGE & MOST AMOUNT USED	PROBLEMS FROM USE? (LAW, JOB, HEALTH)
Alcohol						
Cocaine or crack						
Marijuana/ hash/ pot						
Heroin						
Opium/synthetics						
PCP or Angel Dust						
Hallucinogens (like LSD or mushrooms)						
Methamphetamines						
Other Stimulants						
Benzodiazepines (Valium, Xanax, Ativan)						
Other Tranquilizers						
Barbiturates						
Inhalants (huffing)						
Nicotine						
Other, including abuse of prescription or over the counter medication? : List what you used: _____ _____ _____						

Mid-Plains Center for Behavioral Healthcare Services, Inc.

Region 3 Behavioral Health Services
Eligibility Worksheet for NBHS Funded Services

An initial Eligibility Worksheet must be completed at admission or as soon as possible after admission and must be completed annually thereafter. You may not bill the Region or DHHS for any services for this consumer until Financial Eligility has been established. The worksheet does not need to be completed for services listed on the Emergency Access Services Fee Schedule.

Consumer Name: _____

Is the consumer covered by any of the following? (must check one):

___Private Insurance ___Affordable Care Act (aka Obamacare) ___Medicaid ___Medicare ___Other_____ ___None

Does the above coverage pay for this service? (must check one) **Yes __ No__**

Will filing the insurance pose a risk to the consumer? (Domestic Violence, child abuse or other danger occurring) **Yes____ No ____**

Taxable Monthly Income

Annual Income _____ (Can be computed by dividing annual income by 12)

Less Monthly Total Allowable Liabiilities:

Housing : Monthly rent/lease/ mortgage amount, not to exceed $504 per (Limited to the home or apartment the consumer currently occupies) _____

Utilities: For the house/apartment reflected above, if the utilities are not included in rent/lease amount:
Monthly utilities, not to exeed $452 per month _____
OR
For the house/apartment reflected above, if only a portion of utilities are included in rent/lease amount:
Monthly utilities, not to exeed $204 per month _____

(Utilities refers to heating & cooking fuel, air conditioning, septic tank, water, sewage, trash & basic telephone only)

Transportation: Car payment and average gasoline cost or cost of public transportation, not to exceed $250 per month _____

Daycare: (if paying a 3rd Party)
$200 for each child age one or younger (Number of children ____ x $200) _____
$175 for each child age two or older (Number of children ____ x $175) _____

Total Allowable Liabilities: $ -

Adjusted Monthly Income to be used to determine Eligibility for NBHS funded services: **$ -**
(Taxable Monthly Income less Monthly Total Allowable Liabilities)

Total Number of family members dependent on taxable income: _____
(consumer + spouse (if applicable) + # children (if applicable))

Copayment Amount: (must include) $ _____

By signing this form, I am verifying the above amounts are correct to the best of my knowledge.

Consumer signature _____ Date _____

Note: You may be asked to supply documents for verification of income and liabilities claimed.

Staff Person _____ Date _____

For Agency Use Only:

20% of Adjusted Monthly Income = $ -
(20% is reference for maximum monthly Hardship Copay Only)

Consumer is eligible for Hardship Fee Schedule due to:

_____ SPMI
_____ SED
_____ Medical Bills or Medical Debt in excess of 10% of the taxable annual income
(Taxable Monthly Income x 12 x 10%)

United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States.

— OR —

☐ I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: _____, and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME	_____ (first, middle, last)
SIGNATURE	_____
DATE	_____

Mid-Plains Center for Behavioral Healthcare Services, Inc.

AGENCY VOTER REGISTRATION

I am already a registered voter and there have been no changes: _____ yes _____ no
Consumer is a minor child and not eligible to vote: _____ yes _____ no

Please sign and date below

If you decline to register to vote or decide to register to vote, please note that the information and office to which application was made will remain confidential and be used only for voter registration purposes.

_____ _____
Printed name of applicant or declinee Signature of applicant or declinee Date

To be eligible to register to vote in Nebraska you must:

Be a United States Citizen
Be at least 18 years of age or will be 18 years of age on or before the first Tuesday after the first Monday of November
Live in the State of Nebraska
Have not been convicted of a felony or, if convicted, civil rights have been restored
Have not officially found to be mentally incompetent

If you are eligible to register to vote but you are not registered to vote where you live now, would you like to apply to register to vote here today? _____ yes _____ no
If you do not check either box, you will be considered to have decided not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance or services you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek help is yours. You may fill out this application in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NEBRASKA SECRETARY OF STATE
STATE CAPITOL BUILDING
LINCOLN, NE 68509-4608
402-471-2554

Voter registration form completed? _____ yes _____ no

Voter registration form given to applicant for later mailing (at applicant's request) _____ yes _____ no

_____ _____
Agency Staff Signature Date

Mid-Plains Center for Behavioral Healthcare Services, Inc.

Achieving Excellence in Behavioral Healthcare!

Accredited By COA Council on Accreditation Founded 1977

Payment & Insurance Information

Consumer Name: **Account/Case #**

- You must bring a copy of your most recent tax return or at least 3 months of pay stubs to verify your gross income. Your fees may be based on family size and income, however, without verification your fee will be set at the standard charge for the service you will receive.
- The consumer is responsible to inform Mid-Plains Center of any changes in income, insurance, Medicaid, and Medicare eligibility. Failing to notify Mid-Plains Center of changes may result in the consumer being charged the full fee for the service.
- For consumers who have insurance, third party payers will be billed at the full fee. Consumers who owe a balance after third party payment will be billed monthly. *Where Medicaid agrees to pay for a service, any payment received will be accepted as payment in full

Gross Annual Income:	**Dependents:**	
Consumer Fee as Determined:	**Standard Charge for Service:**	☐ **Hour** ☐ **Day** ☐ **Contact**

INSURANCE INFORMATION

Insurance Company Name:		☐ **The consumer has no Insurance.**
Insurance Address:		

City:	**State:**	**Zip Code:**	**Phone:**
Insured's Name:	**Insured's DOB:**	**Insured's Employer:**	
Insured ID #	**Insured Group #**		
Consumer Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**			
FOR MEDICAID ONLY:	**Date NMES Contacted:**	**Eligible?** ☐ **Yes** ☐ **No**	

ASSIGNMENT OF BENEFITS

The fee has been explained to me and my signature authorizes Mid-Plains Center to provide services to the person listed as the consumer. My signature authorizes the release of any pertinent information to a third-party payer, if applicable, and assigns benefits to Mid-Plains Center. I understand that fee payment is required at the time of each visit unless other arrangements have been made in advance. Prompt payment will be required and past due accounts will be turned over to collection

SIGNATURES

Consumer or Legal Guardian:	**Date:**
MPC Employee:	**Date:**

MID-PLAINS CENTER FOR BEHAVIORAL HEALTHCARE SERVICES, INC.
CONSUMER RIGHTS AND RESPONSIBILITIES

Facility personnel, psychotherapists, teachers, specialized family support workers, and physicians will observe the human rights of the individual consumers.

In turn, the facility has the right to expect appropriate behavior of the consumer, their relatives, and friends. However, we take into consideration the nature of the person's illness and their ability to behave responsibly and reasonably.

It is the policy of Mid-Plains Center for Behavioral Healthcare Services, Inc. to support the rights of each consumer regardless of race, age, gender, disability, medical condition, national origin, religion, or ability to pay for care. As a consumer at Mid-Plains Center for Behavioral Healthcare Services, Inc. you have the right to respectful care with consideration of the psychosocial, spiritual, and cultural variables that influence the perception of various problems, disorders, and illness. The basic rights of human beings for independence of expression, decision, and action and concern for personal dignity in human relationships are of great importance to facility personnel. During various disorders, illnesses, and distressful situations, the presence of these basic human rights become vital and deciding factors in recovery and successful treatment.

Consumer Rights:

- No person shall be denied impartial access to treatment or accommodations that are available and medically indicated on the basis of such conditions as age, race, color, creed, national origin, or inability to pay for care.
- The consumer has the right to considerate, respectful care at all times and under all circumstances with recognition of his/her personal dignity.
- The consumer has the right to personal privacy as manifested by the right to:
  - Wear appropriate clothing and religious and other symbolic items as long as they do not interfere with his/her treatment.
  - Be interviewed and/or assessed in surroundings designed to assure reasonable privacy.
  - Expect that any discussion or consultation involving his/her case will be conducted discreetly and the individuals not directly involved with his/her care will not be present without consumer's permission.
  - Have his/her medical records read only by individuals directly involved in consumer's treatment and the monitoring of its quality; and other individuals only on written authorization or that of consumer's legally authorized representatives.
  - Expect all communication and other records pertaining to consumer's care including the source of payment for treatment to be treated as confidential.
  - Request a transfer to another psychotherapist or psychiatrist.
  - Be placed in protective privacy when considered necessary and requested by the consumer for personal safety.
- The consumer has the right to expect reasonable safety in our clinical/mental health practices and environment. The consumer has the right to know the identity and professional status of individuals providing his/her service. This includes the consumer's right to know the existence of any professional relationship among individuals who are treating him/her as well as the relationship of our center to any other health care or educational institutions involved in his/her care.
- When a consumer does not speak or understand the language of the community, such consumer will have access to an interpreter. The list of interpreters will be provided at the front desk. A listing of employees is also available, as is phone service through the Department of Health and Human Services.
- The consumer has a right to know who is responsible for authorizing further assessments and referrals for other treatment.
- The consumer has the right to consult with a specialist, at his/her request and expense.
- The consumer may refuse treatment to the extent permitted by law, and to be informed of the consequences of refusal.
- The consumer may not be transferred to another clinical facility unless he/she has received a complete explanation of the need for the transfer, the alternatives to a transfer, and unless the transfer is acceptable to another mental health/psychiatric facility.
- Consumers may insert a statement into their record about their problems or about services they are receiving or may wish to receive. This agency will add these statements and responses with the consumers' knowledge.
- The consumer has the right to request and receive an itemized and detailed explanation of his/her total bill for services rendered by the center, regardless of the source of payment for care.
- The consumer has the right to request access to records.
- As a consumer, parent, or guardian you have the right to ask for further consultation or a peer review of treatment being received.
- Consumers will not participate in research projects without following appropriate protocol approved by the executive committee and regional board.
- The right to a reasonable response to request for services; and to be informed of the procedure to file a grievance.
- The consumer, and in the case of a consumer who is a minor, both the consumer and his/her parent or guardian, has a right to refuse to: 1) participate in public performances, 2) make public statements which express gratitude to Mid-Plains Center, and 3) be identified in any form for the purposes of Mid-Plains Center's public relations. No consumer shall be coerced, directly or indirectly, into engaging in or supporting any Mid-Plains Center activities.

Consumer Responsibilities:

- The consumer has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health and family. He/she has the responsibility to report unexpected changes in his/her condition to his/her responsible practitioner. The consumer is responsible for making it known whether or not he/she clearly comprehends the treatment plan and what is expected of him/her.
- The consumer is responsible for following the treatment recommended by the practitioner primarily responsible for his/her care. This may include following the instructions of medical doctors, psychiatrists, nurse practitioners and therapists as they carry out the coordinated plan of care.
- The consumer is responsible for his/her actions if he/she refuses treatment or does not follow instructions.
- The consumer is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.
- The consumer is responsible for following the Mid-Plains Center for Behavioral Healthcare Services, Inc. rules and regulations affecting consumer care and conduct.
- The consumer is responsible for being considerate of the rights of other consumers and facility personnel as well as facility property.
- The consumer is responsible for personal belongings brought into the clinic.
- 24-hour notice is requested if a consumer needs to cancel an appointment. Chronic cancellations or no-shows may require that the therapist and consumer reassess their readiness and need for continued therapy. If you fail to show up for your initial medical evaluation, you will not be rescheduled; however, you may be placed on a standby list if you want to be notified of the next available time and believe that you can be there on time for that appointment.
- As a parent or guardian of a child at the center, you have the following rights:
- You have the right to visit your child or call a therapist at any time during office hours. You have the right to receive information needed to give necessary consent for your child's medical treatment and participate in developing your child's care plan, to the extent permitted by law.
- You have the right to refuse medical treatment for your child to the extent permitted by law. You also have the right to know how this refusal may affect your child's medical and emotional condition.
- Responsibilities of a parent or guardian:
- You have the responsibility to provide complete and accurate information about you and your child's health.
- As a parent or guardian you have the responsibility to be available to clinical staff for consultation and decision-making.
- You have the responsibility to notify caregivers of any change in your health or your child's health, including reporting new or changing information about your health or existing symptoms.
- You have the responsibility to ask questions if you do not understand your diagnosis, psychiatric treatment, counseling, or psychotherapy, or instruction.
- You have the responsibility to tell people involved with your care if you are not satisfied at any time during your treatment or your child's treatment.
- If you refuse treatment, or treatment for your child, or do not follow the plan of care, you are responsible for the consequences, which may occur as a result.
- You share responsibility with Mid-Plains Center and its staff for your treatment, your child's treatment and care. This includes your responsibility to follow the plan of care agreed upon for you or your child, which may include medication or behavioral changes.
- As a parent or guardian, you have the responsibility to respect the rights, privacy, and confidentiality of others.
- Consumers, parents, or guardians who feel their rights have not been respected or who have questions or concerns should talk to their service provider, or the provider's supervisor.

If you feel your concerns have not been adequately addressed or heard, please contact the President & CEO of Mid-Plains Center for Behavioral Healthcare Services, Inc., Corrie Edwards, at 308-395-1044.

Grievance Procedure

If consumers disagree with treatment decisions or practices and procedures at Mid-Plains Center, they have the right to appeal. If consumers believe they have been treated unethically or illegally, consumers are encouraged to follow the grievance procedure as listed below.

- Consumers with a grievance should first attempt to resolve the grievance informally with the staff member concerned, or the staff member's program supervisor.
- If this is unsatisfactory, the consumer should write a brief statement about the problem and submit it to the Director of Quality Improvement. The Director of Quality Improvement will respond to the written statement within two weeks, unless the consumer is admitted into the Crisis Stabilization Unit, the response time will be two business days. The Director of Quality Improvement will attempt to resolve the issue informally by meeting with the consumer and the staff member involved within 30 days. The Director of Quality Improvement will write a summary of resolution and send a copy to the consumer, staff member involved, and the President and CEO of Mid-Plains Center.

. If the consumer is still unsatisfied with this process, he/she may request a formal conference with the President and CEO. After the meeting with the President/CEO, the consumer will receive a written response to the final decision within two weeks.

Consumers also have the right to request changes in their service provider. The first step in this process is for the consumer to inform the current service provider in person that the consumer wishes to change to another care provider. If the consumer experiences difficulties or is unsatisfied with the response given them by the current

service provider, the consumer may take the matter up with the care provider's Program Supervisor (inquire at the Front Desk).

Research:

Any information obtained as part of a research study is confidential. This information may be generalized and used in reports. (e. g. number of days attended school and grades as an indicator of progress in that system.)

Informed refusal:

You may, of course, refuse services. There are risks and benefits to refusing services. Benefits: By refusing services you avoid the risk of 'physician' induced harm. You avoid the discomfort of change. Risks: By refusing services you risk making the 'symptoms' that brought you to seek services increase in frequency, duration, and/or intensity.

Informed Consent

'Informed consent' is a phrase that refers to the fact that you cannot truly agree to anything without knowing what you are agreeing too. You are applying for services with Mid-Plains Center for Behavioral Health Services, Incorporated. You should know that Mid-Plains Center has a commitment to provide quality services of various natures to all individuals without regard to race, color, religion, national origin, gender, age, sexual orientation, or disabilities.

Mid-Plains Center has an obligation to inform you of the purposes, goals, techniques, procedures, limitations, potential risks, alternatives and benefits of services to be performed.

Before you consent to treatment you should have discussed the nature of the choices available to you including: financial issues, duration of treatment, qualifications of the service providers, what is and is not confidential, and how treatment will be terminated. To this end, Mid-Plains Center has developed a list of consumer rights and obligations as part of informing your consent.

In some instances, Mid-Plains Center may obtain information from you that invokes a duty to warn others of your behavior, thoughts, or intentions. Most notably, this involves information that would indicate you are a clear and present danger to yourself or others. An exception to this 'present' danger is information about past child abuse. This must be reported to law enforcement and is the only instance of past behavior that must be reported.

Your records are confidential. Information you provide directly (by statement or document) or indirectly (e.g. test or assessment results) will be protected from unwarranted disclosures within the agency and outside it. Your consent must be obtained before any of your information is shared. Any information asked for will be specific and will release only the information listed in that request. Your consent is not required when a court orders specific information.

HIPPA (Health Insurance Probability and Accountability Act) the federal law that protects personal and medical information and recognizes the rights to relevant medical information of family caregivers and others directly involved in paying for care.

Use of Medication: Your provider may refer you to the Nurse Practitioner or Psychiatrist for a medication evaluation. If medication is prescribed, you have the right to refuse. If you refuse, your medical provider will explain the consequences and how this may affect your course of treatment. If you choose to take the medication, you have the right to receive information that covers the following:

- Name of medication along with dosage, route,
- & frequency
- Potential side effects
- Duration
- Availability of refills
- Expected action of the drug therapy
- Any other information specific to you and/or the medication

Fundamental to informed consent is the concept of autonomy. You are the most important person to be consulted about decisions regarding you, your health, your information, and your treatment. Nothing can happen without your consent and active involvement.

****

As a consumer of Mid-Plains Center you have the right to have your questions answered before signing any of the forms. Your signature below indicates that your questions, if any, have been answered to your satisfaction, and that you are also acknowledging receipt of a copy of the following forms:

- **Consumer's Rights and Responsibilities**
- **Grievance Procedure**
- **Informed Consent**
- **Notice of Information Practices (HIPAA)**
- **Tele-health Information**

Consumer or Legal Guardian

_____

Date

_____

Witness

Mid-Plains Center for Behavioral Healthcare Services, Inc.

Achieving Excellence in Behavioral Healthcare!

Accredited By COA Council on Accreditation Founded 1977

Admission Acknowledgment Form

Client Name:_____

Mid Plains Center strives to ensure that each consumer is involved in his/her care decisions. As a consumer you have the right to have all your questions answered prior to signing any forms or beginning a course of treatment and understand that fee payment is required at the time of each visit unless other arrangements have been made in advance. Prompt payment will be required and past due accounts will be turned over to collection. Further, you have the right to be instructed on the benefits and risks of the treatment that you are consenting to, and at any time you have the choice to change or discontinue the treatment. Your signature authorizes the release of any pertinent information to a third-party payer, if applicable, and assigns benefits to Mid-Plains Center.

☐ CSU	☐ Outpatient Services	
☐ IFP	☐ Transitional Living	☐ Day Living
☐ Opioid Clinic	☐ MST	☐ Crisis Support

STATEMENT OF COMMITMENT AND AUTHORIZATION

I acknowledge that I have been offered copies of the documents listed below. My signature indicates that any questions have been answered satisfactorily.

- Consumer Rights & Responsibilities
- Grievance Procedure
- Informed Consent
- Notice of Information Practices (HIPAA)
- Acceptable Use Agreement Form
- Acknowledgment of Expectations
- Acknowledgment of Surveillance
- Authorizations and Release for Transportation
- Consent to Participate

IF CONSUMER IS A MINOR, my signature below also consents to the admission of my child into the program of service identified above. I understand that my involvement and commitment to my child is critical and that continued eligibility for services is contingent upon my agreeing to notify my service provider prior to any major decisions being made.

My signature further acknowledges my commitment to keeping my child in the family home, and that this will be a priority throughout the treatment process. Out of home placement will not be an option until all other possible remedies have been exhausted.

Consumer:_____ **Date:**_____

Parent/Guardian:_____ **Date:**_____

MPC Staff:_____ **Date:**_____