PERMIACARE

401 E. Illinois
Midland, Texas
432-570-3333

Greetings,

The following forms are what may be used for registration and during the course of treatment. Not all forms may be applicable to you. They are provided for informational purposes, so that our patients may review them ahead of time. The applicable forms will be reviewed with you by PermiaCare staff during treatment to ensure you understand all information being presented.

2025 HEALTH AND HUMAN SERVICES COMMISSION
Local Authority Monthly Ability to Pay Fee Schedule

26 TAC, Section 301.517
26 TAC, Section 301.111

Maximum Monthly Fee By Family Size

Effective February 7, 2025

Annual Gross Income	Monthly Gross Income	1	2	3	4	5	6	7	8	9+	% monthly income family size 1
15,650	1,304	0	0	0	0	0	0	0	0	0	
23,475	1,956	47	0	0	0	0	0	0	0	0	2.50%
26,225	2,185	56	0	0	0	0	0	0	0	0	2.66%
28,975	2,415	66	0	0	0	0	0	0	0	0	2.82%
31,725	2,644	76	47	0	0	0	0	0	0	0	2.98%
34,475	2,873	87	56	0	0	0	0	0	0	0	3.14%
37,225	3,102	99	66	0	0	0	0	0	0	0	3.30%
39,975	3,331	112	76	47	0	0	0	0	0	0	3.46%
42,725	3,560	125	87	56	0	0	0	0	0	0	3.62%
45,475	3,790	139	99	66	0	0	0	0	0	0	3.78%
48,225	4,019	154	112	76	47	0	0	0	0	0	3.94%
50,975	4,248	169	125	87	56	0	0	0	0	0	4.10%
53,725	4,477	185	139	99	66	0	0	0	0	0	4.26%
56,475	4,706	202	154	112	76	47	0	0	0	0	4.42%
59,225	4,935	220	169	125	87	56	0	0	0	0	4.58%
61,975	5,165	238	185	139	99	66	0	0	0	0	4.74%
64,725	5,394	257	202	154	112	76	47	0	0	0	4.90%
67,475	5,623	277	220	169	125	87	56	0	0	0	5.06%
70,225	5,852	297	238	185	139	99	66	0	0	0	5.22%
72,975	6,081	318	257	202	154	112	76	47	0	0	5.38%
75,725	6,310	340	277	220	169	125	87	56	0	0	5.54%
78,475	6,540	363	297	238	185	139	99	66	0	0	5.70%
81,225	6,769	386	318	257	202	154	112	76	47	0	5.86%
83,975	6,998	410	340	277	220	169	125	87	56	0	6.02%
86,725	7,227	435	363	297	238	185	139	99	66	0	6.18%
89,475	7,456	460	386	318	257	202	154	112	76	47	6.34%
92,225	7,685	487	410	340	277	220	169	125	87	56	6.50%
94,975	7,915	514	435	363	297	238	185	139	99	66	6.66%
97,725	8,144	541	460	386	318	257	202	154	112	76	6.82%
100,475	8,373	570	487	410	340	277	220	169	125	87	6.98%
103,225	8,602	599	514	435	363	297	238	185	139	99	7.14%
105,975	8,831	628	541	460	386	318	257	202	154	112	7.30%
108,725	9,060	659	570	487	410	340	277	220	169	125	7.46%
111,475	9,290	690	599	514	435	363	297	238	185	139	7.62%
114,225	9,519	722	628	541	460	386	318	257	202	154	7.78%
116,975	9,748	755	659	570	487	410	340	277	220	169	7.94%
119,725	9,977	788	690	599	514	435	363	297	238	185	8.10%
122,475	10,206	822	722	628	541	460	386	318	257	202	8.26%
125,225	10,435	857	755	659	570	487	410	340	277	220	8.42%
127,975	10,665	892	788	690	599	514	435	363	297	238	8.58%
130,725	10,894	929	822	722	628	541	460	386	318	257	8.74%
133,475	11,123	966	857	755	659	570	487	410	340	277	8.90%
136,225	11,352	1,003	892	788	690	599	514	435	363	297	9.06%
138,975	11,581	1,042	929	822	722	628	541	460	386	318	9.22%
141,725	11,810	1,081	966	857	755	659	570	487	410	340	9.38%
144,475	12,040	1,121	1,003	892	788	690	599	514	435	363	9.54%
147,225	12,269	1,161	1,042	929	822	722	628	541	460	386	9.70%
149,975	12,498	1,202	1,081	966	857	755	659	570	487	410	9.86%
152,725	12,727	1,244	1,121	1,003	892	788	690	599	514	435	10.02%
155,475	12,956	1,287	1,161	1,042	929	822	722	628	541	460	10.18%
158,225	13,185	1,330	1,202	1,081	966	857	755	659	570	487	10.34%
160,975	13,415	1,375	1,244	1,121	1,003	892	788	690	599	514	10.50%
163,725	13,644	1,419	1,287	1,161	1,042	929	822	722	628	541	10.66%
166,475	13,873	1,465	1,330	1,202	1,081	966	857	755	659	570	10.82%
169,225	14,102	1,511	1,375	1,244	1,121	1,003	892	788	690	599	10.98%
171,975	14,331	1,558	1,419	1,287	1,161	1,042	929	822	722	628	11.14%
174,725	14,560	1,606	1,465	1,330	1,202	1,081	966	857	755	659	11.30%

PERMIACARE Assessment

Client Name _____

Client ID: _____

Date: _____

CIGARETTE SMOKING STATUS:

- ○ Current every day smoker
- ○ Current some days smoker
- ○ Former smoker
- ○ Never smoker
- ○ Unknown if ever smoked

Do you live with tobacco user(s)? □Yes □No

USE DETAIL:

○ Currently use cigarettes ○ Currently use pipe ○ Currently use cigars ○ Currently use smokeless

○ Currently use other-e-cig/vap, etc.

○ Previously used cigarettes ○ Previously used pipe ○ Previously used cigars

○ Previously used smokeless ○ Previously used other-e-cig/vape, etc.

If other, please specify: _____

Approximate number of years of tobacco use: _____

Amount of tobacco used per day: _____

Have you ever attempted to quit? ○ Yes ○ No

Number of Attempts: _____

Approximate Date of last quit attempt: _____

Methods used in previous quit attempts: ☐ Acupuncture ☐ Counseling ☐ Cognitive Behavioral Therapy ☐ Hypnotherapy ☐ Over the Counter Medication ☐ Prescription Medication ☐ Without Assistance (aka Cold Turkey) ☐ N/A ☐ If Other, please specify:

READINESS TO QUIT:

○ Not interested in quitting ○ Thinking about quitting within next 30 days ○ Ready to quit

REFERRAL:

○ Referred to: PBCC NRT ○ Other Referral ○ No Referral

○ Provided Quitline Card ○ Provided Quit Smoking Brochure

Other : Please specify: _____

I attest that a face to face Tobacco Use Assessment was completed for this individual.

Signature of Staff Member Completing Assessment:

Staff Signature: _____

PERMIACARE
MHMR • ECI • SUBSTANCE ABUSE

Public Health Provider – Charity Care Program Eligibility Notification

Dear (Patient Name): _____ Case# _____

The purpose if this letter is to provide you with information on how the services at PermiaCare are funded, and what your payment responsibilities are if you do not possess private insurance, Medicaid, or Medicare.

If you do not have third party coverage, you will be assigned a Maximum Ability to Pay (MAP) for any month you receive services from PermiaCare. Your maximum monthly payment is based on a sliding fee scale promulgated by the Health and Human Services Commission. This fee is explained to you and noted on your fee assessment, which you may request a copy of from PermiaCare. The fee is calculated utilizing your income and the Federal Poverty Limit (FPL). You will never be asked to pay more than the amount of your MAP.

The remaining cost(s) associated with your care will be covered by the Public Health Provider – Charity Care Program (PHP-CCP). If you are an individual whose income is less the 200 percent of the FPL, then you are eligible for PHP-CCP coverage. The PHP-CCP program is a federally funded program that PermiaCare is eligible to participate in because of our status as a Local Mental Health Authority.

If you are in receipt of this letter, it should be considered formal notification that you are eligible for the PHP-CCP program, and that the cost for services received above your MAP are covered at least partially by this program. Again, you will never be asked to pay more than your MAP.

Please feel free to contact our benefits eligibility department if you have any questions.

Acknowledged: _____ Date: _____

PERMIACARE
CONSENT TO TAKE AND USE PHOTOGRAPHS

Client:_____ **Case No.:**_____

By my signature below, I give PermiaCare my Consent to interview, photograph, film, and/or record _____ for the following uses:
(Name of Individual)

_____
_____
_____

I understand that the materials may be reproduced, reprinted, or republished in any form at any time by this organization, except as restricted by the following ways (for example, time limits or limits in use of the individual's name):

_____
_____
_____

I understand that I may withdraw my Consent or revise the restrictions on it at any time. I also understand that the organization is not liable for any actions taken in reliance on my Consent as given here before the Consent is withdrawn or revised. To withdraw or modify my Consent, I must contact the organization at:

_____
_____
_____

_____ _____
Signature of Client Date Signature of Witness Date

_____
Signature of Parent or Legally Authorized Representative Date

PERMIACARE

HIPAA Privacy Notice Acknowledgment Form

Client Name: _____ Case Number: _____

I have received the notice of privacy practices under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Client's Signature Date

PermiaCare use only

Reason for not obtaining notification acknowledgement _____

_____

_____

_____

_____

_____

_____

_____ _____

Staff Signature/Credentials Date

CR565 rev 10/06

PERMIACARE
ADMINISTRATIVE PROCEDURE NO. 1 AD066

Revised	Supersedes	Approved:
9/20/2024	1AD066 8/20/2024	Chris Barnhill Chief Executive Officer

SUBJECT: COMPLAINT/GRIEVANCE PROCEDURE

PURPOSE

To define the grievance procedure for individuals who receive services from PermiaCare programs including programs funded and/or licensed by the Texas Health and Human Services Commission. It is the practice of PermiaCare to provide all individuals served, their legally authorized representatives (LAR) or any other individual, with the person's consent, with a method to express their concerns or dissatisfaction, assistance to do so in a constructive way, and to have those concerns reviewed and resolved.

PROCEDURE

1. All PermiaCare staff are expected ensure our clients receive the best possible service experience. We believe that, to the extent that is reasonable, that our clients should not have to wait on administrative processes to occur in order to have their complaints resolved. If any member of the PermiaCare team is able resolve a complaint on the spot, they should do so.

   A complaint may be made by a client at any time. Whenever a client, their legally authorized representative or any other individual with the client's consent expresses dissatisfaction with any aspect of their service experience, the staff member receiving the complaint will take all reasonable action to resolve the complaint immediately. If the complaint is unable to be resolved to the client's satisfaction, the receiving staff member will assist the client in contacting PermiaCare's Client Rights Advocate to file a formal complaint. This contact may occur via any medium preferred by the client including phone, letter or other written form, email, etc. All complaints related to client rights are to be forwarded to the Client Rights Advocate for appropriate action and tracking.

   When a client desires to submit a grievance in writing but is unable to read or write, PermiaCare staff will provide assistance in generating the complaint. Any client may request writing materials, postage, and access to a telephone for the purpose of

filing a grievance, which will be provided by PermiaCare

2. At the time of admission into services and on an annual basis thereafter, PermiaCare will provide all individuals served and their legally authorized representatives written notification in a language or method understood by the individual of PermiaCare's grievance resolution procedure. This notification shall explain:

    a. an easily understood process to request a review of their concerns or dissatisfaction
    b. how the person may receive assistance in requesting the review
    c. that PermiaCare staff are available to assist throughout the process
    d. the timeframes for the review; and
    e. the method by which the person is informed of the outcome of that review.

3. A complaint may include but is not limited to, issues related to:

    a. safety
    b. rights infringement
    c. unsatisfactory treatment by a staff member
    d. the safety service sites
    e. the functionality service sites
    f. the cleanliness of service sites
    g. the accessibility of service sites
    h. the accessibility of service hours
    i. concerns about the quality of services provided
    j. service request denials
    k. adverse determinations.

    Applicable staff including administrators, program directors, or supervisors will be notified immediately when complaints involving abuse, safety, or health issues are received.

4. Complaints involving abuse, neglect, or exploitation will be referred immediately to the Texas Department of Protective and Regulatory Services (TDPRS).

5. Contact information for PermiaCare's Client Rights Advocate and a copy of this procedure will be conspicuously displayed at every service location operated by PermiaCare.

6. When made aware of a complaint, PermiaCare's Client Rights Advocate contact the

individual within 24 hours and will inform the complainant about the complaint process, including expected timelines. The Client Rights Advocate (CRA) will provide a written response to the client within 7 days of receiving the grievance and will take action to resolve all grievances promptly and fairly. At no time will any employee or representative of PermiaCare restrict, discourage, or interfere with client communication with an attorney or with the HHSC for the purposes of filing a grievance.

The Client Rights Advocate will begin their action on the complaint within one business day of receipt. PermiaCare has a target of less than 10 days for the resolution of all complaints. The Client Rights Advocate will remain in communication with the client throughout the complaint resolution process. This Client Rights Advocate may contact the complainant during this process in order to gather more information. At the end of the Client Rights Advocate's investigation, the client will be contacted and made aware of disposition of their complaint.

7. In addition to ensuring that client complaints are resolved, the Client Rights Advocate is also responsible for tracking and documenting all complaints through the process, from receipt to final resolution. Resolution in this procedure means making a determination as to whether a complaint is substantiated, not substantiated, or unable to be substantiated. The Client Rights Advocate will work with the client and Center staff to ensure, in every instance where it is possible and reasonable, that the complainant is satisfied with the outcome of their complaint, regardless of the disposition of the resolution. At all times the complainant will maintain the right to contact the appropriate oversight organization directly regarding their complaint.

8. The Client Rights Advocate will aggregate and regularly report on complaints to PermiaCare's Chief Executive Officer. This report will include instances where clients were not satisfied with the outcome of their complaint. The CEO will evaluate these to determine whether or not the issue warrants systemic correction.

9. The complaint resolution process is reviewed with the individual served and/or their legally authorized representative in their primary language at the onset of services and annually thereafter.

10. At any time during this process, the individual served, or their LAR may contact HHSC at

Health and Human Services Commission
Compliant and Incident Intake
Mail Code E-249

P.O. Box 149030
Austin, TX 78714-9030

Compliant Hotline: 1-800-458-9858, option 6
Email: cii.sa@hhs.texas.gov
Fax: 883-709-5735

Clients may submit complaints directly to HHS at any time using the contact information above.

11. PermiaCare staff will not retaliate against clients who exercise their right to file a grievance, nor will they restrict or discourage a client from exercising this right.

PERMIACARE NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Drug Abuse Prevention, Treatment, and Rehabilitation Act

THIS NOTICE DESCRIBES

- **HOW YOUR MEDICAL AND HEALTH INFORMATION MAY BE USED AND DISCLOSED**
- **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**
- **HOW TO FILE A COMPLAINT CONCERING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION**
- **YOUR RIGHTS CONCERNING YOUR INFORMATION, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

PLEASE REVIEW THIS INFORMATION CAREFULLY.

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE AND TO DISCUSS IT WITH THE CILENT RIGHTS ADVOCATE AT 432-570-3333 IF YOU HAVE ANY QUESTIONS.

When you receive treatment from PermiaCare, we will obtain and/or create health information about you. Health information includes any information that relates to (1) your past, present, or future physical or mental health condition; (2) the health care provided to you; and (3) the past, present, or future payment for your health care.

This notice tells you about PermiaCare's duty to protect your health information, your privacy rights, and how your health information may be disclosed.

PermiaCare's Duties:

- The law requires us to protect the privacy of your health information. We will not use or let unauthorized people see your health information without your permission except in the ways stated in this notice. We will protect your health information and keep it private. This protection applies to all health information we have about you, no matter when or where you received or sought services. We will not tell anyone if you sought, receive, or have ever received services from us, unless the law requires or allows for that sharing.
- We will ask you for your written permission (authorization) to use or share your health information. There are times when your health information may be shared without your permission, as explained in this notice. If you give permission to share your health information, you may take it back that permission at any time. If you take back your permission, PermiaCare will no longer share your health information. To take back your permission once given, give signed, written notice to PermiaCare with the date, the purpose for the permission, and notice saying that you want to revoke your permission.
- PermiaCare must provide you with this notice of our legal duties and privacy practices. We must do what this notice says. We will ask you to sign a form that says you have received this notice. We may change the contents of this notice. If it is changed, we will have copies of the new notice at our facilities and on our website, www.permiacare.org. The new notice will apply to all health information PermiaCare has, no matter when the information was created or received.
- PermiaCare staff protect the privacy of your health information as part of their jobs. PermiaCare staff do not see your health information unless they need it as part of their jobs. Any staff person who does not protect the privacy of patient health information will face consequences. PermiaCare

will not disclose information about you related to HIV/AIDS without your specific written permission, unless the law provides authorization.

- If a data incident occurs that impacts your health information, you will be notified.
- If you are being treated for alcohol or substance abuse, those records are protected by federal law [Code of Federal Regulations C.F.R Title 42, Part 2]. Breaking these laws that protect alcohol or substance abuse treatment records is a crime. If you think a violation may have happened, you may report to the authorities in this notice. Federal law does not provide protection for information about a crime or threat to commit a crime at PermiaCare or against PermiaCare staff. Federal law does not protect information about suspected child abuse or neglect from being reported under law to proper authorities.

Your Privacy Rights at PermiaCare

- You can review or get a copy of your health information from PermiaCare. Sometimes there are reasons why PermiaCare cannot provide a copy of your health information. If this happens, PermiaCare will tell you why in writing. You can appeal this decision in some situations. You can choose to get a summary of your health information instead of a copy. If you want a summary or a copy of your health information PermiaCare may charge a fair fee.
- You can ask us to make corrections to your records if you think the information is wrong. PermiaCare will add the correct information to your record and make a note in your records that you have provided the information. Information that already was in the record will not be removed or changed.
- You can ask for a list of when your health information has been released by PermiaCare over the last six years. In keeping with federal law, the list will not include times your information was released for treatment, payment, health care operations, national security, law enforcement, or releases made with your permission. There will be no charge for one list per year.
- You may ask PermiaCare to limit the ways your health information is used or shared. PermiaCare will consider your request, but the law does not require us to agree to it. PermiaCare cannot agree to limit the uses or sharing of information that are required by law. If we do agree, we will put the agreement in writing and follow it, except in cases of emergency.
- You can ask PermiaCare to contact you in a way that is preferred by you. We will meet your request as long as it is reasonable.
- You can choose someone to act for you.
- You can get a copy of this notice any time you ask for it.

Treatment, Payment, and Health Care Operations

We may use or release your health information without your consent to provide care to you, to get payment for that care, or for health care operations. Details about what these words mean is included below.

Treatment: We can use or release your health information to provide, organize, or manage health care or other related services. This includes giving care to you, reviewing your case with other health care providers, and referring you to other providers. We may also contact you to remind you of upcoming appointments, to offer treatment options, or to give you other health information that may interest you unless you request for this not to happen.

Payment: We may use or release your health information to get payment for providing health care to you or to provide care to you under a health plan such as the Medicaid program.

Health Care Operations: We may also use your health information for healthcare operations:

- Activities to improve health care/
- Reviewing programs;
- Writing procedures;
- Case management and care coordination;

- Reviewing the competence, qualifications, and performance of our staff;
- Conducting training programs and solving conflict within PermiaCare;
- Conducting accreditation, certification, licensing, or credentialing activities;
- Providing medical review, legal services, or auditing functions; and
- Business planning and management or general administration.

Unless you are receiving treatment for alcohol or drug abuse, PermiaCare may use or disclose your health information without your permission for the following purposes.

- **When required by law.** We may use or release your health information as required by state or federal law.
- **To report suspected child abuse or neglect**. We may disclose your health information to a government authority, if necessary, to report suspected abuse or neglect of a child.
- **For serious threats to health or safety.** We may use or release your health information to medical or law enforcement personnel if you or someone else are in danger and the information is necessary to prevent physical harm.
- **For research.** We may use or release health information if a research board review confirms it can be used for a research project if information identifying you is removed from the health information. Information that identifies you will be kept confidential.
- **To a government authority if we think that you are a victim of abuse.** We may release your health information to a person legally authorized to investigate a report that you have been abused or have been denied your rights.
- **Disability Rights Texas** We may disclose your health information to Disability Rights Texas, in keeping with federal law, to investigate a complaint by you or on your behalf.
- **For public health and health oversight activities**. We may release your health information when we are required to collect information about diseases or injuries, for public health reviews, or to report vital statistics.
- **To comply with legal requirements.** We may release your health information to a staff member or agent of a doctor or other professional who is treating you, to comply with statutory, licensing, or accreditation requirements, as long as your information is protected and is not disclosed for any other reason.
- **For purposes relating to death.** If you die, we may release health information about you to your personal representative and to coroners or medical examiners to identify you or determine the cause of death.
- **To a correctional institution**. If you are in a correctional institution, we may release your health information to the institution so they may provide health care to you.
- **For government benefit programs.** We may use or disclose your health information as needed to operate a government benefit program, such as Medicaid.
- **To your legally authorized representative (LAR).** We may share your health information with a person appointed by a court to represent your interests.
- **If you are receiving services for intellectual and developmental disabilities,** we may give health information about your current physical and mental condition to your parent, guardian, relative, or friend.
- **In judicial and administrative proceedings.** We may release your health information in any criminal or civil proceeding if a court or administrative judge has issued an order or subpoena that requires us to release it. Some types of court or administrative proceedings where we may disclose your health information are:
  - -- **Commitment proceedings** for involuntary commitment or for court-ordered treatment or services.
  - -- **Court-ordered examinations** for a mental or emotional condition or disorder.
  - -- **Proceedings regarding abuse or neglect** of a resident of an institution.
  - -- **License revocation proceedings** against a doctor or other professional.
- **To the Secretary of Health and Human Services.** We must disclose your health information to the United States Department of Health and Human Services when requested in order to enforce the privacy laws.

If you are also being treated for alcohol or drug abuse, PermiaCare will not inform any unauthorized person outside that you have been admitted to PermiaCare or that you are being treated for alcohol or drug abuse, without your written permission. We will not disclose any information identifying you as an alcohol, drug, or substance user, except as required or allowed by law.

PermiaCare may only disclose information about your treatment for alcohol or drug abuse without your permission in the following circumstances:

- To comply with a special court order that was issued under 42 Code of Federal Regulations Part 2 Subpart E;
- To medical personnel in a medical emergency;
- To qualified people for research, audit, or program evaluation;
- To report suspected child abuse or neglect;
- To Disability Rights Texas and/or the Texas Department of Protective and Regulatory Services, as allowed by law, to investigate a report that you have been abused or have been denied your rights.

Federal and State laws prohibit redisclosure of information about alcohol or drug abuse treatment without your permission.

Other privacy rights when you are being treated for alcohol or drug abuse:

One consent is needed to share records for treatment, payment, and healthcare operation.

The receiving organization may share your records after consent is obtained.

Consent for treatment, payment, and healthcare operations can be revoked at any time in writing.

You can opt out of sharing your information for fundraising purposes.

You have rights over your records and these rights can be explained to you.

You will be notified if a record breach occurs.

Your records may or may not be shared to be used against you for civil, administrative, criminal, or legislative proceedings.

COMPLAINT PROCESS:

If you believe that PermiaCare has violated your privacy rights, you have the right to file a complaint. You may complain by contacting:

Amber Johnson
(432) 570-3333
401 E. Illinois
Midland, TX 79701

You may also file a complaint with:

HHS Office of the Ombudsman
(877) 787-8999
hhs.texas.gov/ombudsman
P.O. Box 13247
Austin, Texas 78711

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775
www.hhs.gov/ocr/privacy/hipaa/compliants

You must file your complaint within 180 days of when you knew or should have known about the event that you think violated your privacy rights.

For complaints against alcohol or drug abuse treatment programs, you can also contact:
Health and Human Services Commission
Complaint and Incident Intake

Mail Code E29
P.O. Box 149030
Austin, TX 78714
1-800- 458-9858, option 6
cii.sa@hhs.texas.gov

PermiaCare will not retaliate against you if you file a complaint.

Effective Date: April 23, 2014. Last Revision: 5/2025

Acronyms:

DSHS	**Department of State Health Services**
DFPS	**Department of Family and Protective Services**

PermiaCare

Child and Adolescent Mental Health
COLLATERAL INFORMATION FORM

Client Name: _____ **Case #:** _____

SCHOOL INFORMATION

School Child Currently Attends: _____

School Address: _____

School Telephone: _____

Teacher's Name: _____

Counselor's Name: _____

Principal's Name: _____

PHYSICIAN INFORMATION

Physician's Name: _____

Physician's Telephone: _____

If your child receives services from another agency please indicate by checking which agency below.

_____ **CHILD PROTECTIVE SERVICES**

Case Worker Name: _____

_____ **JUVENILE COURT/PROBATION**

Case Worker Name: _____

_____ **TEXAS YOUTH COMMISSION**

Case Worker Name: _____

_____ **OTHER SOCIAL SERVICE**

Case Worker Name: _____

_____ _____

Parent or LAR Signature Date

PERMIACARE CONSENT FOR A TELEHEALTH CONSULTATION

I have been asked by my health care provider to take part in a telehealth consultation. This will be done with PermiaCare staff.
The purpose is to assess my current condition. This is done through an audio/video link-up with a health care provider at PermiaCare.
I understand that:

1. I, my health care provider, or both of us will talk through the audio/video link with the health care provider at PermiaCare location.
2. Some parts of the session may be completed. I may ask to have the session stopped at anytime.
3. I understand that this procedure will be done through an audio/video link.
4. I understand that there are possible risks with the use of this new technology.
   These include but are not limited to:
   - Interruption or disconnection of the link.
   - A picture that is not clear enough to meet the needs of the consultation.
   - The audio/video link is conducted through the Internet. There is a small chance someone could tap into the consultation.

   If any of these risks occur, the procedure might need to be stopped.
5. I authorize the release of any relevant information that pertains to me to the health care provider at PermiaCare, or their agents. The information may include my name, age, birth date, or other information that is necessary to conduct the telehealth consultation.
6. I understand that this consultation will become part of my medical record kept by PermiaCare.
7. I understand that I will not receive any royalties or other compensation for taking part in the telehelp consultation service.
8. I understand that I must give my informed consent to participate in telehelp consultation services.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand its contents. I volunteer to participate in the above named health care provider. I authorize PermiaCare and the health care providers to perform procedures that may be necessary for my current medical/psychological condition.

_____	_____
Consumer Name (Print)	Consumer ID
_____	_____
Signature of Consumer	Date
_____	_____
Signature of Legal Authorized Representative	Date
_____	_____
Signature of Witness	Date

Authorization for an Individual to Disclose LTSS Screening Information
for Referral to Another Agency/ Organization

Name:	Record Number:
Date of Birth:	Social Security Number:

☒ I acknowledge/authorize PermiaCare to use, disclose, create, transmit, maintain Individual's Information, or Protected Health Information (PHI) obtained when responding to the Long Term Services and Supports (LTSS) Screening and Referral System questions.

Based on the questions, the information provided may contain personal identifying information about the individual named on this form, including, without limitation, descriptions of physical conditions, intellectual disability, mental health or substance use disorder conditions, other treatments, procedures, medications, medical or lab tests and diagnoses, disabilities, pregnancies or drug screens, descriptions of activities of daily living, various functional limitations to those activities of daily living and other Individual and/or Protected Health Information or other benefit related information or existing services.

The responses to the LTSS Screening questions will be shared with agencies or referral organizations that may help meet any potentially identified need for possible future health or community based services.

Expiration Date: Unless revoked earlier, this acknowledgement/ authorization expires on: _____
(shall not exceed six years from date signed)

Signatures:

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative (LAR) Date

_____
Relationship of LAR to Patient

Notice to Individual:

Signing this acknowledgement/ authorization does not guarantee that services will be initiated or provided.

Once you authorize PermiaCare to release your information, PermiaCare is not responsible for any disclosures of the information by the recipient.

You can withdraw permission you have given PermiaCare to use or disclose health information that identifies you, unless PermiaCare has already taken action based on your permission. You must withdraw your permission in writing.

Patient and Family Education Acknowledgement

Client Name: _____ Case# _____

Information Given

____**National Institute of Mental Health (NIMH) Bi-Polar Disorder Packet**

____**National Institute of Mental Health (NIMH) Depressive Disorders Information Packet**

____**National Institute of Mental Health (NIMH) Schizophrenia and Related Disorders Packet**

____**Other (specify)**

_____

_____

_____

Patient Acknowledgement: ***By signing, I acknowledge that I was provided with information related to my or my loved ones mental health disorder. It was adequately explained to me, and I was informed of who to contact should I have any questions.***

_____ _____

Patient Signature **Date**

_____ _____

PermiaCare Staff/Title **Date**

OPPORTUNITY TO REGISTER TO VOTE

1. If you are not registered to vote where you live now, would you like to register to vote here today?

☐ YES ☐ NO

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

3. IF YOU HAVE NOT CHECKED EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO VOTE AT THIS TIME AND WILL BE ASKED TO SIGN BELOW.

4. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private and put in the mail yourself.

5. 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, you may file a complaint with the Elections Division of the Secretary of State, P.O. Box 12060, Austin, Texas 78711, 1-800-252-8683.

6. If you decline to register to vote, this decision will remain confidential and be used only for voter registration purposes.

7. If you decide to register to vote, information regarding the office to which the application was submitted will remain confidential, and again will only be used for voter identification purposes.

DECLINATION OF VOTER REGISTRATION

I decline to register to vote today.

FOR DADS/DSHS USE ONLY:
Applicant Refused to Sign _____
Applicant Unable to Sign _____
Applicant Took Form to Mail ____
(Staff Initial Appropriate Block)

_____ ___/____/___
Signature of Applicant Date

_____
Printed Name of Applicant

Denial of Services Notification

Client Name _____ Case#_____

Date: _____

Based on the Intake Assessment completed on _____, PermiaCare has determined that you do not meet the criteria necessary for admission to PermiaCare's Mental Health Clinic. The reason(s) for this determination is as follows:

(Check all that apply)

___ Does not meet Intervention Need Threshold

___ Does not qualify for level of care

___ Lack of medical necessity

___ Does not reside in catchment area

___ Referred to Bridges

___ Single diagnosis of MR, PDD, or SA Disorder

___ Resident of an ICF or nursing facility

___ Receiving needed services from another provider

___ Refuses Services

The following referral(s) and recommendation(s) were provided:

_____
_____
_____

If you disagree with this decision, you have the right to appeal using the "Notification of Appeals Process" that has been provided to you in writing. Feel free to contact us in the future should your situation and/or symptoms change or become worse.

By signing, you are acknowledging that you understand the reason for denial and that you have received the reason in writing. Your signature does not necessarily mean you agree with the decision.

_____ _____

Client Signature Staff Signature

_____

LAR Signature

PERMIACARE
TREATMENT PLAN
MEDICATION RELATED SERVICES

Client Name: _____ Case #: _____

Date of Plan: _____ RU #: _____

Problem/Need***: (Required***) _____

Objective:

_____ Client will be able to report problems and/or progress in regard to symptomatology at every physician appointment.

_____ Client will demonstrate a reduction in symptoms resulting in discharge from active treatment.

_____ Client will return to the highest level of functioning possible resulting in discharge from active treatment.

Strategy: Client will participate in Medication Related Services provided by the physician and/or Registered Nurse at least once every 90 days for a maximum of 45 minutes or as agreed upon by the consumer and in accordance with physician's orders to include:

_____1103	Administration of Injection
_____1102E	Medication-Related Services (training, administration, monitoring by nursing personnel only)
_____1102A	Pharmacological Management
_____1102B	Medication-Related Services incidental to physician's services
_____1101	Psychiatric Diagnosis
_____142	Case Management
_____1505	Crisis Intervention Services
_____1508$	Flexible Community Supports
_____Q3014	Telemedicine Facilitation
_____1509	Individual Peer Support Services
_____1511	Group Peer Support Services

_____ _____
Client Signature/Date LPHA Signature/Credentials/Title/Date

_____ _____
Parent/Legally Authorized Representative/Date Case Manager's Signature/Credentials/Title/Date

_____ _____
Estimated Achievement Date Date of Next Review

PERMIACARE

Mental Health and Intellectual Disabilities
600 N. Grant Ave. Odessa, Texas 79761
(432) 550-1100 Fax (432) 580-2679

Information Needed for Psychiatric Evaluation

Walk-ins Monday through Thursday, 8:00am – 3:00pm

Choose 1 item in each box:

• Social Security card • Copy of Social Security card
• Driver's license • ID card
Proof of income • W2 form • Last month's check stubs • Letter of the person providing assistance, Form 4506 if applicable, and zero income statement
• Social security letter, if applicable
• Food stamp letter, if applicable
Proof of Residency • Electricity bill • Lease agreement • Correspondence or letter from the person in whose home the applicant lives
• Insurance card or insurance information (if applicable)

Additional child screening requirements:

- Birth certificate
- Notarized letter from the primary caregiver that the parents are absent and agree to be legally and financially responsable (if applicable)
- Custody officer registry (Divorced Parents)
- Child's Social Security card

PermiaCare Smartcare Prod

Consent to MH Services

Client Name: **Client ID:**

DOB: **Effective Date:**

Consent to services

I hereby request and consent to services for myself/dependent which may include, but is not limited to routine/crisis screening, diagnostic assessments, laboratory screens, residential services, and other treatment/services (e.g. counseling, vocational training, field trips, transportation for provided services, etc.) recommended and considered necessary by Permian Basin Community Centers for MHMR/dba PermiaCare. I understand that upon completion of assessments, a more detailed plan of services will be offered to me. I understand that I have the option to accept or reject any recommendations for services. Yes No

I have been informed that any information regarding Permian Basin Community Centers for MHMR/dba PermiaCare is subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that identifying information about me may be exchanged between components of the Texas Health and Human Services (HHSC) delivery system and other designated/contracted providers for continuity of care purposes.

I understand that this consent can be revoked by the undersigned at any time, except to the extent that action has been taken in reliance on them. In order to revoke consent, I will contact my Case Manager/Rehabilitation Service Provider for assistance.

Rights Acknowledgement

I have received a copy of and a complete explanation of my rights as an individual in services of the MHA. I have been informed that my family/guardian/advocate would receive a copy of the rights that have been explained to me. I understand that if I have questions about my rights, I may ask MHA staff for clarification, and all of my rights will be reviewed with me annually.

I have received a copy of the "Handbook of Consumer Rights" Yes No

I have received a copy of the "Rights of the Elderly" Yes No

I have received a copy of the Local Authority "General Public Complaint and Positive Feedback Procedure" Yes No

I have received a copy of the Local Authority "Appeals Procedure" Yes No

Automated Appointment Reminders

I understand that I may receive reminders through automated phone calls, texts or emails. I understand that it is my responsibility to secure the different mediums (voicemail, cell phone, or email account) by which I may receive an automated reminder.

I agree to receive reminders Yes No

Communication for Opportunities to Participate in Improvement of Healthcare Operations

I understand that I may be notified by Permian Basin Community Centers for MHMR/dba PermiaCare of opportunities to participate in programs designed to improve the quality of care. I understand that participation in these programs are voluntary and will not affect the receipt of services in Permian Basin Community Centers for MHMR/dba PermiaCare. I understand that I may receive notifications of these programs through, but not limited to, the following mediums (phone, mail, email, in person).

I agree to be notified of opportunities to participate in improvement of healthcare operations Yes No

Receipt of Notice of Privacy Practices

I have received a copy of the "HIPAA Notice of Privacy Practices" Yes No

Patient Authorization for Release of Information to Regional Health Information Exchange

Permian Basin Community Centers for MHMR/dba PermiaCare securely shares data with regional Health Information Exchanges (HIE) for the purposes of coordination of care, quality improvement of individual's care, and for statistical analysis.

I have reviewed the Patient Authorization specific to the regional HIE that I am receiving services in and authorize the release of information to those HIE or HIEs. Yes No

For Medicaid Recipients Only

Patient Authorization to review and receive information for the Medicaid Eligibility Health Information System (MEHIS) for the multiple purposes of: Yes No

1. Enables verification of Medicaid patient eligibility.
2. Allows provider staff to check-in patients at time of appointment
3. Reduces duplication of services and aides in better coordination of care
4. Provides the ability for providers and their delegates to view a patient's:
    a. Health Summary page
    b. Vaccination information
    c. Prescription drug information
    d. Health events, including diagnosis and treatment
    e. Lab information

I understand these statements Yes No

Disability Forms

Psychiatric evaluations are conducted for the purpose of delivering clinical care and/or for determining the necessary level of care, and are not designed to evaluate for the presence or absence of a disability. Therefore, Permian Basin Community Centers for MHMR/dba PermiaCare psychiatrists may provide treatment records, but will not complete forms that request a determination of a disability, or that relate to a request for a benefit based on presence or level of disability.

I understand these statements Yes No

Opportunity to Register to Vote

I was given the opportunity to register to vote upon admission to services Yes No

Clinician: **Signature Date:**

Permian Basin Community Centers for MHMR/dba PermiaCare

PermiaCare MH Consents

Client Name **Client ID:**

DOB: **Effective Date:**

Y/N Client's Consents and Rights Intake and Annual

CONSENT FOR SERVICES

I hereby request and consent to services for myself/dependent recommended and considered necessary by PermiaCare Services. I understand that upon completion of assessments, a more detailed plan of services will be offered to me. I understand that I have the option to accept or reject any recommendations for services.

INDIVIDUAL RIGHTS

A. In accordance with State and Federal laws, information maintained about me at this agency will be protected from unauthorized disclosure. No information will be sent to my employer, family members, friends, or anyone else, unless it is discussed with me ahead of time and permission is obtained. Disclosure is permitted under State and Federal laws for situations which may be applicable to me such as:

1. In the interest of public safety (life threatening situations).
2. In response to a Court Order.
3. Where state laws require that information be disclosed (e.g. suspected child or adult abuse, communicable disease).
4. When required for the purpose of management audits, program evaluation, or research, staff members may disclose information to qualified personnel, but such personnel may not identify me directly or indirectly in any report of such research, audit or evaluation, or otherwise disclose my identity in any manner.
5. Information may be exchanged between components of the State of Texas (other mental health/mental retardation centers, state hospitals and state schools) and Advocacy Incorporated when such information is needed in the investigation of a complaint brought by me or on my behalf if I do not have a legal guardian. Exempted from this disclosure without written consent are records subject to attorney-client privilege.

B. I understand that receiving services from PermiaCare does not obligate PermiaCare staff to testify or give evidence in any Court.

EMERGENCY CARE, CONSENT AND CONTACTS

In the event, a sudden illness or accident occurs, I authorize PermiaCare to obtain medical care for myself/dependent from the emergency contact and/or emergency physician that was provided, or the nearest accessible physician or hospital. I authorize the responsible physician to provide medical, surgical, x-ray or other appropriate medical or dental care as, in his/her judgment, is proper and necessary.

I realize that in arranging for said services, the PermiaCare for mental health assume no responsibility for the services rendered or costs incurred therein.

CONSENT FOR TRANSPORTATION

I hereby authorize PermiaCare to provide myself/dependent with transportation services. This service may include transportation to and from the Center and home, as well as for participation in Center activities requiring transportation.
In the event, I cannot bring my minor child or the person for whom I am legal guardian/custodian to the Program, then I give PermiaCare permission to bring the individual to the Program and participate in treatment as needed.

Rights Acknowledgement

I acknowledged that I have received the following information and each item was explained to me. I understand that if I have questions about my rights, I may ask PermiaCare staff for clarification. The following rights will be reviewed with me annually (*).

Notice of HIPAA Privacy Practices - A description of how medical information about me may be used and disclosed and how to get access to my information.

"Your Rights When Receiving Mental Health Service in Texas" Booklet - An explanation of rights and how to make a complaint if I think one of my rights have been violated.

Telehealth Consultation - I have agreed to take part in telehealth consultation for the purpose is to assess my mental health. This is done through a two-way audio/video link up with a health care provider.
I understand that:

1. I, my health care provider, or both of us will talk through the audio/video link with the health care provider.
2. I can ask that the exam and/or audio/video link be stopped at any time.
3. This procedure done through a two-way audio/video link will be equal to a face-to-face visit with a health care provider.
4. There are possible risks with the use of this new technology. Included but not limited to:
    a. Interruption or disconnection of the audio/video link.
    b. A picture that is not clear enough to meet the needs of the consultation.
    c. The audio/video link is conducted through the Internet. There is a small chance that someone could tap into this consultation.

    If any of these risks occur, the procedure might need to be stopped.
5. I authorize the release of any relevant medical information that pertains to me to the health care provider at Permian Basin Community Centers for MHMR/dba PermiaCare, or their agents. Information may include my name, age, birth date, or other information necessary to conduct this telehealth consultation.
6. This consultation will become part of my medical record kept by Permian Basin Community Centers for MHMR/dba PermiaCare. This consultation may be recorded and used for evaluation. I consent to such use. Any recorded images will not be used outside of the health care setting without my prior written consent.
7. I understand that I will not receive any royalties or other compensation for taking part in this telehealth consultation.
8. I understand that I must give my informed consent to participate in this consultation.

Notification of Appeals Process- An explanation of rights receiving services and how to appeal dissatisfied decisions made by PermiaCare.

* **Patient and Family Education Form**- I acknowledge that I was provided information related to myself/ my dependent's mental health disorder.

* **Long Term Services and Supports (LTSS) Screening** – A authorization to disclose my responses to be shared with agencies or referral organizations that may help meet any potentially identified need for possible future health or community-based services.

* **Advanced Directive Planning Form** (+65 years) – I attest that PermiaCare staff has discussed Advance Care Planning with me. At this time,

I do not wish to discuss Advance Care Planning or matters related to surrogate decision making.

I have an Advanced Care Plan and the name of my surrogate is:

Surrogate:

Appointment Reminders

I agree to receive reminders through automated or non-automated phone calls, texts or emails. I understand that it is my responsibility to secure the different mediums (voicemail, cell phone, or email account) by which I may receive an automated reminder.

Patient Authorization for Release of Information to Regional Health Information Exchange

I have reviewed the Patient Authorization specific to the regional Health Information Exchanges (HIE) that I am receiving services in and authorize the release of information to those HIE or HIEs.

Consent to Take and Use Photographs

I hereby grant and authorize PermiaCare to take a photograph of myself/dependent for the purpose of identification in the agency's web-based electronic health record (EHR) application.

Opportunity to Register to Vote (Adults Only)

I was given the opportunity to register to vote upon admission into services.

In signing this Consent, I acknowledge that I am either 18 years of age or older and have not been declared incompetent by a Court of law; or legally appointed guardian of the individual who is to be served, if such individual is 18 or older; or the parent/legally appointed guardian or authorized adult of the individual to be served, if such individual is 18 years of age or younger; or at least 16 years of age or older, and am legally empowered to consent for services per the conditions outlined in Section 2.20.00/00 of the Centers' Policies and Procedures manual and/or applicable provisions of the Texas Family Code Section 32.003, 32.004 and 32.005.

Clinician: **Signature Date:**

PERMIACARE

Notification of Receipt of Information

MH Programs

Initial/Annual

Client Name: _____ Client I.D.#_____

By signing below, I am acknowledging that I have received the following information and it was orally discussed with me.

_____ Did you fill out and receive a copy of your Authorization for Disclosure of information for SSA and HHSC?

_____ Were your HIPAA Privacy Rights explained and were you given a copy of them?

_____ Did you receive a copy of the PermiaCare Client's Rights Handbook?

_____ Did you receive a copy of the Notification of Appeals?

_____ Did you receive information concerning Charges for Community Based Services?

_____ Did you receive a copy of the Annual Explanation of Services & Supports?

_____ Did you get a copy of your Financial Assessment?

_____ Was the telemedicine program explained and do you consent to using Telemedicine in your treatment?

_____ Was the Consent for Services explained and did you receive a copy?

_____ Do you give consent to be photographed for purposes of identification?

Client Signature Date

PERMIACARE
MEDICAL INFORMATION SURVEY AND MEDICATION PROFILE

Client Name:_____ Case #_____

1. Do you now have **any** physical problems which bother you or for which you are being treated by any doctor?

HEENT/Neurological

Yes	No	
( )	( )	Injury or blow
( )	( )	Frequent/severe headaches
( )	( )	Frequent dizziness/fainting
( )	( )	Stroke
( )	( )	Seizures
( )	( )	Period of unconsciousness
( )	( )	Trouble swallowing
( )	( )	Trouble with eyes ears, nose, throat

Respiratory/Cardiac/Hematology

Yes	No	
( )	( )	Hay fever/asthma
( )	( )	Chronic cough
( )	( )	Shortness of breath
( )	( )	Treatment for chest pain/pressure
( )	( )	Heart problem
( )	( )	High or low blood pressure
( )	( )	Blood diseases

Gastrointestinal Tract

Yes	No	
( )	( )	Ulcers
( )	( )	Frequent nausea/vomiting
( )	( )	Frequent indigestion
( )	( )	Frequent diarrhea/constipation
( )	( )	Gallbladder problems
( )	( )	Colon problems
( )	( )	Stomach pain, bleeding, cramps, gas

Genitourinary Tract

Yes	No	
( )	( )	Kidney problems
( )	( )	Bladder problems
( )	( )	Painful/frequent urination
( )	( )	Female problems
( )	( )	Painful/irregular menses
( )	( )	Prostate problems

Orthopedic

Yes	No	
( )	( )	Painful/swollen joints
( )	( )	Spine/back/neck problems

Other Conditions

Yes	No	
( )	( )	Diabetes
( )	( )	Thyroid Problems
( )	( )	Treatment of cancer/tumors
( )	( )	Sexually Transmitted Diseases
( )	( )	Hepatitis
( )	( )	Jaundice
( )	( )	Tuberculosis
( )	( )	Alcohol/drug abuse
( )	( )	Skin disorders
( )	( )	Excessive weight gain/loss
( )	( )	Rheumatic Fever

Childhood Diseases (List)

_____
_____
_____
_____
_____

Describe Yes Answers (List)_____

_____
_____
_____
_____
_____

2. Have you ever had any serious injury or illnesses other than noted above? (include abnormal pregnancy/delivery) ( ) Yes ( ) No

   If yes, describe and give age/dates:_____

3. Have you ever had or been advised to have any operations? ( ) Yes ( ) No

   If yes, describe and give age/dates:_____

4. Physician's Name:_____ Phone:_____

   Address:_____

   Date of last complete physical exam:_____ Date when last seen by a medical doctor:_____

5. Female clients: Last menstrual period _____ Are you pregnant? ( ) Yes ( ) No Method of birth control _____

6. **All known allergies to any drugs or foods** (if any, specify and describe reaction):_____

   _____

7. **Prescribed medications** in past **six** months:

   A. Medications, strengths, dosages from other physicians:

   1._____ 3._____

   2._____ 4._____

8. **Please list name and telephone number of individual to contact in case of an emergency:**

   Name:_____ Phone Number:_____

9. **Non-prescribed medications** in past **six** months (include alcohol, all over-the-counter items, and illicit uses of other drugs):

   1._____ 3._____

   2._____ 4._____

Comments/Referrals _____

_____

_____

_____ _____
Authorized Signature/Title Date

_____ _____
Reviewing Physician Signature Date

Form is to be completed annually and updated with any changes throughout the year.
RN/LVN or Physician to sign and date each entry.

PERMIACARE

MHMR • ECI • SUBSTANCE ABUSE

If you or someone you know has a mental health emergency, contact PermiaCare's 24-hour crisis hotline anytime:
1-844-420-3964.

Si usted o alguien que conoce tiene una emergencia de salud mental, comuníquese con la línea directa de crisis de PermiaCare las 24 horas en cualquier momento:
1-844-420-3964.