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.

Federal Poverty Income Level Guidelines

2025 HHSC Substance Use Disorder Financial Eligibility Sliding Scale

Family Size	Income From / To	0 to 100% FPIL	>100% to 133% FPIL	>133% to 185% FPIL	>185% to 200% FPIL	>200% to 225% FPIL	>225% to 250% FPIL	>250% to 275% FPIL	>275% to 300% FPIL	>300% to 325% FPIL	>325% to 350% FPIL	>350% FPIL
1	From	$0	$15,651	$20,816	$28,954	$31,301	$35,214	$39,126	$43,039	$46,951	$50,864	$54,776
	To	$15,650	$20,815	$28,953	$31,300	$35,213	$39,125	$43,038	$46,950	$50,863	$54,775	and over
2	From	$0	$21,151	$28,131	$39,129	$42,301	$47,589	$52,876	$58,164	$63,451	$68,739	$74,026
	To	$21,150	$28,130	$39,128	$42,300	$47,588	$52,875	$58,163	$63,450	$68,738	$74,025	and over
3	From	$0	$26,651	$35,446	$49,304	$53,301	$59,964	$66,626	$73,289	$79,951	$86,614	$93,276
	To	$26,650	$35,445	$49,303	$53,300	$59,963	$66,625	$73,288	$79,950	$86,613	$93,275	and over
4	From	$0	$32,151	$42,761	$59,479	$64,301	$72,339	$80,376	$88,414	$96,451	$104,489	$112,526
	To	$32,150	$42,760	$59,478	$64,300	$72,338	$80,375	$88,413	$96,450	$104,488	$112,525	and over
5	From	$0	$37,651	$50,076	$69,654	$75,301	$84,714	$94,126	$103,539	$112,951	$122,364	$131,776
	To	$37,650	$50,075	$69,653	$75,300	$84,713	$94,125	$103,538	$112,950	$122,363	$131,775	and over
6	From	$0	$43,151	$57,391	$79,829	$86,301	$97,089	$107,876	$118,664	$129,451	$140,239	$151,026
	To	$43,150	$57,390	$79,828	$86,300	$97,088	$107,875	$118,663	$129,450	$140,238	$151,025	and over
7	From	$0	$48,651	$64,706	$90,004	$97,301	$109,464	$121,626	$133,789	$145,951	$158,114	$170,276
	To	$48,650	$64,705	$90,003	$97,300	$109,463	$121,625	$133,788	$145,950	$158,113	$170,275	and over
8	From	$0	$54,151	$72,021	$100,179	$108,301	$121,839	$135,376	$148,914	$162,451	$175,989	$189,526
	To	$54,150	$72,020	$100,178	$108,300	$121,838	$135,375	$148,913	$162,450	$175,988	$189,525	and over
For each additional person, add		$5,500	$5,500	$7,315	$10,175	$11,000	$12,375	$13,750	$15,125	$16,500	$17,875	n/a
Client Fee		0%	0%	0%	0%	10%	20%	35%	50%	65%	80%	100%
HHSC Portion		100%	100%	100%	100%	90%	80%	65%	50%	35%	20%	0%

Based on the *U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs*, as published by the Office of the Assistant secretary for Planning and Evaluation of the U.S. Department of Health & Human Services (https://aspe.hhs.gov/poverty-guidelines)

PERMIACARE
CONSENT FORM

Individual: _____ Case No.:_____

CONSENT FOR SERVICES

PermiaCare (PERMIACARE) provides services to individuals who have emotional, developmental, and substance abuse problems. Staff members are trained to provide appropriate treatment as needed to help the individual.

INDIVIDUAL RIGHTS

A. I understand that my Consent for Services is voluntary, unless Court ordered, and I may terminate services when I desire, unless Court ordered.

B. I understand that I have the right to an explanation of any common or probable consequences, risks and benefits of services. I further understand that I may appeal any staff decision regarding my care.

CONFIDENTIALITY

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 heath/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. The cost of services has been explained to me in a manner I understand.

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

In signing this Consent, I acknowledge that:

Circle One

1. I am either 18 years of age or older and have not been declared incompetent by a Court of law, or (circle one)
   a. I am the legally appointed guardian of the individual who is to be served, if such individual is 18 or older, or
   b. I am 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
   c. I am 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.

I agree to treatment/services as offered by the Area Program for:

☐ Myself ☐ My Child ☐ The person for whom I am legally authorized representative

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 _____ _____permission to bring the individual to the Program and participate in treatment as needed.

_____ _____

Signature of Individual Date Signature of Witness Date

_____ _____

Signature of Parent or Legally Authorized Representative Date

PERMIACARE
CONSENT FORM

Individual: _____ Case No.:_____

EMERGENCY CARE, CONSENT AND CONTACTS
(Required for all individuals)

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

_____ _____
Signature of Individual Date Signature of Witness Date

_____ _____
Signature of Parent or Legally Authorized Representative Date

I realize that in arranging for said services, the PermiaCare for Mental Health and Mental Retardation assume no responsibility for the services rendered or costs incurred therein.

EMERGENCY CONTACT: EMERGENCY PHYSICIAN:

Name: Name: Medical center hospital

Address: Address: 500 w. 4th St,

City: City: Odessa

State: Zip State: TX Zip 79761

Phone: Phone:432-640-4000

Drug Allergies:

CONSENT FOR TRANSPORTATION
(Complete if applicable)

I hereby authorize the PermiaCare to provide me 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.

_____ _____
Signature of Individual Date Signature of Witness Date

_____ _____
Signature of Parent or Legally Authorized Representative Date

PERMIACARE
EMERGENCY MEDICAL INFORMATION
Name: Case #
Address:
Phone #: D.O.B: Age:
SS#: Medicaid: #
Diagnosis:
If MR check level: ☐Mild ☐Moderate ☐Sever ☐Profound
Allergies (Medication, Food, Environmental Agents) LIST IN RED:
Medications:
Emergency Physician:
Address:
Phone #
Phone #
Emergency Contact Person:
Address: Phone:
Date of Last Tetanus
Seizures ☐Yes ☐No If Yes, Specify Type & Frequency:
Ambulation: ☐Normal ☐Impaired ☐W/C ☐Walker ☐Crutches
Physical Limitations ☐Blind ☐Deaf ☐Visual Aids ☐Hearing Aids ☐Diet ☐Special Eating Precautions
☐Other
Communication: ☐Verbal ☐Non-Verbal
Language Spoke:
Behavior Problems:
Activities to be Avoided:

_____ _____

Prepared by: Date

PERMIACARE
Education Acknowledgement Form

Client Name:_____ Case #: _____

TUBERCULOSIS EDUCATION

I certify that I have been provided education about tuberculosis. I was offered a referral for voluntary confidential screening for Tuberculosis.
I understand that these educational services and referrals are made available to each person admitted for services.

_____ _____
Client Signature Date

_____ _____
Staff Signature/Credentials Date

TOBACCO PRODUCTS AND NICOTINE ADDICTION EDUCATION

I certify that I have been provided education about the health risks of tobacco products and nicotine addiction.
I understand that this education is made available to each person admitted for services.

_____ _____
Client Signature Date

_____ _____
Staff Signature/Credentials Date

HEPATITIS B & C EDUCATION

I certify that I have been provided education about Hepatitis B & C. I was also offered a referral for voluntary confidential screening for Hepatitis C.
I understand that these educational services and referrals are made available to each person admitted for services.

_____ _____
Client Signature Date

_____ _____
Staff Signature/Credentials Date

HIV AND SEXUALLY TRANSMITTED DISEASE EDUCATION

I certify that I have been provided education about HIV and Sexually Transmitted Diseases (STDs). This educational information included a definition of HIV and Aids, methods of transmission, and methods of prevention.
In addition, I was offered voluntary, anonymous or confidential testing and counseling services concerning HIV infections and syphilis. I was also offered a referral for voluntary confidential screening for other Sexually Transmitted Diseases (STDs).
It has been explained to me and I understand that these services and referrals are routine for this facility and are offered to each person admitted for services.

_____ _____
Client Signature Date

_____ _____
Staff Signature/Credentials Date

FETAL ALCOHOL SYNDROME EDUCATION

I certify that I have been provided education about fetal alcohol syndrome. I was offered a referral for voluntary confidential screening at Texas Tech Health Services.
I understand that these educational services and referrals are made available to each person admitted for services.

_____ _____
Client Signature Date

_____ _____
Staff Signature/Credentials Date

PERMIACARE
SUBSTANCE ABUSE - CONSENT TO TREATMENT

(To be completed prior to admission)

Client Name:_____ Client #:_____

1. Your specific condition to be treated:_____
2. Your recommended course of treatment:_____
3. The expected benefits of treatment:_____
4. The client's probable health and mental health consequences of not consenting:_____
   _____
5. Your side effects and risks associated with the treatment:_____
   _____
6. Any generally accepted alternatives and whether an alternative might be appropriate:_____
   _____
7. Qualifications of staff who will provide treatment:_____
   _____
8. Name of Primary Counselor:_____
9. Your estimated daily charges, including an explanation of any services that may be billed separately to a third party or to the client, based on an evaluation of the client's financial resources and insurance benefits:_____
   _____
10. The program's services and treatment process:_____
    _____
11. Opportunities for family to be involved in treatment:_____
12. Consequences or searches utilized to enforce program rules:_____

Please have the client initial the following:

1. _____This information has been explained to me in simple, non-technical terms, in my primary language when possible.
2. _____No coercive or undue influence has been used to obtain this consent.
3. _____The consenter may revoke consent at any time and for any reason.
4. _____The Client Bill of Rights has been read and explained to me, I understand it, and I have been given a copy of it this date.
5. _____The client grievance procedure has been read and explained to me, I understand it, and I have been given a copy of it this date.
6. _____have received a copy of the program rules/expectations on this date. I have read and understand the rules including rules about visits, telephone calls, mail, and gifts, etc., including the violations that can lead to disciplinary action or discharge.
7. _____have received a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Drug Abuse Prevention, Treatment, and Rehabilitation Act.
8. _____have received a copy of the Texas Department of State Health Services complaint contact information form.
9. _____have received a copy of PermiaCare' client abuse and neglect reporting/complaint contact information form.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature/Credentials Date

PERMIACARE
SUBSTANCE ABUSE OUTPATIENT PROGRAMS
CLIENT BILL OF RIGHTS

Client Name: _____ Case#: _____

You have certain rights as a client of PermiaCare Substance Abuse Programs. Your rights are protected by law and the PermiaCare Client Rights Officer.

Your rights are listed below:

1. You have the right to accept or refuse treatment after receiving this explanation.
2. If you agree to treatment you have the right to change your mind at any time (unless specifically restricted by law).
3. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4. You have the right to be free from abuse, neglect, and exploitation.
5. You have the right to be treated with dignity and respect.
6. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
7. You have the right to be told about the program's rules and regulations before you are admitted, including, without limitation, the rules and policies related to restraints and seclusion. Your legally authorized representative, if any, also has the right to be and shall be notified of the rules and policies related to restraints and seclusion.
8. You have the right to be told before admission:
    a. the condition to be treated;
    b. the proposed treatment;
    c. the risks, benefits, and side effects of all proposed treatment and medication;
    d. the probable health and mental health consequences of refusing treatment;
    e. other treatments that are available and which ones, if any, might be appropriate for you; and
    f. the expected length of stay.
9. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
10. You have the right to meet with staff to review and update the plan on a regular basis.
11. You have the right to refuse to take part in research without affecting your regular care.
12. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
13. You have the right to be told in advance of all estimated charges and any limitations on the length of services of which the facility is aware.
14. You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
15. You have the right to make a complaint and receive a fair response from PERMIACARE within a reasonable amount of time.
16. You have the right to complain directly to Health and Human Services at any reasonable time.
17. You have the right to get a copy of these rights before you are admitted, including the address and phone number of:
    Health and Human Services Commission
    Complaint and Incident Intake
    Mail Code E-249
    P.O. Box 149030
    Austin, TX 78714
    Complaint Hotline: 1-800-458-9858, option 6
    Email: cii.sa@hhs.texas.gov
    Fax: 883-709-5735
18. You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of being admitted.

In signing this form, I acknowledge that:

1. The above rights have been explained in a manner which is understandable to me.
2. I have received a written copy of these rights.
3. I may receive staff explanation upon request of these rights at any time throughout the span of treatment.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature/Credentials Date

PERMIACARE
SUBSTANCE ABUSE CLIENT TRANSITION PLAN

Client Name: _____ Case Number: _____

Upon discharge from (name of Program): _____

The client's needs, preferences, and progress during treatment will be continually assessed and analyzed. The client will be assisted throughout the discharge process with transition into other services or back into the community. Care decisions are based on the client's identified needs, preferences, and priorities. These needs and priorities are continually assessed throughout treatment to facilitate timely and appropriate discharge and continued care or support services and the specific resources to be utilized to meet those needs.

This form is to be completed during the Discharge Planning Session with counselor, client and the client's significant other and/or family member if possible. The client is to complete everything except for #11, which the counselor completes.

1. I plan to live at the following address: _____
   City, state and zip: _____
   Phone number(s): _____

   _____ alone or
   _____ with parents name(s) _____
   _____ with relatives names(s) _____
   _____ with friends name(s) _____
   _____at facility name _____

2. I plan to attend the following program(s) to continue my aftercare. Place a check in the blanks where you plan to continue services. Write in the name of the professional, the program or facility you plan to attend.

   _____ Substance Abuse Residential Treatment _____
   _____ Substance Abuse Outpatient Counseling _____
   _____ Half-way House placement _____
   _____ Individual Therapy _____
   _____ Group Therapy _____
   _____ Family Therapy _____
   _____ Marriage/Relationship Therapy _____
   _____ Church/Clergy Counseling _____
   _____ Education/Vocation Counseling _____
   _____ Employment Counseling _____
   _____ Physician _____
   _____ Psychiatrist _____
   _____ Psychotropic Medication Monitoring _____
   _____ Community MHMR _____
   _____ Other _____

3. I plan to attend the following support group(s) to continue my aftercare. Place a check in the blanks for support service you plan to attend. Write in the support group name, the program or facility you plan to attend.

   X_____ Alcoholics Anonymous (AA) _____
   _____ Narcotics Anonymous (NA) _____
   _____ SMART Recovery (Self Management and Recovery Training) _____
   _____ Faith Based Support Group _____
   _____ Religious Support Group _____
   _____ Other _____

4. I plan to attend 2-3 number of AA or other support groups each week.
   I will have a sponsor/mentor within 30 days.

PERMIACARE
SUBSTANCE ABUSE CLIENT TRANSITION PLAN

Client Name: _____ Case Number: _____

5. _____ I plan to fulfill the requirements of probation/parole (if applicable).

   Name of my probation/parole officer: _____

6. I plan to continue my education: _____ enrolling in school _____, GED, or other (specify)_____
   _____

7. I am currently employed at _____
   Address: _____

8. In order to find employment I plan to: WorkForce Solutions

9. Name of Significant other and/or family member who is supportive of my recovery: ____

10. Significant other and/or family member plans to participate in the following activities and/or support groups. Place a check in the blanks for support service planned to attend. Write in the support group name, the program or facility planned to attend.

    _____ Individual Therapy _____
    _____ Group Therapy _____
    _____ Family Therapy _____
    _____ Marriage/Relationship Therapy _____
    _____ Church/Clergy Counseling _____
    _____ Al Anon _____
    _____ Faith Based Support Group _____
    _____ Religious Support Group _____
    X_____ Other _____

11. My counselor/treatment team has made the following recommendations and referrals for aftercare services:
    Attend CBSG Meetings
    Get a Sponsor
    Maintain gainful Employment
    _____
    _____
    _____
    _____

By signing this Transition Plan, I confirm my participation in the discharge planning process and acknowledge that I have received a copy of this plan.

_____ _____
Client Signature Date Family Member/Significant Other Date

_____
Staff Signature (include credentials) Date

INSTRUCTIONS:
1. Enter all information gathered from the client during the interview.
2. Print completed form, then obtain signature from client and staff.
3. As soon as possible: Upload signed attestation form and other documents (Proof of Income and Proof of Residency, if any) as an attachment to **CMBHS Financial Eligibility**.

Client Name: _____

CMBHS Client# : _____

Provider: _____

PermiaCare SA
Attestation Form

Residency:

I, _____, attest that I am a resident of the state of Texas, and that I currently reside at: _____ in _____ county.

My phone number is _____. I am currently living with _____ and they may be reached at _____.

Income:

I attest that I am currently ☐ Unemployed ☐ Employed

If **employed**, I am working ☐ Full-time ☐ Part-time

I make or receive $_____ (check one) ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly

The funds come from: _____.

By signing this form, I understand that falsifying this information could lead to my dismissal from the _____ program.

_____ Client Signature _____ Date

Witnessed By:

_____ Staff Signature/Title _____ Date

Group Rules

1. Always maintain confidentiality. What is shared by the group is not to be repeated or discussed at any other time or place.
2. Phones must be paced on silence during the group session.
3. Attendance is important. If you must miss a group, its preferred that you contact the counselor 24 hours ahead, if possible.
4. If you are 15 minutes late or more, you will not be allowed in the group
5. Remember to sign in for group therapy
6. Avoid interrupting or having side conversations.
7. Take responsibility for the quality of the discussion
8. Do not monopolize the discussion
9. Speak from you own experience. Do not give advice.
10. Refrain from speaking offensive language.
11. Do not use alcohol/ drugs before coming to group.
12. Do not discuss another member that is not present.
13. Please stay on topic.
14. Be mindful of others in the group. Is what you're sharing beneficial to you and other group members?
15. You may bring beverages and snacks for yourself and /or the group any session.

Individual Session Expectations

1. It is your responsibility to schedule your individual session with primary counselor.
2. If you No Show/ No call it will be marked in your chart. It is better to call and cancel.
3. If you are going to be late, call the counselor, if you do not call and are 15 minutes or more late, you will need to reschedule.

By signing I agree to follow all rules/ expectations. I acknowledge that I have been given a copy of this document in my Client Handbook.

Signature _____ Date_____

PERMIACARE
Participant's Rights

All Participants have the right to:

1. Be free from abuse, neglect and exploitation;
2. Be treated with dignity and respect; and
3. Make a complain to the program or DSHS at any time

Participants in an intervention program also have the tight to:

1. A humane environment that provides reasonable protection from harm;
2. Be informed of the program rules and regulations before participation; and
3. To accept or refuse services after being informed of services and responsibilities.

When participants receive individualized services in an intervention program the provider shall inform participants and consenters (if applicable) about:

1. Program goals and objectives;
2. Rules and regulations; and
3. Participants rights

Programs that provide services to identified individuals shall maintain the confidentiality of participants Identifying Information as required by federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, Code of Federal Regulations (CFR), Title 42, Part 2.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Staff (witness) Signature _____ Date _____

PERMIACARE
SUBSTANCE ABUSE PROGRAMS
ATTESTATION STATEMENT

Client Name:_____ Date:_____

Parent/Guardian Name (if applicable):_____

I hereby attest to the following:

Please have the client or parent/guardian (if applicable) initial all the statements that apply.

_____ This is in direct reference of my inability to provide income verification or proof of no income:

_____I understand that income eligibility calculation is consistent with household annual income not personal annual income.

_____I have no income of substantial amounts, and cannot provide proof of my income for the past 6 months.

_____I am currently unemployed and have been since date _____.

_____I have not filed an income tax return in the last year, nor has anyone listed me as a dependent/spouse/significant other, on his/her income tax return in the last year.

_____If someone has listed me as a dependent/spouse/significant other on his/her income tax return in the last year, they contribute this amount $_____ towards my monthly expenses of food, clothing, shelter, and personal necessities for myself and/or my child(ren).

_____I do not receive any child support for my child(ren).

_____I do not receive any TANF (food stamps), SSI, SSDI, HUD Housing incentives, WIC, unemployment benefits, alimony, or retirement income.

_____I am an appointed Foster Parent by CPS and have no financial responsibility of this perspective client.

_____Due to being destitute this amount $_____ is contributed each month for my monthly expenses of food, clothing, shelter, and personal necessities for myself and/or my child(ren), by (name of individual) _____ relationship to client _____.

_____ _____

Client Signature Date Prepared By Signature Date

_____

Parent/Guardian Signature Date

PERMIACARE
SUBSTANCE ABUSE PROGRAMS
ATTESTATION STATEMENT

Client Name:_____ Date:_____

Parent/Guardian Name (if applicable):_____

I hereby attest to the following:

Please have the client or parent/guardian (if applicable) initial all the statements that apply.

_____ This is in direct reference of my inability to provide income verification or proof of no income:

_____I understand that income eligibility calculation is consistent with household annual income not personal annual income.

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_____I am currently unemployed and have been since date _____.

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_____If someone has listed me as a dependent/spouse/significant other on his/her income tax return in the last year, they contribute this amount $_____ towards my monthly expenses of food, clothing, shelter, and personal necessities for myself and/or my child(ren).

_____I do not receive any child support for my child(ren).

_____I do not receive any TANF (food stamps), SSI, SSDI, HUD Housing incentives, WIC, unemployment benefits, alimony, or retirement income.

_____I am an appointed Foster Parent by CPS and have no financial responsibility of this perspective client.

_____Due to being destitute this amount $_____ is contributed each month for my monthly expenses of food, clothing, shelter, and personal necessities for myself and/or my child(ren), by (name of individual) _____ relationship to client _____.

_____ _____

Client Signature Date Prepared By Signature Date

_____

Parent/Guardian Signature Date

PERMIACARE
1012 MacArthur, Texas 79763
(432) 335 9659

Participant/Client Grievance Procedure

It is the policy of PermiaCare that every effort shall be made to resolve a participant/client/family member's grievance in a fair and equitable manner; and that the client grievances will be investigated and resolved promptly in accordance with the Texas Department of State Health Services (DSHS).

1. All staff members shall be aware of a participant/client's needs and shall pay close attention to those situations that could lend to a grievance situation. Participants/clients may grieve directly to any staff member, participants/clients may grieve about any violation or client right or DSHS standards.
2. Staff members will make every effort to resolve the grievance informally by discussing the situation or circumstances with the participant/client.
3. Staff members who are involved will not be included in acceptance, investigation or decision-making concerning the grievance.
4. Participants/clients/family members who are not able to resolve their grievance by discussion must put in their grievance in writing including date and their signature.
5. Staff will provide pens, paper, envelopes, postage, and access to a telephone upon request in order to file a complaint. Staff will provide assistance to participants/clients who cannot read or write or have difficulty reading or writing.
6. The Program Coordinator will investigate the grievance and interview the client as necessary.
7. A written report of the investigation and initial disposition shall be made to the client by the Program Coordinator or designee within seven (7) days.
8. A client who is still dissatisfied may appeal the decision to the Program Coordinator, and a written report of the decision will be given to the client within seven (7) days of receipt of the complaint.
9. A client who is not satisfied may appeal the decision to the Executive Director, and a written report of the decision will be given to the client within seven (7) days of receipt of the complaint.
10. A client who is still dissatisfied may appeal the decision to the Board of Directors, and a written report of the decision will be given to the client within thirty (30) days of receipt of the complaint.
11. There shall be no retaliation, formal, or informal, against a grievant.
12. Permian Basin Regional Council on Alcohol & Drug Abuse shall retain full records of all grievances in a confidential file for three years, but not in a client's case file.
13. Participants/clients/family members may submit their grievances any time directly to
    Texas Department of State Health Services, Substance Abuse Compliance Group Investigation
    110 West 49th Street
    Austin, Texas 78756-2823
    (800) 832-9623
    Texas State Board of Medical Examiners (for reporting complaints against Licensed Physician)
    1812 Centre Creek Drive, Suite 300
    Austin, Texas 78754
    Texas Health and Human Services Hotline (800) 252-5400
    Texas Rehabilitation Commission Service Number (800) 628-5515
    Texas Department of Criminal Justice (TDCJ)
    8712 Shoal Creek Blvd, # 260
    Austin, Texas 78757
    (512) 451-8442
    Texas Department of Protective and Regulatory Service- Child Protective Services
    (800) 252-5400

I acknowledge that I have read, been given an explanation that I understood, and have received a copy of the grievance procedure.

_____ _____
Participant/Client/Family Member's Signature Date

_____ _____
Signature of Staff Member Providing Information Date

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

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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.