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.

TEXAS Health and Human Services

Local Authority
Monthly Ability-To-Pay Fee Schedule 2026

26 TAC, Sections 301.111 and 301.509

Effective February 12, 2026

Maximum Monthly Fee by Family Size

Annual Gross Income	Monthly Gross Income	1	2	3	4	5	6	7	8	9+	% monthly income family size 1
0 - 23,939	0 - 1,994	0	0	0	0	0	0	0	0	0	**N/A**
23,940	1,995	50	0	0	0	0	0	0	0	0	**2.50%**
26,780	2,232	59	0	0	0	0	0	0	0	0	**2.66%**
29,620	2,468	70	0	0	0	0	0	0	0	0	**2.82%**
32,460	2,705	81	50	0	0	0	0	0	0	0	**2.98%**
35,300	2,942	92	59	0	0	0	0	0	0	0	**3.14%**
38,140	3,178	105	70	0	0	0	0	0	0	0	**3.30%**
40,980	3,415	118	81	50	0	0	0	0	0	0	**3.46%**
43,820	3,652	132	92	59	0	0	0	0	0	0	**3.62%**
46,660	3,888	147	105	70	0	0	0	0	0	0	**3.78%**
49,500	4,125	163	118	81	50	0	0	0	0	0	**3.94%**
52,340	4,362	179	132	92	59	0	0	0	0	0	**4.10%**
55,180	4,598	196	147	105	70	0	0	0	0	0	**4.26%**

Annual Gross Income	Monthly Gross Income	1	2	3	4	5	6	7	8	9+	% monthly income family size 1
58,020	4,835	214	163	118	81	50	0	0	0	0	**4.42%**
60,860	5,072	232	179	132	92	59	0	0	0	0	**4.58%**
63,700	5,308	252	196	147	105	70	0	0	0	0	**4.74%**
66,540	5,545	272	214	163	118	81	50	0	0	0	**4.90%**
69,380	5,782	293	232	179	132	92	59	0	0	0	**5.06%**
72,220	6,018	314	252	196	147	105	70	0	0	0	**5.22%**
75,060	6,255	337	272	214	163	118	81	50	0	0	**5.38%**
77,900	6,492	360	293	232	179	132	92	59	0	0	**5.54%**
80,740	6,728	384	314	252	196	147	105	70	0	0	**5.70%**
83,580	6,965	408	337	272	214	163	118	81	50	0	**5.86%**
86,420	7,202	434	360	293	232	179	132	92	59	0	**6.02%**
89,260	7,438	460	384	314	252	196	147	105	70	0	**6.18%**
92,100	7,675	487	408	337	272	214	163	118	81	50	**6.34%**
94,940	7,912	514	434	360	293	232	179	132	92	59	**6.50%**
97,780	8,148	543	460	384	314	252	196	147	105	70	**6.66%**
100,620	8,385	572	487	408	337	272	214	163	118	81	**6.82%**
103,460	8,622	602	514	434	360	293	232	179	132	92	**6.98%**
106,300	8,858	632	543	460	384	314	252	196	147	105	**7.14%**
109,140	9,095	664	572	487	408	337	272	214	163	118	**7.30%**
111,980	9,332	696	602	514	434	360	293	232	179	132	**7.46%**
114,820	9,568	729	632	543	460	384	314	252	196	147	**7.62%**
117,660	9,805	763	664	572	487	408	337	272	214	163	**7.78%**
120,500	10,042	797	696	602	514	434	360	293	232	179	**7.94%**

Annual Gross Income	Monthly Gross Income	1	2	3	4	5	6	7	8	9+	% monthly income family size 1
123,340	10,278	833	729	632	543	460	384	314	252	196	**8.10%**
126,180	10,515	869	763	664	572	487	408	337	272	214	**8.26%**
129,020	10,752	905	797	696	602	514	434	360	293	232	**8.42%**
131,860	10,988	943	833	729	632	543	460	384	314	252	**8.58%**
134,700	11,225	981	869	763	664	572	487	408	337	272	**8.74%**
137,540	11,462	1,020	905	797	696	602	514	434	360	293	**8.90%**
140,380	11,698	1,060	943	833	729	632	543	460	384	314	**9.06%**
143,220	11,935	1,100	981	869	763	664	572	487	408	337	**9.22%**
146,060	12,172	1,142	1,020	905	797	696	602	514	434	360	**9.38%**
148,900	12,408	1,184	1,060	943	833	729	632	543	460	384	**9.54%**
151,740	12,645	1,227	1,100	981	869	763	664	572	487	408	**9.70%**
154,580	12,882	1,270	1,142	1,020	905	797	696	602	514	434	**9.86%**
157,420	13,118	1,314	1,184	1,060	943	833	729	632	543	460	**10.02%**
160,260	13,355	1,360	1,227	1,100	981	869	763	664	572	487	**10.18%**
163,100	13,592	1,405	1,270	1,142	1,020	905	797	696	602	514	**10.34%**
165,940	13,828	1,452	1,314	1,184	1,060	943	833	729	632	543	**10.50%**
168,780	14,065	1,499	1,360	1,227	1,100	981	869	763	664	572	**10.66%**
171,620	14,302	1,547	1,405	1,270	1,142	1,020	905	797	696	602	**10.82%**
174,460	14,538	1,596	1,452	1,314	1,184	1,060	943	833	729	632	**10.98%**
177,300	14,775	1,646	1,499	1,360	1,227	1,100	981	869	763	664	**11.14%**
180,140	15,012	1,696	1,547	1,405	1,270	1,142	1,020	905	797	696	**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
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

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 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

Information on After-Hours Coverage

If you or your loved one needs assistance outside of regular clinic hours, including assistance needed during a mental health crisis, please contact 1-844-420-3964. This number is operational 24 hours a day, 7 days a week, 365 days a year.

Thank you

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.

Handbook of Consumer Rights

Mental Health Services

Consumer Services and Rights Protection

2007

This Book Belongs To:

_____

_____

Table of Contents

Handbook of Mental Health Consumer Rights

This handbook is provided to make you aware of the rights guaranteed to you while you are receiving services within the Department of State Health Services (DSHS) system. This listing of rights is not complete, but rather, it should increase your awareness that you retain your rights as a citizen unless there is a specific reason to restrict them under law or court order.

The information in this handbook should not be considered the granting or denying of any right guaranteed under the law. In addition to your rights, as a consumer of mental health services, you may also have responsibilities. These may include, but are not limited to, active participation in treatment, attending scheduled appointments, taking medications as prescribed, and following through on treatment recommendations. If you have a question or concern regarding your rights and responsibilities as a consumer of services in the public mental health system, you should contact the Rights Protection Officer at the facility or community MHMR center where you are being served.

Under law, the state facility or community mental health center is responsible for making sure that you have been informed of your rights. The DSHS system is required to respect and provide for your rights.

To help you determine which rights in this handbook apply to you, you should be aware of your status with respect to the following conditions:

- the type of treatment program you are in (outpatient, inpatient, or other residential);
- your legal status (competent adult, adult or minor with a guardian, emancipated minor, or minor with a conservator);
- your admission status (voluntary, emergency detention, Order of Protective Custody, Court Order for Temporary or Extended Services, or Forensic Commitment).

If you are not sure of your status, ask your treatment provider or ask for assistance from your Rights Protection Officer.

Your Right to be Informed of Your Rights

You have the right to be given a copy of these rights before you agree to accept voluntary services or when you are admitted to involuntary services. A copy can also be given to the person of your choice. If a guardian has been appointed for you, or you are less than 18 years-of-age (less than 16 years-of-age if you have been admitted voluntarily to inpatient services), another copy will be given to your guardian, parent, or conservator.

You also have the right to have these rights explained to you aloud in a language you can understand within 24 hours of being admitted for services. This same explanation must also be given to your guardian, parent, or conservator, as appropriate.

Your Right to Make a Complaint

You have the right to make a complaint and to be informed of whom to call for help. The addresses and phone numbers are listed below. You have the right to make a complaint without any form of retaliation.

If you believe any of your rights have been violated or you have other questions, concerns, or complaints about your rights or your care, you may contact one or more of the following:

- Rights Protection Officer –
  see stamp on front of handbook.
- Texas Department of State Health Services
  Office of Consumer Services and Rights Protection
  Mail Code 2019
  P.O. Box 12668
  Austin, TX 78711-2668
  1-800-252-8154
- Advocacy, Inc.
  7800 Shoal Creek Blvd., Suite 171-E
  Austin, TX 78757
  1-800-252-9108 (voice and TDD)

- Joint Commission on Accreditation
  of Healthcare Organizations [1]
  One Renaissance Blvd.
  Oakbrook Terrace, IL 60181
  1-800-994-6610

You have the right to be told about Advocacy, Inc. when you first enter an inpatient unit and also when you leave. Advocacy, Inc., is a federally-funded agency which is independent of DSHS and whose purpose is to protect and speak up for your rights.

If you believe you have been abused or neglected, you can complain to:

Texas Department of Family and Protective Services
P.O. Box 149030
Austin, TX 78714-9030
Mail Code E-561
1-800-647-7418

If you believe your attorney did not prepare your case properly or that your attorney failed to represent your point of view to the judge when you were involuntarily committed, you may report the attorney's behavior to the State Bar of Texas by writing or calling:

State Bar of Texas
Chief Disciplinary Counsel
La Costa Center, Suite 300
6300 La Calma Dr.
Austin, TX 78752
1-800-932-1900

You have the right to be offered the opportunity to complete a satisfaction survey at discharge from an inpatient program, telling us what you did like or did not like. You may request an early survey at any time during your stay by asking your social worker or by contacting the Office of Consumer Services. This right extends to your family.

[1] Applies to inpatient programs and accredited outpatient programs.

Basic Rights for All Persons Receiving Mental Health Services

(Outpatient as well as Residential Inpatient Programs)

1. You have all the rights of a citizen of the State of Texas and the United States of America, including the right of *habeas corpus* (this means you have the right to ask the court if it is legal, based on the procedures of your court commitment, for you to be kept in the hospital), property rights, guardianship rights, family rights, religious freedom, the right to register and vote, the right to sue and be sued, the right to sign contracts, and all the rights relating to licenses, permits, privileges, and benefits under the law.

2. You have the right to be presumed mentally competent unless a court has ruled otherwise.

3. You have the right to be treated without discrimination due to your race, religion, sex, ethnicity, nationality, age, sexual orientation, or disability. If you believe you have been discriminated against for any of the reasons listed above, you may contact the HHSC Civil Rights Office at 1-888-388-6332.

4. You have the right to be treated in a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and are treated with respect and dignity.

5. You have the right to appropriate treatment in the least restrictive, appropriate setting available that provides protection for you and the community.

6. You have the right to be free from mistreatment, abuse, neglect, and exploitation. If you believe you have been abused, neglected or exploited, you should contact DFPS at 1-800-647-7418.

7. You have the right to protection of your personal property from theft or loss.

8. You have the right to be told in advance of all estimated charges being made, the cost of services provided, sources of the program's reimbursement, and any limitations on length of services. You should be given a detailed bill of services upon request, the name of an individual to contact for any billing questions, and information about billing arrangements and available options if insurance benefits are exhausted or denied. You may not be denied services due to an inability to pay for them.

9. You have the right to fair compensation for any work performed in accordance with the Fair Labor Standards Act.

10. When you are admitted to an inpatient or outpatient program, you have the right to be informed of all rules and regulations related to those programs.

Confidentiality

11. You have the right to review the information contained in your medical record. If your doctor says you shouldn't see parts of your record, you have the right to have the decision reviewed. The right to review your records extends to your parent or conservator if you are a minor (unless you have admitted yourself to services) and to your legal guardian.

12. You have the right to have your records kept private. You also have the right to be told about the conditions under which information about you can be shared without your permission. You should be aware that your records may be shared with employees of the DSHS system (state facilities and community MHMR centers) who need to see them in order to provide services to you. You should also be aware that your status as a person receiving mental health services may be shared with jail personnel if you are incarcerated.

13. You have the right to be informed of the use of any media devices, such as one-way vision mirrors, tape recorders, television, movies, or photographs.

14. Except in an emergency, medical and/or surgical procedures require your permission or the permission of your guardian or legal representative. You have the right to know the advantages and disadvantages of medical and surgical procedures

15. You have the right to consent or withhold consent to take medication unless a court has ordered you to take them, your guardian has consented to their administration, or there is an emergency situation in which you or someone else might be harmed due to your behavior.

16. You have the right to consent or withhold consent to participate in research.

17. You have the right to withdraw your permission at any time in all matters for which you have previously consented. If you do not grant consent or if you withdraw your consent for any particular treatment, it will have no effect upon your eligibility for any other care and treatment.

Care and Treatment

18. You have the right to an individualized treatment plan. You have the right to take part in developing that plan, as well as the treatment plan for your care after you leave the hospital or community program. Your parent/conservator (if you are a minor), or your legal guardian, has the right to participate in the development of the treatment plan. You have the right to request that any other person that you choose take part in the development of the treatment plan. Your request should be reasonably considered and you will be informed of the reasons for any denial. Staff must document in your medical record that the parent, guardian, conservator, or other person of your choice was contacted and invited to participate.

19. You have the right to be free from unnecessary or excessive medication.

20. You have the right to be told about the care, procedures, and treatment you will be given. You also have the right to be told about the risks, side effects, and benefits of all medications and treatment you will receive, including those that are unusual or experimental, the other treatments that are available, and what may happen if you refuse the treatment.

21. You have the right to meet with the staff responsible for your care and to be told of their disciplines, job titles, and responsibilities. In addition, you have the right to know about any proposed change in the appointment of professional staff responsible for your care.

22. You have the right to request and receive a second opinion from another professional treatment provider at your own expense. You have the right to be granted a review of your treatment plan or a specific procedure by in-house staff.

23. You have the right to be told why you are being transferred to any program within or outside of the agency.

24. You should be notified of your right to appeal a decision by a community MHMR center to deny, terminate, or reduce services or support. If you are a Medicaid recipient, you also have the right to request a Medicaid Fair Hearing.

25. You have the right to receive services that address both psychiatric and substance use disorders.

26. You have the right to appeal a decision made by the MHMR center to deny, terminate or reduce services or support, based on non-payment.

Additional Rights of Persons Admitted to Inpatient/Residential Programs

1. You have the right to exercise religious freedom, including the right to refuse religious activity.

2. You have the right to ask to be moved to another room. The staff must pay attention to your request and give you an answer and a reason for the answer as soon as possible.

3. You have the right to receive treatment for physical or medical problems which affect your treatment. If your physician believes treatment of the physical problem is not required for your health, safety, or mental condition, you have the right to seek treatment outside the inpatient unit at your own expense.

4. If you are in a state hospital or a state center and there is no way to pay for your own transportation home when you are released, the state will pay the cost of transportation.

5. If you are an adult, without a guardian, who has been admitted to an inpatient program, you have the right to be given information about your health care decisions and to execute advanced directives as allowed by state law.

6. You have the right to have individuals of your choosing notified of your admission and/or discharge.

7. You and your family have the right to be notified of the availability of the trust fund for the safekeeping of your personal funds.

8. You have the right to be informed in writing about any prescription medications ordered by your treating physician, including the name of the medication, the conditions under which it may be prescribed, any risks, benefits, and side-effects and the source of the information provided. This right extends to your family, so long as you agree to it.

9. You have the right to receive a written list of the medication prescribed to you within four (4) hours of requesting it in writing. The list must include the name of each medication, its dosage, how it is given, and how often it is given as well as the name of the doctor who prescribed it. This right extends to your family, with your consent.

10. You have the right to be free from physical restraint and seclusion unless a physician orders it. You may be restrained or secluded in an emergency situation without a physician's order. If the physician does not agree with this decision, you will be released. You must be told why you were restrained or secluded and what you must do to be released.

If you are in an inpatient program, the following rights (11-16) may be limited by your physician, but only on an individual basis in order to maintain your physical and/or emotional well-being or to protect another person. The reasons for any limitation must be written in your medical record, dated, signed by your physician, and fully explained to you and any person legally authorized to represent your interest. Unless otherwise specified, the limit on your rights must be reviewed no less often than every seven- (7) days and if renewed, renewed in writing.

11. You have the right to communicate with others, in writing, by phone and in person, with as much privacy as possible. These rights are:
    - reasonable visiting hours,
    - opportunities for parents to visit with their minor children,
    - access to a telephone, and to send and receive sealed and uncensored mail.

12. In no case may your right to contact an attorney or an attorney's right to contact you be limited. You also have the right to have unrestricted visits with the Rights Protection Officer, Advocacy, Inc. representative, private physicians, and other mental health professionals at reasonable times and places.

13. You have the right to keep and use your personal possessions, including the right to wear your own clothing and religious or other symbolic items. You have the right to wear suitable clothing, which is neat, clean, and well fitting. If you do not have adequate clothing, it will be made available for you.

14. You have the right to daily opportunities for physical exercise and to spend time outside, with or without supervision. A physician's order limiting this right must be reviewed and renewed no less often than every three (3) days. Any limitation to this right must be written in your medical record and explained to you, your parent, or guardian.

15. You have the right to go to areas of the campus away from the unit, including recreation areas, the canteen or snack area, with or without supervision, when you are not supposed to be participating in treatment activities.

16. You have the right to have opportunities to meet with persons of the opposite sex, with or without supervision, as your treatment team considers appropriate for you.

Additional Rights of Persons Admitted to Inpatient Programs

Voluntary Admissions-Special Rights
NOTE: This section does not apply to forensic commitments.

1. You have the right to request your discharge from voluntary admission to a hospital or crisis stabilization unit at any time. You can make this request in writing or by telling a staff person. The staff person must document your request for discharge.

2. By law, you have the right to be discharged from the hospital within four (4) hours after you make a request to be discharged. There are only three reasons why you would not be released:
   - If you change your mind and decide to stay, you can sign a paper that says that you do not wish to leave, or you can tell a staff member that you do not want to leave. The staff member has to write it down for you.
   - If you are under 18 years old and the person who admitted you (your parents, guardian, or conservator) does not want you to leave, you may not be able to leave. If you request your release, staff must explain to you whether or not you can sign yourself out and why. The hospital or crisis stabilization unit must notify the person who has the authority to sign you out and inform them of your request to leave. The doctor or another member of your treatment team must talk to your parent or guardian and document the date, time, and outcome of the conversation in your medical record.
   - You may be detained longer than four (4) hours if a doctor has reason to believe that you might meet the criteria for court-ordered services or emergency detention because:
     - You are likely to cause serious harm to yourself,
     - You are likely to cause serious harm to others, or
     - Your condition will continue to deteriorate and you are unable to make an informed decision as to whether or not to stay for treatment.

- If the doctor thinks you meet the criteria for court-ordered services or emergency detention, he or she must examine you in person within 24 hours of your filing the discharge request. You must be allowed to leave the hospital upon completion of the in-person examination unless your doctor confirms that you meet the criteria for court-ordered services and files an application for court-ordered services. The application asks the judge to issue a court order requiring you to stay at the facility for services.
- Even if an application for court-ordered services is filed, you cannot be detained at the hospital beyond 4:00 p.m. of the first business day following the in-person examination unless a court order (order for emergency detention or order of protective custody) is obtained.
- If the judge agrees with the physician's request, a court order requiring you to stay at the facility will be issued. You have the right to speak with your attorney prior to your court hearing. You also have the right to attend and participate in all scheduled court hearings unless you waive this right. If you waive the right to appear at your court hearing, however, an order for court-ordered services may be issued without your input.

3. You have the right not to have an application for court-ordered services filed while you are receiving voluntary services at an inpatient unit unless your doctor determines that you meet the criteria for court-ordered services and:
   - you request your discharge,
   - you are absent without authorization,
   - your doctor believes you are unable to consent to appropriate and necessary treatment, or
   - you refuse to consent to necessary and appropriate treatment and your doctor states in a certificate of medical examination that:
     - there is no reasonable alternative treatment and
     - you will not benefit from continued inpatient care without the recommended treatment.

Your doctor may consider the option of discharging you if you refuse to consent to treatment.

4. The doctor must document in your medical record and inform you about any plans to file an application for court-ordered treatment or for detaining you for other clinical reasons. If the doctor finds that you are ready to be discharged, you should be discharged without further delay.

5. You have the right to be free from threats or misleading statements about what might happen if you request to be discharged from a voluntary admission to the inpatient program.

Note: The law is written to ensure that people who do not need treatment are not committed. The Texas Health and Safety Code says that any person who intentionally causes or helps another person cause the unjust commitment of a person to a mental hospital is guilty of a crime punishable by a fine of up to $5,000 and/or imprisonment in county jail for up to one year.

Emergency Detention– Special Rights

(Admission for up to 48 hours for evaluation)
NOTE: This section does not apply to forensic commitments.

1. You have the right to be told:
   - where you are,
   - why you are being held, and
   - that you might be held for a longer time if a judge decides that you need treatment.

2. You have the right to call a lawyer. The staff must help you call a lawyer if you ask. If you contact a lawyer and engage his or her services, the cost of those services is your responsibility.

3. You have a right to be examined by a doctor as soon as possible, but in no case more than 12 hours after you have been apprehended. You will not be allowed to leave if the doctor believes that you may seriously harm yourself or others, the risk of this happening is likely unless you are detained in an inpatient setting, and emergency detention is the least restrictive means of restraint. If the doctor decides you do not meet all of these criteria, you must be allowed to leave within 48 hours after you were detained, except on weekends and legal holidays, when the decision and your release may be delayed until 12:00 noon on the first regular workday. The decision and your release may also be delayed in the event of an extreme weather emergency. If the court is asked to order you to stay longer, you must be told that you have a right to a hearing within 72 hours.

4. If the doctor decides that you do not need to stay in the inpatient unit, the hospital or crisis stabilization unit will arrange for you to be taken back to where you were picked up if you want to return, or to your home in Texas, or to another suitable place within reasonable distance.

5. You have the right to be told that anything you say or do may be used in legal proceedings for further detention.

Order of Protective Custody – Special Rights

(Admission for up to 14 days)
NOTE: This section does not apply to forensic commitments.

1. You have the right to call a lawyer or to have a lawyer appointed to represent you in a hearing (called a "probable cause hearing") to determine whether you must remain in custody until a hearing on court-ordered mental health services (temporary or extended commitment) is held. The court appointed lawyer represents you at no cost to you.

2. Before a probable cause hearing is held, you have the right to be told in writing:
   - that you have been placed under an order of protective custody,
   - why the order was issued, and
   - the time and place of a hearing to determine whether you must remain in custody until a hearing on court-ordered mental health services can be held. This notice must also be given to your attorney.

3. You have the right to a probable cause hearing within 72 hours of your detention on an order of protective custody, excluding weekends or legal holidays, when the hearing may be delayed until 4:00 in the afternoon on the first regular workday, or in the event of an extreme weather emergency.

4. You have the right to be released from custody if:
   - 72 hours have passed and a hearing has not taken place(except weather emergencies and extension for week-ends and legal holiday),
   - an order for court-ordered mental health services has not been issued within 14 days of the filing of an application (30 days if a delay was granted by the court), or
   - a doctor finds that you no longer need protective custody or court-ordered mental health services.

Court-ordered Services-Special Rights

Temporary (up to 90 days) or Extended (up to 12 months Commitment)
NOTE: This section does not apply to forensic commitments.

1. You or another person may, at any time during your commitment, ask the court to grant a motion for re-hearing.

2. If you are on a court order for extended mental health services, you may ask a judge to order a physician to re-examine you to determine whether you still meet the criteria for commitment. If the judge agrees to review the commitment, a physician must file a certificate of medical examination with the court within ten (10) days of the filing of your request with the court.

3. If the physician says that you continue to meet the criteria for commitment, or if no certificate of medical examination has been filed within ten (10) days and you have not been discharged, the judge may set a time and place for a hearing on your request. If the doctor says that you do not meet the criteria for commitment, you must be discharged.

www.dshs.state.tx.us/mentalhealth.shtm

Consumer Services and Rights Protection

www.dshs.state.tx.us/mhservices/MHConsumerRights.shtm

Stock No. 16-9 12/2007

PERMIACARE
FEE ASSESSMENT/BENEFIT SCREENING FORM

Client ID: _____ **Client Name**: _____ **Date**:_____
U.S. Citizen: Yes____ No____ If no, Legal Resident? Yes____ No_____ If yes, how long:_____
DOB: _ _/_ _/ _ _ _ _ **SSN:** _ _ _ - _ _ - _ _ _ _ **Medicaid Number** _____ **Type:** _____
Medicare Number:_____ **Part A**:_____ **Part B**:_____
Address:_____**City**:_____ **ST**:___ **Zip**:_____
Contact Phone Number: (_____)-_____-_____ **Home**___ **Cell**___ **Work**___ **Other**___
Advocate/Parent/Guardian _____ **Relationship to client**: _____
Address: _____**City**: _____ **ST:** _____**Zip** _____
Home: (_ _ _) - _ _ _ - _ _ _ _ **LAR**: __**Yes** __**No** __**Unknown** **LAR Documentation Rec'd** __ **Yes** __ **No**

WAGE INFORMATION

Earned Income	**Monthly Dollar Amount**		**Unearned Income**	**Consumer Monthly Dollar Amount**	**Spouse's Monthly Dollar Amount**	**Parent's Monthly Dollar Amount**
CONSUMER:						
Income/Wages: *			SSDI/Social Sec/Medicare:			
Self-Employment Inc: **			SSI/Medicaid			
			VA Benefits			
			Unemployment			
			Worker's Comp.			
			Retirement Income			
SPOUSE:			Rental Income			
Income/Wages: *			Royalties			
Self-Employment Inc: **			Inheritance			
			Life Insurance			
			Dividends and Interest			
			Food Stamps *(Not counted in MMF)*			
PARENT:						
Father's Income: *			TANF (AFDC/Welfare): *(Not counted in MMF)*			
Mother's Income: *						
Step Father: (Not in MMF)			Child Support/Alimony: *(Not counted in MMF)*			
Step Mother: (Not in MMF)						
Total Family Wages *						
Total Self Empl. Inc. **			**Client Has no Income:**			
Gross Earned Income			**Gross Unearned Income:**			
TOTAL INCOME:						

RESOURCES:
CD's_____ IRA's_____ Stocks_____ Bonds_____ Trust Fund_____
Do you own any property? Yes ____ No_____, If yes please describe_____
_____
Do you own any vehicles? Yes____ No_____ How many?_____

Checking Account:	Yes _____ No _____	Savings Account:	Yes _____ No _____
Balance Today:	$	Balance Today:	$

1ST LEVEL SCREENING:
Screening as ineligible if:
(If yes is checked on any of the following they are screened out at 1st level screening.)

Consumer is already receiving SSI. Yes__ NO __
Consumer reports earned income of $_____or more per month. Yes ____ No ____
Consumer reports PERSONAL assets in excess of $2000.00 Yes ___ No ___

_____ _____
Signature of Screener Date

PermianCare
Fee Assessment/Benefits Screening Form

Client ID		Client Name		Date	
Restricted Billing?	Yes ___ No ___	OBRA ___ TEA ___ Nursing Home Resident ___ CFMR ___ Aging ___ Other ___			
Assignment of Benefits		Yes ___ No ___	Assignment Date		
Are other family member(s) currently being served here?		Yes ___ No ___	ID of Family Member	Name of Family Member	Chg Cap
Family Size # Dependents					

Wage Information					Extraordinary Expenses		
Family Wages		Self Employment Income			Major Medical Expenses (for the past year)		
Social Sec. Receipts		Unemployment			Major Casualty Losses (past year)		
Worker's Comp		Veteran's Benefits			Child Care Expenses		
Trust Fund Receipts		Retirement Income			Other		
Dividends & Income		Rental Income			Gross Extraordinary Expenses		
Other		Client Has No Income			Family Adjusted Annual Income		
Gross Income							

Income/Expenses Documentation Verified	Yes ___ No ___ Not Verifiable ___	Reason Not Verified	1.Pending ___ 2. Not Available ___ 3.Client Refused to Submit ___
Alternate Name on Statement?	Yes ___ No ___	Alternate Name	
Mail or Hold Statement	Mail ___ Hold ___		
Address to Send Statement		CAP/MMF	

Client Payer/Plan Information							
Payer/Plan Name			Payer Type	**Medicaid**: QMB __ MQMB__ Traditional__ **Medicare**: A __ B __ Replacement __ **Private Insurance: __**			
Active Date		Deactivation Date		Payer Sequence		Policy Holder Other Than Client?	Yes ___ No ___
Relation to Individual	Child Other Self Spouse		Policy Holder's Last Name			Suffix	
Policy Holder's First Name			Policy Holder's Middle Initial		Policy Holder's Date of Birth		
Policy Holder's SS Number			Policy Holder's Street Address				
City			State			Zip	
Policy Holder's Individual ID No.		Policy Holder's Group ID Number				Co-pay	
Comments							

Additional Client Payer/Plan Information							
Payer/Plan Name			Payer Type	**Medicaid**: QMB __ MQMB__ Traditional__ **Medicare**: A __ B __ Replacement __ **Private Insurance: __**			
Active Date		Deactivation Date		Payer Sequence		Policy Holder Other Than Client?	Yes ___ No ___
Relation to Individual	Child Other Self Spouse		Policy Holder's Last Name			Suffix	
Policy Holder's First Name			Policy Holder's Middle Initial		Policy Holder's Date of Birth		
Policy Holder's Social Security			Policy Holder's Street Address				
City			State			Zip	
Policy Holder's Individual ID No.		Policy Holder's Group ID Number				Co-pay	
Comments							

ID of Staff Performing Assessment		Staff Performing Assessment	Date
Program ID		Program name	
Client Authenticated Financial Assessment by Signature		Yes___ No___	Client Initials _____

I request that payments under any medical insurance for which I qualify be made directly to PermiaCare for services provided by PermiaCare. I acknowledge that I am responsible for any deductible or co-insurance amounts not paid by third-party payers that are less than or equal to my monthly cap. I understand that I may voluntarily pay more than my maximum monthly fee.

I authorize the release of any medical or other information necessary to process any of my insurance claims. I also request payment of benefits either to PermiaCare in accordance with the above assignment or to myself in the event that I have paid amounts owed to PermiaCare. I have received a copy of the Monthly Ability to Pay Fee Schedule, The Fee Assessment, and the Community Based Services brochure.

I understand that I may discuss any concerns regarding the determination of ability to pay with my treatment team.

Signature of Client/Legally Authorized Representative _____ Relationship to Client _____ Date _____

White – Record Yellow – Data Entry Pink – Client

PERMIACARE
FEE ASSESSMENT/BENEFIT SCREENING FORM

(Conducted by Financial Clerk)

Client ID: _____ Client Name: _____ Date: ___ / ___ / _____

Living Arrangements __ Alone __ With Spouse __ With Relative __ Parent(s) __ With anyone else	Housing: __ Rent __ Own __ Lease __ Homeless __ Transitional Housing __ Shelter __ Other:	Section 8 Housing? (Check One) Yes ___ No ___ If No, denied ___ or on Section 8 waiting list ____ ?
LIST HOUSEHOLD MEMBERS: (attach separate sheet if more room is needed)		
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

EMPLOYMENT INFORMATION

1) In the last 5 years, how much have you worked? Nearly all the time __ Half the time __ Less than half the time __ Hardly at all ___

2) What kinds of work have you done? Labor-Unskilled ___ Labor-Skilled/Trades ___ Sales ___ Clerical ___ Technical ___ Management/Professional ___ Other: (Describe) _____

3) Are you currently employed? Yes ____ No ____ Hours per month (approx)? _____

4) How long at current job? _____

5) When did you last work? (approx)_____

6) Reason for leaving last employment? Lay-off/Job Complete _ Fired _ Quit __

DISABILITY INFORMATION

1) Client's current diagnosis: _____

2) When were you first diagnosed with a mental illness? Yr_____ Where:_____

3) Have you ever been hospitalized for treatment of a mental illness? Yes __ No __ (if no go to question 4) How many times? ____

Describe three most recent hospitalizations:

	FACILITY	HOW LONG
1:	_____	
2:	_____	
3:	_____	

4) Have you received SSI or SSDI previously? Yes __ N0 __
When _____ Benefits Received _____
Why were benefits stopped? _____
Have you ever applied for SSI or SSDI? Yes_____ No_____

5) Do you have physical limitations? Yes ___ No ___ Describe them _____
_____

6) Current Alcohol/Drug abuse/addiction? Yes ___ No ___ If previous, when stopped?
_____

7) How has your disability affected your ability to do the things you did previously?
Working ___ Going to school ____ Maintaining good relationships ____ Other _____
_____

What is the Charge for Mental Health Services?

The mental health services we offer are funded by the State of Texas, local government and consumers who can pay.

Charges for services

We will not deny you services. Our charge for services is based on your ability to pay. The way we determine your ability to pay is fair and the same for everyone.

To determine your ability to pay for services, we need information regarding:

- Your income
- Any extraordinary expenses (for example, major medical expenses)
- Child care expenses, major property loss or damage
- The number of people in your family

Your responsibility of payment

Your income (minus any extraordinary expenses) and the number of people in your family will be applied to a fee schedule to get your maximum monthly fee. You will receive the form used to determine your maximum monthly fee. If your maximum monthly fee is more than zero, you will receive a bill for services. You have a choice to pay more than your maximum monthly fee.

Note: *Parents are not responsible for their adult children's maximum monthly fee. Adult children are not responsible for their parent's maximum monthly fee. If more than one family member receives services, the maximum monthly fee is for the family.*

A recipient of Medicaid or Medicare benefits

Medicaid-covered services will be billed directly to Medicaid, and you will not be billed for them. If you have Medicare, you are responsible for co-payments, co-insurance, and deductibles up to your maximum monthly fee. If your services are not covered by Medicaid or Medicare, you can be charged up to your maximum monthly fee.

TEXAS Health and Human Services

Mental Health Services offered:

- Crisis Intervention Services
- Crisis Residential Treatment
- Crisis Stabilization Unit Treatment
- Crisis Transportation
- Mobile Crisis Outreach Team
- Case Management
- Inpatient Hospitalization Services
- Pharmacological Management
- Counseling
- Medication Training and Support Services
- Psychosocial Rehabilitative Services
- Skills Training and Development
- Health Community Collaboratives
- Project Access
- Permanent Supportive Housing
- Projects for Assistance in Transition from homelessness
- Jail-Based Competency Restoration
- Outpatient Competency Restoration
- Texas Correctional Office on Offenders with Medical or Mental Impairments
- Assertive Community Treatment
- Consumer Benefits
- Illness Management and Recovery
- Person-Centered Recovery Planning
- Supported Employment

Note: Not all services are offered at all locations.

It is our goal to work with you, so you can continue to receive services.

A recipient of private health insurance

If you have private health insurance and complete an assignment of benefits, we will bill your insurance directly for covered services. You are responsible for charges your insurance does not cover. If you have insurance and do not complete an assignment of benefits, we can charge you the full standard charge for services. If we are not a provider for your insurance plan, we will assist you in locating a provider who can accept your insurance. You have the right to appeal this decision. Instructions for appeal are in the written notification you will receive if services are denied. To request the appeal decision be reviewed by the Ombudsman for Behavioral Health Unit, call 800-252-8154.

Note: *If we do not accept your private health insurance and refer you to another provider to receive services, you can appeal this decision as a denial of services.*

Trusts and charges for community services

Some people or their family members set up trusts to provide for their own or their loved ones' care and treatment. Trusts can be subject to claims for some or all mental health services. Anyone concerned about protecting trusts from liability should consult with an attorney. For example, a statute in the Texas Health and Safety Code, §534.0175, protects a trust from liability for the person's support, including mental health services if the trust's assets do not exceed $250,000 and certain criteria for the trust are met.

Financial hardship

If it is difficult to pay all charges owed, we can arrange for you to temporarily pay a lesser amount each month. If you have private health insurance and financial hardship prevents you from paying your full co-insurance, co-payments, or deductibles, we will make an arrangement with you to pay no more than your maximum monthly fee (or $5 a month, if your maximum monthly fee is zero) until your balance is paid.

Reduction or termination of services for non-payment

It is our goal to work with you, so you can continue to receive services. If charges remain unpaid and not because of financial hardship, we can propose to reduce or stop your services. You have the right to appeal this decision. Instructions are in the written notification you will receive before services are reduced or terminated. To request the appeal decision be reviewed by the Ombudsman for Behavioral Health Unit, call 800-252-8154.

Revised date 11/22/2019

Local Mental or Behavioral Health Authority

Name

Address

Phone number

Questions or concerns:

If you have any questions or need additional information:

Contact person

Phone number

TEXAS Health and Human Services

20D0006

Persons receiving services in PermiaCare programs that are funded by the Department of State Health Services (DSHS) and/or the Department of Aging and Disability Services (DADS) have the right to a notification and appeals process. This not only applies to clients expressing their concerns or dissatisfaction with decisions concerning services/supports provided, but also applies to the denial or termination of services/supports. Persons will be notified in writing by PermiaCare of the process to appeal by requesting a review of the following decisions:

- A decision to deny the person services/supports at the conclusion of PermiaCare's procedure, which determines whether a person meets the criteria for the target population.
- Decision to terminate services/ supports and follow along from PermiaCare or its contractor, if appropriate.
- Written notification must be given or mailed to the person within ten (10) working days of the date the decision was made.

The written notification must state the reason for the decision and explain that the person may contact either PermiaCare or its contractor; whichever is appropriate, within thirty (30) days of receiving notification if dissatisfied with the decision.

PermiaCare does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, and activities, or in employment. All PermiaCare facilities are wheelchair accessible. For further information, please contact the Human Resources Department at 432-570-3325.

Staff of PermiaCare shall not discourage, intimidate, harass, or seek retribution against clients who try to exercise their rights or file a grievance. PermiaCare shall not restrict, discourage, or interfere with an attorney or with a respective funding agency for purposes of filing a grievance.

Persons may file a grievance or appeal by writing to:

PermiaCare
401 East Illinois, Suite 403
Midland, TX 79701

If you need assistance with understanding the appeal process, please contact your case worker/service coordinator or the Client Rights Advocate.

PERMIACARE

NOTIFICATION OF APPEALS PROCESS

FOR PERSONS RECEIVING SERVICES/SUPPORTS FUNDED BY THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS) AND/OR THE TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS) AND PROVIDED OR CONTRACTED FOR BY PERMIACARE

PermiaCare Mission Statement:
Our mission is to enhance the behavioral and developmental health and wellness of our community by helping people live their best lives.

CR765a 5/18

Who Has the Right to Appeal?

Persons receiving services in PermiaCare programs which are funded by the Texas Department of State Health Services (DSHS) and/or the Texas Department of Aging and Disability Services (DADS) have the right to a notification and appeals process. You have the right to appeal a decision made by PermiaCare if:

1. You have been denied services and/or supports because you do not meet the criteria for the priority population, or
2. Services and/or supports have been terminated, or
3. Services and/or supports have been reduced including the amount, duration, or scope.

You will be notified that:

1. You have been denied services and/or supports, or
2. Your services and/or supports have been terminated, or
3. Your services and/or supports have been reduced.

You or your legally authorized representative will be given, or will receive in the mail, written notification detailing the reason for the decision to either deny, terminate, or reduce services within ten (10) working days of the date the decision was made.

A request that the decision be reviewed may be submitted. Persons dissatisfied with decisions may contact PermiaCare Client Rights Advocate at 432-570-3333 or Toll Free at 888-570-3310.

If a person believes that PermiaCare or its' contractor has made a decision to involuntarily reduce services by changing the amount, duration, or scope of services and/or supports provided, and is dissatisfied with that decision, then the person may request in writing that this decision be reviewed.

1. The review shall begin within ten (10) working days of receipt of the request for review, and be completed within ten (10) working days of the time it begins, unless an extension is granted by the Executive Director.
2. Also if the decision to involuntarily reduce services is related to a Crisis Service and the person requests in writing that this decision be reviewed, the review shall begin immediately upon receipt of the request and be completed within five (5) working days.
3. The review shall be conducted by an individual or individuals who are not involved in the initial decision.

The review shall:

1. Include a review of the original decision which led to the person's dissatisfaction.
2. Result in a decision to uphold, reverse, or modify the original decision.
3. Provide the person an opportunity to express his/her concerns in person, or by telephone, to the individual reviewing the decision.
4. Allow the person to have a representative talk with the reviewer, or submit his/her concerns in writing, on tape, or in some other fashion.

Following a review, PermiaCare shall explain to the person in writing, and also in person or by telephone, if requested, the action PermiaCare will take or, if no action will be taken, why the review did not change the decision or why it is believed that changing the action would not be in the person's best interest. This is the final step in the review process.

This does not preclude a person's right to reviews, appeals, or other actions that accompany other funds administered through PermiaCare or its contractors, or to other appeals processes provided for by other state and federal laws, e.g., Medicaid Statutes; Texas Human Resources Code, Chapter 73.

DECLARATION FOR MENTAL HEALTH TREATMENT

I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment" means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, and preferences regarding emergency mental health treatment.

(OPTIONAL PARAGRAPH) I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychoactive medications are as follows:

☐ I consent to the administration of the following medications:

_____

☐ I do not consent to the administration of the following medications:

_____

☐ I consent to the administration of a federal Food and Drug Administration approved medication that was only approved and in existence after my declaration and that is considered in the same class of psychoactive medications as stated below:

_____

_____

Conditions or limitations:_____

_____

_____

CONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding convulsive treatment are as follows:

☐ I consent to the administration of convulsive treatment.

☐ I do not consent to the administration of convulsive treatment.

Conditions or limitations:_____

_____

_____

PREFERENCES FOR EMERGENCY TREATMENT

In an emergency, I prefer the following treatment FIRST (check one):
☐ Restraint ☐ Seclusion ☐ Medication

In an emergency, I prefer the following treatment SECOND (check one):
☐ Restraint ☐ Seclusion ☐ Medication

In an emergency, I prefer the following treatment THIRD (check one):
☐ Restraint ☐ Seclusion ☐ Medication

_____I prefer a male/female to administer restraint, seclusion, and/or medications.

Options for treatment prior to use of restraint, seclusion, and/or medications:

_____

_____

Conditions or limitations:_____

_____

ADDITIONAL PREFERENCES OR INSTRUCTIONS

_____

_____

Conditions or limitations: _____

_____

Signature of Principal: _____ Date: _____

SIGNATURE ACKNOWLEDGED BEFORE NOTARY PUBLIC

State of Texas

County of_____

This instrument was acknowledged before me on _____(date) by _____(name of notary public).

_____
NOTARY PUBLIC, State of Texas

Printed name of Notary Public:

_____

My commission expires:_____

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal's name has been represented to me by the principal, that the principal signed or acknowledged this declaration in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, and that I am not a provider of health or residential care to the principal, an employee of a provider of health or residential care to the principal, an operator of a community health care facility providing care to the principal, or an employee of an operator of a community health care facility providing care to the principal.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to and do not have a claim against any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature: _____

Print Name: _____

Date: _____

Address: _____

Witness Signature: _____

Print Name: _____

Date: _____

Address: _____

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. The instructions that you include in this declaration will be followed only if a court believes that you are incapacitated to make treatment decisions. Otherwise, you will be considered able to give or withhold consent for the treatments.

This document will continue in effect for a period of three years unless you become incapacitated to participate in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapacitated.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapacitated. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED BY A COURT TO BE INCAPACITATED. A revocation is effective when it is communicated to your attending physician or other health care provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration is not valid unless it is either acknowledged before a notary public or signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Client Information
Client Name: Client ID:
DOB: Effective Date:

Public Health Provider – Charity Care Program Eligibility Notification

This is to let you know how services at PermiaCare are paid for, and what you're responsible for if you don't have private insurance, Medicaid, or Medicare.

If you don't have any coverage, you'll be given something called a "Maximum Ability to Pay," or MAP and this will be most you'll need to pay for services received. It's decided by looking at how much money you make and how that compares to the Federal Poverty Limit (FPL) or poverty guidelines from the government. We use a special chart called a sliding fee scale that was made by the Health and Human Services Commission to figure this out. You'll be told what your monthly fee is during your fee assessment. You can ask PermiaCare for a copy of your fee paperwork anytime. You'll never have to pay more than your MAP.

The rest of the costs will be paid for by a program called the Public Health Provider – Charity Care Program, or PHP-CCP. This is a program funded by the federal government, and PermiaCare can use it because we are a Local Mental Health Authority. If your income is less than 200% of the Federal Poverty Limit, you qualify for this program. That means PHP-CCP will help pay for the services you receive that go beyond your MAP.

Getting this letter means you are eligible for PHP-CCP. So, this program will help cover at least some of the costs of your care beyond your monthly payment. Again, you will never have to pay more than your MAP.

If you have questions or need help understanding this better, please contact our benefits eligibility department.

Clinician: Signature Date

_____ _____

PERMIACARE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. *Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.*

CLIENT INFORMATION (Complete all information below)

Name of Individual: _____ Other Name(s) Used: _____ Date of Birth: _____
Phone Number: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION (Check at least one below):
PermiaCare, 401 E Illinois Ave Midland, TX 79701 (432) 570-3333

☐ Early Childhood Intervention Program
☐ Intellectual and Developmental Disability Services
☐ Mental Health Services and Clinic
☐ Substance Abuse Services
☐ Basin Assistance Services (HIV)
☐ Other (e.g. primary care): _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION (Complete all information below)

Person/Organization: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Fax Number: _____

REASON FOR DISCLOSURE (Check at least one below)

☐ Treatment/Continuing Medical Care ☐ Billing or Claims ☐ Insurance ☐ Legal Purposes ☐ Disability Determination
☐ School ☐ Employment ☐ At the Request of the Individual ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? *Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.*

Dates to be released: _____

(Check at least one below)

☒ All health information ☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results ☐ Physician's Orders ☐ Patient Allergies ☐ Progress Notes
☐ Discharge Summary ☐ Billing Information ☐ Other_____

Your consent is required to release the following information. Please select all that apply:

_____Mental Health Records
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____. **RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice to PermiaCare stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. **SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature X _____ **Date** _____

Printed Name _____ ☐ **Self** ☐ **Parent of minor** ☐ **Guardian** ☐ **Other** _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

Signature of Minor Individual _____ **Date** _____

Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. *Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law . (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508). The authorization provided by use of the form means that PermiaCare can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.* ***Definitions*** *- In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)). Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including: • Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501). • Drug, alcohol, or substance abuse records. • Records or tests relating to HIV/AIDS. • Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).* ***Note on Release of Health Records*** *- This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual' s health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a health care provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).* ***Limitations of this form*** *- This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.* ***Charges*** *- Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 41.154).* ***Right to Receive Copy*** *– The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.* ***Notice and Copy of Consent to Accompany Disclosure*** *– If the records authorized for release pursuant to this authorization include <u>any</u> alcohol, drug, or substance abuse information the information is protected by federal law. 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.*

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 confirm that I received information about my mental health condition or my loved one's mental health condition. PermiaCare explained the information to me in a way I can understand. PermiaCare informed me who to contact if I have any questions.***

_____ _____

Patient Signature **Date**

_____ _____

PermiaCare Staff/Title **Date**

Denial of Services Notification

Client Name _____ Case#_____

Date: _____

Based on the Intake Assessment done on _____, PermiaCare decided that you do not qualify for services at the PermiaCare Mental Health Clinic. The reason(s) you do not meet criteria:

(Check all that apply)

___Your needs do not meet the level required for services

___ You have only one diagnosis (MR, PDD, or Substance Use Disorder)

___ You do not qualify for this level of care

___ You live in a nursing home or ICF facility

___ Services are not medically necessary

___ You already receive needed services from another provider

___ You do not live in the service area

___ You declined services

The following referral(s) and recommendation(s) were given to you:

_____
_____
_____

If you do not agree with this decision, you have the right to appeal by using the "Notification of Appeals Process" that was given to you in writing. Feel free to contact us in the future if your situation changes or your symptoms get worse.

By signing, you are acknowledging that you understand why services were denied, and you received this notice in writing. Your signature does not mean you agree with the decision.

_____ _____

Client Signature Staff Signature

_____

LAR Signature

401 E. Illinois Ave., Suite 200
Midland, TX 79701
Phone: (432) 570-3300
Fax: (432) 570-3425

Information Needed for Screening

Walk-ins are welcome Monday – Friday from 8:30am-4:00pm

Choose 1 item from each box below:

• Social Security Card or • A copy of your Social Security Card
• Driver's License or • Picture ID
Proof of Income (choose 1): • W2 Form or • Last month's check stubs (2 or 4, depending on how often you get paid) or • A letter from the person helping you and a statement saying you have zero income
• Social Security letter **if you get Social Security**
• Food Stamp letter **if you receive Food Stamps**
Proof of Residence (choose 1): • Utility Bill or • Lease Agreement or • A letter from the person you live with
• Insurance Card or other proof of insurance **if you have insurance**

Additional Requirements for Children:

- Birth certificate
- Notarized letter from primary caregiver stating parents are absent and they agree to be legally and financially responsible
- Official custody records (divorced parents)
- Child's Social Security Card

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 understand and authorize PermiaCare to use, share, create, send, and keep my information, and/or protected health information (PHI) that is collected when I answer the Long Term Services and Supports (LTSS) Screening and Referral System questions.

The information I provide may contain personal identifying information about the person named on this form. This may include descriptions of physical conditions, intellectual disability, mental health or substance use disorder conditions, other treatments, procedures, medications, medical or lab tests, diagnoses, disabilities, pregnancies, drug screens, descriptions of daily living activities, limitations to daily living activities. The information I provide may also include other individual 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 community partners that may help meet any identified need for possible health or other services.

Expiration Date: Unless I cancel this agreement sooner, it will expire 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 agreement is not a guarantee that services will be available.

If PermiaCare shares your information with an organization that is not a health care provider, they may not fall under the HIPAA privacy rule. If this occurs your information may be re-shared by them and you would likely no longer be protected by the HIPAA privacy rule.

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

OPPORTUNITY TO REGISTER TO VOTE

1. Would you like to register to vote today?

   ☐ YES ☐ NO

2. Your decision to register or not won't impact any assistance you receive from this agency.

3. If you leave the box blank, you'll be considered to have declined and will be asked to sign below.

4. Need help with the registration form? We're here to assist, but you're welcome to fill it out privately and mail it yourself if you prefer.

5. If someone interferes with your ability to register, declines your request for privacy, or pressures you, you can file a complaint by mail, phone call, or email.

   Elections Division of the Secretary of State
   P.O. Box 12060
   Austin, TX 78711
   1-800-252-8683
   elections@sos.state.tx.us

6. If you choose not to register, that decision remains confidential and will be used only for official voter registration purposes.

7. If you do register, the information about where you submitted the application will be kept confidential and used solely for voter identification.

DECLINATION OF VOTER REGISTRATION

I decline to register to vote today.

_____ ____/_/____
Signature of Applicant Date

_____
Printed Name of Applicant

FOR STAFF USE ONLY:

Applicant Refused to Sign _____

Applicant Unable to Sign _____