MCHD MONTGOMERY COUNTY HEALTH DEPARTMENT

11191 Illinois Route 185 Hillsboro, Illinois 62049 (217) 532-2001

Name: _____

Appointment Date: _____

Appointment Time: _____

Please arrive on time to fill out the initial paperwork. If you are unable to keep this appointment, please contact us at (217) 532-2001, at least 4 hours prior to the appointment time.

Please remember the following things:

* If you are bringing in more than 1 child for an assessment. You need to have another adult with you to assist with the children.

* Proof of insurance (if any) must be brought (Medical Card, Medicare, Private Insurance)

* Proof of income **MUST** be brought in. If you fail to do so your appointment will be rescheduled or you will be charged $50.00 for you assessment.

The State of Illinois has set new guidelines for documentation of proof of income and household size. These guidelines, which went into effect 7/1/10, make it mandatory for our agency to have documented proof of income on file for each client. This includes income earned by everyone in the household, even if you are living with someone who is not financially responsible for your bills. This requirement applies to all clients, regardless of health insurance or Medicaid coverage. We are required to update this information every six months. The following items are acceptable for proof of income:

- Income taxes from previous year
- Two most recent paycheck stubs
- Letter from social security office
- If you have direct deposit, your bank statement

Example of household size documentation are:

- Income taxes
- Medical Card

If you have any additional questions, please call 532-2001 ext. 143

Monday, Wednesday, Friday	8:00 am to 4:00 pm
Tuesday	8:00 am to 8:00 pm
Thursday	8:00 am to 5:00 pm

Montgomery County Health Department - Division of Mental Health

CLIENT RIGHTS, RESPONSIBILITIES AND GRIEVANCE PROCEDURE

The client's right shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5). All appropriate records kept at the Montgomery County Health Department are subject to the Freedom of Information Act (5U.S.C. 552).

MISSION STATEMENT: The Montgomery County Health Department- Division of Mental Health, operates to provide professional, confidential services to persons experiencing symptoms of a mental health or substance abuse disorder, as well as, educate the community to promote a better understanding of such symptoms. These services are available to all persons regardless of race, color, creed, religious affiliation and/or spirituality, age, gender, sexual orientation or ability to pay.

CLIENT RIGHTS:

The staff at Montgomery County Health Department wants you to know that your rights are important to us. Our goal is to provide quality services that respect the rights and dignity of the recipients. Receiving services here does not affect your legal rights in any way. As service providers we will work to protect your rights which include the following:

- To have access to services that will not be denied on the basis of race, color, creed, religious affiliation and/or spirituality, age, gender, sexual orientation or ability to pay.
- To have services provided in the least restrictive environment available.
- To confidentiality regarding HIV/AIDS status and testing as governed by the AIDS Confidentiality Act [410 ILCS 305] and the AIDS Confidentiality and Testing Code (77 Ill Adm Code 697).
- To nondiscriminatory access to services as specified in the Americans With Disabilities Act of 1990 (42 USC 12101).
- To receive confidential services as governed by the Confidentiality Act of Alcohol and Drug Abuse Patient Records regulations (42 CFR 2(1987)), of the Alcohol, Drug Abuse and Mental Health Administration, of the Public Health Service, of the United States Department of Health and Human Services and the Mental Health, of the Developmental Disabilities Confidentiality Act [740 ILCS 110] and the Health Insurance Portability and Accountability Act of 1996 [42 U.S.C. & 1320dd2]. Only in cases of suspected child abuse/neglect, in cases of imminent harm to yourself or someone else, or in the case of necessary communication with parents of minor children can information be released without consent. Please note that the only individuals with access to our files are professional staff members, support staff and any entity having direct administrative control over services provided.
- To receive appropriate, humane services. The staff will strive to provide the best treatment within our resources. You have a right to be free of physical, verbal, emotional, sexual, and/or financial abuse as well as neglect, humiliation or exploitation as per the Mental Health and Developmental Disabilities Code [405 ILCD 5].
- To receive any intrusive procedures such as injections, ect, in a safe manner, with consideration to the physical, developmental and abuse history of the persons served.
- To choose whether or not to participate in research projects.
- To receive concurrent services, i.e. to see the doctor and/or a counselor, case manager, ect.
- To participate in developing your treatment plan and to be informed of the composition of your Treatment Team.
- To have you bill and specific charges explained to you and to question any charges you believe may be in error.
- To contact the Network Manager for the Department of Human Services.
- To know what medication is prescribed for you, why it is prescribed and possible side effects it may cause.
- To review your record with the assistance of program staff in accordance with agency policy.

- To the right to give or withhold informed consent regarding treatment and regarding confidential information.
- To request alternative channels of communication.
- To refuse treatment or any specific treatment procedure and be informed of the consequences resulting from such refusal in a timely manner to allow you to make an informed decision regarding your treatment.
- To be free from retaliation for expression of concerns, problems, grievances, ect.
- To terminate services- our services are voluntary and require your cooperation.
- You will not be denied, suspended or terminated from services, or have services reduced for exercising any of the above named rights.
- To be free from seclusion and/or restraint.

CLIENT RESPONSIBILITIES:

As a service recipient you have the following responsibilities:

- To be an active participant in the treatment process and development of a treatment plan. It is expected that you will work on tasks aimed toward helping you attain your stated goals away from, as well as during, treatment sessions.
- To honestly discuss any changes you want to make in your treatment plan, usage of medication, or desire to continue in treatment sessions.
- To be on time for scheduled sessions. If you must cancel we ask that you notify us 24 hours in advance of your appointment. It is our policy to bill for failed appointments.
- To pay your bill in full for services provided, or make arrangements with the business office to make payments. We will do what we can to accommodate you, but you must ask.
- To protect the confidentiality of other members of any group or program in which you participate.
- To refrain from any tobacco use on any MCHD property, including personal vehicles on MCHD property.
- To neither bring or be in possession of any illicit drugs and/or weapons of any type onto MCHD property.
- To avoid behaviors that can result in the termination from or restrictions of services, including:
    - Inappropriate gestures or comments of a sexual nature toward other persons served or staff.
    - To be in the possession of dangerous or hazardous materiel or weapons.
    - Possession of illegal or illicit drugs on MCHD property, exception will be made for those voluntarily relinquishing custody to a clinician.
    - Any remarks or speech that intentionally reduces the self esteem of staff or persons served that includes, but is not limited to, remarks of race, religion, national origin, gender/transgender, sexual orientation, and physical/mental handicaps.
    - Intentional misuse of prescribed medications.
    - To physically threaten or assault other persons served or staff.

GRIEVANCE PROCEDURE:

If you feel a decision made regarding your treatment or the treatment of the individual you are guardian of was unfair, or there has been an infringement of your rights, you have the right to appeal.

The appeal process is as follows:

You must indicate to your counselor/therapist/case manager in writing that you have a grievance and the nature of the grievance. If your grievance is with your counselor/therapist/case manager you may present your written grievance to their supervisor. He/She will then contact you to set a meeting time with you to discuss your concerns within 72 hours of your request.

If you are not satisfied with the results of this conference you may appeal in writing to the following people:

1. Director of Mental Health
2. Administrator of the Health Department

The process of appeal must start with the first step and you may go through each step until you are satisfied. At each step you will be provided with a written response to your grievance with in ten (10) working days of your meeting.

All staff member dealing directly with clients will advise all individuals of their rights in accordance with documents cited above.

If you need assistance with writing your grievance, please let us know and an impartial staff member will be assigned to assist you.

If you have a grievance which you believe was not satisfactorily resolved after completion of the agency grievance procedure, you may contact:

Illinois Department of Human Services, Office of Alcoholism and Substance Abuse
Division of Licensing and Monitoring
222 South College, Second floor
Springfield, Illinois 62704
(217) 782-0685

Illinois Department of Human Services, Office of Mental Health and Developmental Disabilities
401 S. Spring
Springfield, Illinois 62701
(217) 782-9375 1-800-843-6154

Guardianship and Advocacy Commission (GAC)
Metro East Regional Office
Pine Cottage
4500 College Ave
Alton, IL 62002-5099
(618) 474-5503 Fax (618) 474-5517

Equip for Equality
427 E. Monroe Street
Springfield, Illinois 62701
(217) 544-0464

Illinois Department of Human Services, Office of Children and Family Services
1010 N. High
Carlinville, Illinois 62626
(217) 854-2566

Land of Lincoln Legal Assistance
413 East Broadway
Alton, IL 62002
(618)462-0029
800-642-5570

Department of Corrections
1301 Concordia Court
Springfield, Illinois 62794-9277
(217) 522-2666

Network Manager for the Department of Human Services
901 South Wind Road
Springfield, IL 62703

NAMI
Gateway Regional Medical Center
2100 Madison Ave. 4th floor
Granite City, IL 62040
618-798-9788

Alcoholics Anonymous
Southern Illinois District 18
800-307-6600

Our services are funded in part by the Department of Human Services: the Office of Mental Health and Developmental Disability, and the Office of alcoholism and Substance Abuse. The Federal Government also provides funding dollars.

Rev. 5-07, 6-07, 8-10
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AUTHORIZATION AND ASSIGNMENT

Please check one

_____ I hereby give authority to Montgomery County Health Department (MCHD) to furnish all information which my insurance company may request and need in connection with my illness and condition; at the same time, I give authority to the insurance company to make payable to MCHD any medical benefits which may be due to me under this policy as a result of my illness.

_____ I hereby choose to not have my services billed to my insurance company and agree to pay all costs myself or per other arrangements made with the financial department at MCHD.

I hereby authorize MCHD to examine any and all medical records maintained in connection with my treatment for any illness or condition, and to obtain copies of such records as my therapist/physician shall deem necessary.

If applicable, I authorize MCHD to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. This information can contain but is not limited to my name and demographic information. I understand this information will be kept in my clinical record as well as the data base of the Department of Human Services. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or the party who accepts assignment.

I understand that MCHD does not accept responsibility for collection of my insurance benefits or negotiating the settlement of a disputed claim. I am responsible for the payment of all clinic charges regardless of anticipated insurance coverage, unless prearranged through employer or third party payee.

I understand that disclosure of my social security number is required pursuant to federal regulations 42 U.S.C. Section 405 (c) (2). I further understand that my social security number may be used for identification; determination of Medicaid and, for substance abuse clients, contract eligibility for services; accumulation of benefits across payers; and detection and possible prosecution of fraud.

I understand that MCHD uses Electronic Billing for Medicare, Blue Cross and Blue Shield and Illinois Department of Public Aid. Therefore, I understand if I carry any of these insurances that my claims will be submitted electronically. Although I have requested the Health Department to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable amount of time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangement for prompt payment of the bill.

SIGNATURE_____ DATE _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE MAY MAKE A COPY OF YOUR CARD FOR OUR RECORDS.

Revised 04/10

MONTGOMERY COUNTY HEALTH DEPARTMENT
DIVISION OF MENTAL HEALTH
AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby authorize the use or disclosure of protected health information about me as described below:

_____ I hereby authorize:
_____
_____
_____
_____

_____ I hereby authorize:
Montgomery County Health Dept
Division of Mental Health
11191 IL. Rt. 185
Hillsboro, IL 62049

To release to:
Montgomery County Health Dept
Division of Mental Health
11191 IL Rt. 185
Hillsboro, IL 62049

To release to:
_____
_____
_____
_____

The following information: (Initial items wanted, cross out items not wanted, or write in items)
Blanket consent for unspecified information shall not be valid [740 ILCS 110/5 c]

_____Summary of contacts
_____Psychiatrist Notes
_____Psychological report
_____ Mental Health Assessment
_____ Treatment Plan
_____Discharge summary
_____Other
_____
_____
_____

_____Copy of evaluation
_____Therapist/Counselor/Case Manager notes
_____Legal history
_____Health history
_____Driving record
_____Substance use/abuse history
_____Compliance with tx recommendations

_____ Copy of records only
_____ Access to review chart only
From (date): _____ **To (date): _____** (Must be actual dates of the records)

Must mark one.

For the purpose of:

_____Transfer of treatment to another agency, facility or person
_____Consultation with other persons participating in the treatment process
_____Court testimony
_____At the request of the client/parent/guardian
_____Other (**specify**)_____

(Only one client per form)

Regarding: Name:_____ DOB: _____

Address:_____ Chart #:_____
_____

I understand that:

1. My records cannot be released without my permission in writing except in cases of suspected child abuse/neglect, cases of imminent harm to yourself or others, or in the communication with care givers.
2. I understand that I may revoke this authorization by notifying the Montgomery County Health Dept. in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have an affect on actions already taken by the Montgomery County Health Dept. in reliance on this authorization.
3. This release is invalid if I am acutely impaired by a mood altering substance.
4. I understand that information released by the Montgomery County Health Department is no longer covered by HIPAA rules and may be re-released by the recipient.
5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits
6. Consequences of refusing to consent to this authorization are:
   - No release of information
7. I must pay a fee for making copies of my records for personal use. These costs are:
   92 cents for the 1st through 25th pages
   61 cents for the 26th through 50th pages
   31 cents for all pages in excess of 50
   (Plus postage where applicable)

This consent is valid until (Check and complete one):

_____ _____, 20_____.

OR

_____ On the happening of the following event that relates to me or the purpose of the use or disclosure:_____

_____

_____

This form has to be fully completed before signing. Non-complete forms will be returned.

_____ _____

Signature of Client Date

_____ _____

Signature of Client's Representative (if under 18) Date

_____

Description of Client's Representative, if applicable

_____ _____

Witness Signature Date

A copy of this fully completed and signed must be given to the client.

NOTICE TO REVEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health & Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. Under the Federal Act of July 1, 1975 Confidentiality of Alcohol and Drug Abuse Patients Records, no such records, nor ay information from such records may be further disclosed without specific authorization for such a re-disclosure.

7/03 – Revised – MCHD, 8/07,6-08,11/10