New Client Data Sheet

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____ Race/Ethnicity: _____

Sex: Male_____ Female_____

Phone: (primary) _____ Work: _____

E-mail: _____

Marital Status (circle one): Single Married Separated Divorced Widowed

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Insurance Information

Insurance Company Name: _____ ID#: _____

Group Name or #: _____

Policy Holder Information (if different from above)

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to client (If applicable): _____

Street Address: _____City: _____State: _____ Zip: _____

Phone Number (primary): _____ Date of Birth: _____

SSN: _____ Sex: Male_____ Female_____

317 Koehler Drive
Lebanon, KY 40033
(270) 321-4198
www.hopeinky.org

Terms of Confidentiality

Your treatment with us will be confidential. The staff at Helping Others Pursue Excellence (HOPE) will not discuss you or your treatment and will not release records about you or your treatment without your authorization and informed consent. There are limited situations in which confidentiality might be broken. If deemed necessary to do this, please be assured we will do so in a respectful fashion and will adhere to the Minimum Necessary Standard which means we will disclose only information necessary to fulfill our legal requirements and/or to provide you with the best care possible. The following are situations in which HOPE

Counseling will or might disclose information about you without your consent:

- When mandated by state or federal law (e.g., to report abuse or neglect or children or vulnerable adults)
- When there is a credible threat of imminent physical harm to a readily identifiable third party or oneself
- When compelled to do so by a judge's court order
- When being audited by a third-party payer (your insurance company)
- When being audited by the State
- In a medical emergency to medical personnel or to qualified personnel for research, audit, or program evaluation(s)
- If your commit or threaten to commit a crime either at HOPE Counseling or against any person who works for HOPE Counseling
- If you develop an outstanding balance due and have not made payment for more than 120 days, your account may be turned over to a collection agency
- Between and among staff at HOPE Counseling in an effort to collaborate and provide you with the best treatment possible; OR -To coordinate your treatment with another healthcare provider. If any of this becomes necessary, we will work with you, keep you informed as much as possible, and will do so respectfully.

Client or Guardian's Signature: _____ Date: _____

HOPE Representative Signature: _____ Date: _____

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Client Financial Responsibility

Every effort is given to provide accurate information regarding copays and/or deductibles prior to your visit.

We provide the information given to us by your health plan and are notified of the below disclosure each time.

Benefit Disclaimer

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLE MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

While we take every effort to provide accurate information to you it is your responsibility to know and understand your insurance policy and fees associated with it prior to your visit.

As claims are processed if additional patient responsibility is listed you will receive an invoice from our office, as well as an explanation of benefits from your insurance company.

Routine Copay/Deductible Waiver Violates The Law

It is not illegal to write off a patient's copay/deductible balance if the provider makes a good-faith attempt to collect. However, when a provider has a policy of not attempting to collect copays/deductible that becomes illegal. Health and Human Services, Office of Inspector General, identified several suspect behaviors that indicate illegal routine copay/deductible waiver.

- Advertisements that state that Medicare will be accepted as payment in full.
- Advertisements that promise discounts to Medicare beneficiaries.
- Routine use of financial hardship forms without attempt to determine patient's financial situation.
- Collection of copayments only where patient has supplemental insurance that pays for copays.
- Charging more to Medicare beneficiaries to offset the waiver of coinsurance. Sham insurance programs that offer to cover copays but have insignificant premiums.

In a recent federal court case, a provider sued Cigna for failing to pay out-of-network claims. Cigna then countersued the provider for potential injunctive relief under certain ERISA laws, and the court found there was merit for the countersuit, so Cigna was able to attempt to obtain damages for unjust enrichment and intentional tortious interference with contractual relations

- The Employee Retirement Income Security Act (ERISA) is a broad set of federal laws that govern health insurance (among other things).
- The injunction would be filed to stop the provider from discounting the services based on the "in" vs. "out" of network rates.
- Commercial insurance providers have contracts (i.e., legally binding agreements) to provide health insurance to employers and employees- and now, under the Affordable Care Act, to individuals as well.
- Commercial insurance providers charge a premium for that health insurance. The employer, employee, and/or individual pays that premium.
- The health insurance contract establishes mutually agreed-upon deductible and copayment amounts for both in-network and out-of-network providers.
- Typically, the contract also establishes a financial incentive for beneficiaries to use in-network providers as well as a financial disincentive to use out-of-network providers.
- Because this is a contract--which, again, is a legally binding agreement with an employer or individual- if a provider comes along and decides to unilaterally waive patient deductibles and copays, then the provider is reducing the covered person's contractual financial obligation.
- So, by waiving deductibles and copays, the provider is interfering with the employer's and/or individual's contract with the insurance carrier--and that puts the provider at risk of being sued for damages.

Patient Printed Name: _____ Date: _____

Patient or Guardian's Signature: _____ Date: _____

HOPE Representative's signature: _____ Date: _____

Payment Policy

Thank you for choosing H.O.P.E. We understand that many patients find insurance coverage and financial responsibility issues complex and confusing, so we have outlined our agency's policy.

What is your financial responsibility?
Patients are required to provide a valid credit card at the time of their first initial session for the office to keep in their file. If no payment is received within 30 days of the statement date, a payment will be automatically charged to the client's credit card on file. The client will be notified in advanced of the transaction.

Payment will be provided for the following services (check each service type you are, or anticipate, receiving from H.O.P.E.):

___ Initial Intake
___ Group Counseling Sessions
___ Individual Counseling Sessions
___ Family Counseling sessions

Patients Who Are Minors
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages, or must provide complete and accurate information about the guarantor on the insurance that will be billed.

I, (patient/guardian) _____, understand that I am ultimately liable for the balance on my account for any services provided by H.O.P.E. regardless of the status of my insurance situation. With my signature, I agree to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to H.O.P.E. I authorize the release of medical or other protected health information necessary to process insurance claims.

The credit card attached to your account will be charged $ _____for each therapy session. H.O.P.E, will be including an additional amount to each payment. This amount will go toward the client's account balance. Please indicate which additional amount you choose to be charged to the account. If an amount is not selected the lowest option ($25) will be automatically chosen. (Circle one: $25.00 $50.00 $100.00)

Card Holder Name: _____ Card Number: _____

Exp. Date: _____ Security Code: _____ Billing Zip Code: _____

I authorize H.O.P.E. to associate the following credit card with my account for payment of services rendered.

Patient Printed Name: _____ Date: _____

Patient/Guardian Signature: _____

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H.O.P.E.
Behavioral Health Services – Rights and Responsibilities

Overview of Services
H.O.P.E. provides behavioral health services to individuals with complex mental health treatment needs. H.O.P.E. has a strong clinical focus and is treatment goal driven. Behavioral health services are intensive services provided in a limited time frame. Our goal is to help stabilize the individual in the home and community setting and to reduce the risk of hospitalization.

Client and Parent Rights
As a recipient of behavioral health services from the H.O.P.E, you have the right to:
• Participate as a team member in all treatment decisions
• Be treated with consideration, respect, and personal dignity
• Establish a 24-hour crisis plan with providers
• Confidentiality in regard to your participation in this program
• Have questions and concerns answered in a timely manner
• Contact the providers prior to selection so that you may determine the best provider for yourself
• At any time you may choose another provider by notifying the current provider
• File a grievance regarding the services you have received, according to the agency grievance policy
• Give written, informed consent regarding research participation
• Request a written statement of the charge for a service and be informed of the policy for the assessment and payment of fees (if applicable)
• Review your own client record by written request via the Clinical Director
• Receive one (1) free copy of your own client record, if requested

Provider Responsibilities
As Behavioral Health Professionals and/or Community Support Associates we have the responsibility to:
- Honor all appointments
- Follow through with our responsibilities as outlined in the treatment plan
- Make weekly face-to-face contacts as established in the treatment plan
- Provide individual treatment plans
- Provide individual crisis plans
- Collaborate with other resources when appropriate
- Ensure confidentiality regarding participation in program
- Report all incidents of harm and/or threats of harm to self or others
- Report any significant suspicions of abuse or neglect to the appropriate authorities

Client and Parent Responsibilities
To ensure consistent and effective treatment from H.O.P.E, it is imperative that clients participate in all aspects of service delivery and planning. A client's lack of involvement in their treatment will result in reassessment of treatment provision and could lead to termination of services.
Regarding consistent and effective treatment, we require all established appointments be honored or appropriate notification of cancellation be given. Appropriate notification consists of at least 24-hour notice concerning the cancellation or re-scheduling of an appointment. Frequent cancellation or failure to give appropriate notification of cancellation will result in termination of services.

Court
It is important to know that while providers do not seek opportunities to testify, they can be subpoenaed prior to court or while at court to testify or provide documents like leasing agreements. While the overall policy is that the service providers try to not testify and at times provides legal council to assist with this, if ordered by the court system, we will comply with the order.

If you, the client(s), feel(s) that you have been treated unfairly or the Program did not implement goals necessary to promote the success of your treatment, you may file a grievance by contacting your case manager, or by calling the Executive Director Beth Osbourne.

I, the client (Print Name) _____, agree to join in collaboration with H.O.P. E's behavioral health program. I have read and understand the above rights and responsibilities and I further agree to uphold my rights and responsibilities as outlined in this agreement.

_____ _____
Client (Guardian) Signature Date

_____ _____
HOPE Representative Signature Date

Revised: 1-18-22

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

H.O.P.E. (Helping Others Pursue Excellence) understands that your medical and health information is personal. In order to provide you with quality care and to comply with certain legal requirements, we create a record of the care and services you receive from our providers. Your record contains personal information about you and your health. Information about you and your care that may identify you and that relates to your past, present, or future physical or mental health and related health care services is referred to as Protected Health Information ("protected health information").

H.O.P.E. (Helping Others Pursue Excellence) is and will always be totally committed to maintaining the confidentiality of the individuals we serve and the records we keep. We will only release healthcare information about you in accordance with federal and state laws and the highest ethical standards of the counseling profession.

This notice describes our policies related to how we may use and disclose your protected health information in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), and regulations promulgated under HIPAA including the HIPAA Privacy and Security Rule.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT

Your protected health information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose protected health information to any other consultant only with your authorization.

PAYMENT

We may use and disclose protected health information so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of protected health information necessary for purposes of collection.

HEALTHCARE OPERATIONS

We may need to use information about you to review or support our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities. For example, we may share your protected health information with third parties that perform various business activities (e.g., billing or typing

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services) provided we have a written contract with the business that requires it to safeguard the privacy of your protected health information.

OTHER USES AND DISCLOSURE OF YOUR INFORMATION NOT REQUIRING YOUR CONSENT

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

- **Child Abuse or Neglect.** We may disclose your protected health information to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
- **Judicial and Administrative Proceedings.** We may disclose your protected health information pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
- **Deceased Patients.** We may disclose protected health information regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. protected health information of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
- **Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight.** If required, we may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** We may disclose protected health information to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your protected health information based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, we may use or disclose your protected health information for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** We may disclose your protected health information if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
- **With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of protected health information; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

For more information, please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
Signature of this form acknowledges receipt of privacy practices.

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HIPPA Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Act of 1996 (HIPPA). I understand that:

- I have been informed of or given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA.
- H.O.P.E. reserves the right to change terms of the notice from time to time and that I may contact you at any time to obtain the more currant copy of this notice.
- I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare, but that you are bound to comply with this restriction.
- I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to that date I revoke this consent is not affected.
- I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out my treatment and services.

By signing bellow, I recognize that I have been provided with the "HIPPA Notice of Privacy Practices" packet and read through it thoroughly. With my signature, I am acknowledging that I approve of the practices explained in the Notice packet and listed above at this time.

Print Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (If Applicable): _____ Date: _____

HOPE Representative Signature: _____ Date: _____

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HOPE
(Helping Others Pursue Excellence)
AUTHORIZATION FOR HEALTH INFORMATION

_____ _____
Print **Client Name** Date of Birth

I, _____, authorize HOPE to ☐ **Obtain from** ☐ **Release to**
a copy of my health information as identified below (**name and address of recipient):**

_____

_____

for the following purposes: (**describe each purpose of use/disclosure**)

_____

By **initialing** the spaces below, I specifically authorize the use or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____ Please send the entire medical record (all information) to the above-named recipient.

_____ Discharge Summary
_____ Most recent history/physical
_____ Laboratory reports
_____ Medical records needed for continuity of care
_____ School records
_____ Dental records
_____ Specialty Clinic Notes
_____ Criminal/domestic violence history
_____ Billing statements
_____ Diagnostic imaging reports
_____ Treatment Plans
_____ Other: _____

Method of Disclosure: ☐ on site review ☐ mail requested documents ☐ fax requested documents ☐ Phone/Email

I understand that, for certain information to be disclosed, state or federal laws and regulations require my specific written authorization as follows (please **initial** to verify authorized use or disclosure):

_____ HIV/AIDS related health information and/or records
_____ Genetic testing information and/or records
_____ Mental health information and/or records
_____ Drug/alcohol diagnosis, treatment or referral information. (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the redisclosure of such information.)

Describe:_____
_____.

_____ Psychotherapy notes. (If this authorization is for the use or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality requirements.

I also understand that the person I am authorizing to use or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire six (6) months from the date of signing or upon occurrence of the following event specified by the signee.

Print client's name: _____

Signature of Client/Guardian: _____ Date: _____

Print name of Guardian (if applicable) _____ Relationship to client: _____

Signature of HOPE Representative: _____ Date: _____

24-hour cancellation Policy

Cancellation & late arrival phone number: (270) 321-4198

Please store this number where it will be convenient for you if you need it.

ABOUT THE 24-HOUR CANCELLATION POLICY: You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.

Reason for this policy: Notifying your therapist of your intention to cancel or reschedule 24 hours in advance gives them an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list or may also be looking for an opportunity to reschedule for a different time. As much advance notice as possible is always appreciated.

IF YOU CANCEL YOUR APPOINTMENT WITH LESS THAN 24 HOURS NOTICE, YOU WILL BE CHARGED FOR THE MISSED APPOINTMENT.

If you simply do not show up for a scheduled appointment, you will be charged for the missed appointment.

This cancellation policy is standard in the medical and mental health fields and will be strictly enforced. On occasion, there will be understandable reasons for missing appointments, but exceptions to this policy will be rare. Arriving late with notification: If you notify counselor, even a few minutes ahead of time by calling the number below, your appointment time will be held for you and you will have the time which remains in that hour. As long as you arrive within your scheduled hour, you will not be charged for a missed appointment.

Arriving late without notification: Your therapist will wait for you for 15 minutes after which he will assume you are not coming and may leave the office. In such a case, you will be charged for a missed appointment.

If you have questions about this cancellation policy, you should discuss this with your therapist at the start of therapy.

Failure to make contact: If therapist is unable to make contact with client for a thirty-day period we will assume services are no longer needed and close client's chart. Please be courteous of your therapist and their time. This will allow us to get people on a waiting list in sooner when services are not being utilized by current clients.

Thank you.

Please sign below to indicate you have read, understand, and agree to abide by my cancellation policy.

_____	_____	_____
Client Printed Name	Client or Guardian's Signature	Date

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Telehealth Consent

I agree to participate in a telemedicine evaluation and/or ongoing treatment performed by an independently contracted provider who assumes sole responsibility and liability for treatment. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small]. I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person. I understand that medical records of telemedicine services will be kept at H.O.P.E.

_____ _____

Client or Guardian Date signed

_____ _____

Hope Representative Date signed

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Video Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to [legal entity/organization], its affiliates and agents, to use my image and likeness and/or any interview statements from me in its publications, advertising, or other media activities (including the Internet). This consent includes, but is not limited to:

(a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice.

(b) Permission to use my name.

(c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity and does not require prior approval by me.

Client's Name:

Client or Guardian's Signature:

Address:

Date:

Signature of Videographer/Photographer:

_____ _____

Date Signature of Organization

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What is Targeted Case Management?

Targeted Case Management (TCM) is a set of services provided to a Target Population that helps individuals gain access to needed medical, social, vocational and educational services to improve the quality of their lives.

What does Targeted Case Management services offer?

(ex. SNAP, food pantry, doctor appointments, supported employment, FAFSA, housing)

Making referrals for needed services
Removing barriers that limit access to recommended programs and services
Performing follow-up services to make sure needs are being met
Performing regular updates on changing needs
Educating family or the individual on the value of treatment

How are Targeted Case Management services provided?

Targeted Case Manager will provide these services on a face-to-face basis with the individual a minimum of two to three times a month.

In addition to the face-to-face services, there will be at least two more services provided during the month to coordinate services and supports to make sure that needs are being met.

Do you think you might be interested in receiving this additional support?

_____ Yes _____ No

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Revised: 1-18-22

Freedom of Choice Form

As the client (print name): _____, I understand that the choice of providers is my responsibility and right as the client. I further understand that I have the right to contact the providers (HOPE) prior to selection so that I may determine the best provider for my needs.

I have chosen HOPE to provide me with the following services:

- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Collateral
- ☐ Case Management
- ☐ Medication Management
- ☐ Other: _____

I understand that I have the right to terminate services at any time, at any point during my treatment. I also understand that I have the right to choose a different provider after completing termination confirmation paperwork to avoid issues and fees.

Signature of Client or Guardian: _____ Date: _____

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Grievance Procedure

What do I do if I disagree with a decision about the eligibility of myself for behavioral health services or a denial or reduction of behavioral health services?
All behavioral health services eligibility and ongoing authorizations for service approval are handled by the client's Managed Care Organization (MCO). If you are denied eligibility or services and you disagree with the decision you should follow the following procedure:

- Work closely with the case manager or therapist from your agency of choice to contact Provider Relations with your specific Managed Care Organization (MCO). You must follow the policy outlined in their Participant Manual to appeal eligibility and denial decisions.
- If the original decision of denial is upheld, you as the client have the right to request a formal hearing with Medicaid. A written request must be postmarked and mailed to the following address:

The Department for Medicaid Services
Division of Member and Provider Services
Program Integrity Section
275 East Main Street
Frankfort, KY 40621

You have the right to review case record relating to the issue and submit additional information in support of your claim.

What do I do if I am unhappy with the quality of services I am receiving, feel myself or my family has been treated unfairly by the agency I have chosen, or if I am concerned about a provider's behavior, action or statement to myself or my family?
The behavioral health services program is based upon a freedom of choice model. You have the right to transfer your business to another approved provider at any time. If you wish to pursue a grievance, please follow the steps below:

- Ask the agency for a copy of the Client Grievance Policy. This is a required document for all providers and should be located in the on-site Policies and Procedures manual. All internal agency policies and procedures for grievance issues should be followed first.
- If you are not satisfied with the agency's resolution of the issue, you have the right to notify the Cabinet for Health and Family Services of your grievance.

Cabinet for Health and Family Services Ombudsman
The Office of the Ombudsman
Cabinet for Health and Family Services
275 E. Main Street, 1E-B
Frankfort, KY 40621
1.800.372.2973
1.800.627.4702 TTY

By signing below, I acknowledge that I have been provided with a copy of H.O.P.E.'s Grievance Procedure Form.

_____ I understand that I have the right to file a grievance at any time if I am unsatisfied with my services.

_____ I have been advised and understand the process of filing a grievance

_____ _____
Participant or Legal Guardian Signature Date

_____ _____
H.O.P.E. Representative and Title Date