



# MANAGED CARE MANUAL ATTACHMENTS

# ATTACHMENTS TO MANAGED CARE MANUAL

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# ATTACHMENT A

## Medical Necessity Criteria

MHP 33.00



Subject: <b>DAY TREATMENT PROGRAM REQUIREMENTS FOR YOUTH IN OUT-OF-COUNTY PLACEMENTS</b>	Policy No.:  <b>MHP 33.00</b>	Original Issue Date:  <b>10-01-03</b>	Revision Dates:  2-10-04, 9-18-07, 10.16.09, 10-19-09, <b>09-25-15</b>
Approved by BHS Director:  <b>Signature on File</b>	Supersedes: MHP 33.00 Intensive Day Treatment for Youth in Out of County Placements	Review Dates:  2-10-04, 9-18-07, 10.16.09, 10-19-09, <b>09-25-15</b>	

**POLICY:**

Day treatment intensive services may be provided to Madera County youth who are in out of county placements.

**PURPOSE:**

To provide a structure that delineates for youth, an Intensive Day Treatment program that meets State criteria.

**DEFINITION:**

Description

Day Treatment Intensive (DTI) is a structured, multi-disciplinary program of therapy that may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the child in a community setting, which provides services to a distinct group of beneficiaries. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and collateral.

DTI Programming

Day treatment intensive shall be billed as half days or full days of service.

The following requirements apply for claiming of services based on half days or full days of time:

- 1 A half-day shall be billed for each day in which the child/youth receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.
- 2 A full-day shall be billed for each day in which the child/youth receives face-to-face services in a program with services available more than four hours per day.
- 3 Although the child/youth must receive face-to-face services on any full-day or

half-day claimed, all service activities during that day are not required to be face-to-face with the child/youth.

#### Required Service Components

- Day Treatment Intensive programs are required to include a daily community/milieu meeting, a therapeutic milieu, contact with significant support person(s), skill-building groups, adjunctive therapy, and psychotherapy.
- Day Treatment Intensive may include process groups in addition to psychotherapy. Additionally, Day Treatment Intensive Programs must have established protocol for responding to a child/youth's mental health crisis and a required posted schedule and staffing ratio.
- Both Day Treatment Intensive and Day Rehabilitation require additional standards of certification by the MHP who will conduct, at a minimum, a review of the provider's program description to ensure the regulations are in force; for individual and group providers, this review will not be required to be on-site, however for organizational providers, this review must be included in the required on-site review.

#### Therapeutic Milieu

Required Day Treatment therapeutic milieu components.

Day Treatment Intensive programs are required to have a **"Therapeutic Milieu"** that:

- Provides the foundation for the provision of day treatment program and differentiates these services from other specialty mental health services;
- Includes a therapeutic program that is structured by well-defined service components with specific activities performed by identified staff ;
  - Includes a requirement for **"continuous hours of operation"** which does not preclude short breaks (for example, a school recess period) between milieu activities. A lunch or dinner break may also be appropriate, depending on the program's schedule. These breaks do not count towards the total hours of operation of the day program for purposes of determining minimum hours of service;
- Enables the therapeutic milieu to be, at least, an average of three hours for full-day programs and an average of two hours per day for half-day programs (average in a day);
- Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction;
- Supports peer/staff feedback to children/ youth on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
- Empowers children/youth through involvement in the program (such as the opportunity to lead community meetings and to provide feedback to peers) and a supportive environment to take risks; and
- Supports behavior management interventions that focus on teaching self-management skills that children/youth may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

### A. Skill-Building Therapies

Skill-building groups: Staff help clients to identify barriers/obstacles related to their psychiatric/ psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

### B. Adjunctive Therapies

Staff and clients participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

### C. Process Groups<sup>79</sup>

- Staff facilitate these groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.
- Process groups are based on the premise that much of human behavior and feeling involves the individual's adaptation and response to other people and that the group can assist individuals in making necessary changes by means of support, feedback and guidance. It is a process carried out by informally organized groups that seek change.

### D. Psychotherapy

- Psychotherapy includes the use of psychosocial methods within a professional relationship to assist the child or children to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, and/or to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes.
- This service may only be provided to the child/youth by licensed, registered, or waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention. Psychotherapy is a required component of Day Treatment Intensive programming.

### E. Community/Milieu Meetings

Community meetings are to occur, at a minimum, once a day to address issues pertinent to the continuity and effectiveness of the therapeutic milieu. The community meeting may address relevant items including, but not limited to what the schedule for the day will be, current events, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, debriefing, or wrap up. Community meetings shall actively involve staff and clients and include one staff person whose scope of practice includes psychotherapy for Day Treatment Intensive programs.



#### F. Protocol in Crisis Response to Mental Health Crisis

A requirement for Day Treatment Intensive is an established protocol for responding to children/ youth experiencing a mental health crisis. Components of this protocol must include:

- 1 The assurance and availability of appropriately trained and qualified staff ;
- 2 Protocols or procedures established on how to address a crisis situation;
- 3 Referrals for Crisis Intervention, Crisis Stabilization, or other specialty mental health services to address a child's urgent or emergent psychiatric condition; and
- 4 The capacity to handle a crisis until the child/youth is linked to these services if located outside of the Day Treatment program.

#### Contact and Site Requirements (Day Treatment Intensive)

- Day Treatment Intensive Services shall have a clearly established site for services, although all services need not be delivered at that site. Additionally, services must be provided face-to-face and provided during continuous hours of operation (excluding short breaks between milieu activities and appropriate breaks for meals); these breaks do not count towards the total hours of operation when determining the minimum hours of service.
- A clear audit trail is required for accounting dedicated staff ratios and program operations as well as required curriculum schedule (community meetings, verification of therapeutic milieu, etc.) that is made available to the children, and as appropriate, to their families, caregivers, or significant support persons.
- This detailed weekly schedule must include when and where the activities are scheduled and the program staff, their qualifications, and their scope of responsibilities including who will be providing the services detailed on the schedule.

**“Contact with a Significant Support Person”** is required in Day Treatment Intensive Programs. At least, one contact (face-to-face or by an alternative method such as telephone) is to be made each month with a family member, caregiver, or other significant support person who is legally responsible adult for the child/youth. Contact with a Significant Support Person must be documented in the chart.

- If contact is made by letter, best practice recommends that a copy of the correspondence be placed in the chart as a substantiation of compliance. The practice of due diligence in assuring confidentiality should be made whenever Protected Health Information (PHI) is sent to a Significant Support Person.
- If contact is made by phone, charting should include what transpired in the communication with the Significant Support Person and what actions are being taken in supporting the client's reintegration into the community.

Program staff may be required to spend time on day treatment intensive activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts.

## Claiming Unit (Day Treatment Intensive)

“Full Day” Day Treatment Intensive service programs shall be claimed as a full day service for each day in which the child receives face-to-face services in a structured program (see Service Activities) and attends at least 50% of the scheduled program. Full Day Intensive services are defined as more than four hours per day.

“Half Day” Day Treatment Intensive services programs shall be claimed as half day service for each day in which the child receives face-to-face services in a structured program and attends more than 50% of the scheduled program. Half Day Intensive services are defined as services available at least three hours, up to four hours per day.

When a child meets medical necessity (MHP 33.A1 Medical Necessity and MHP 33.A2 Title 9 Medical Necessity) for day rehabilitation and no rehabilitation program is reasonably available, an MHP may authorize a program certified as Day Treatment Intensive which will be billed and reimbursed as Day Rehabilitation.

Note: In the event the child/youth attends less than 50% of either Full or Half Day Intensive services in a single day, no claim shall be made by the provider.

## Authorization

Initial authorization from the MHP for Day Treatment Intensive is required prior to the submission of claims for this service. Continued services must be reauthorized at least, every three months. Adjunct specialty mental health service providers shall be on the same concurrent authorization cycle as the Day Treatment Intensive (every three months). MHP initial authorization is required for counseling, psychotherapy or other similar therapeutic interventions that meet the definition of Mental Health Services (excluding emergency and urgent conditions) that will be provided on the same day as Day Treatment Intensive. TBS services, with MHP authorization, may be provided concurrently as a supplemental service with Day Treatment Intensive Services, but must not be included as part of the staffing ratio for the Day Treatment Intensive program.

## Lock-outs (Day Treatment Intensive)

Day Treatment Intensive services are not reimbursable on days when Crisis Residential, Psychiatric Inpatient, or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.

Mental Health Services are not reimbursable when provided by Day Treatment Intensive staff during the same time period that Day Treatment Intensive services are provided. However, if authorized by the MHP, Mental Health Services may be provided on the same day as Day Treatment Intensive and Day Rehab programs outside of program hours.

Two full-day or one full-day and one half-day or two half-day programs may not be provided to the same child/youth on the same day.

Medication Support Services are NOT a lockout during the hours of DTI and Day Rehab

and can be provided during the hours of DTI and Day Rehab if authorized and appropriate.

#### Staffing (Day Treatment Intensive)

At a minimum, there must be an average ratio of at least one person, per eight children/youth, whose time is dedicated to the Day Treatment Intensive program during the hours of operation from the following list providing Day Treatment Intensive services.

1. Physicians
2. Licensed/waivered/registered Psychologists
3. Licensed Clinical Social Workers (LCSW) or related registered professionals (ASW)
4. Marriage and Family Therapists (MFT) or related registered professionals (MFT-Intern [IMF])
5. Registered Nurses (RN)
6. Licensed Vocational Nurses (LVN)
7. Psychiatric Technicians (PT)
8. Occupational Therapists (OT)
9. Mental Health Rehabilitation Specialists as defined in Section 630 (MHRS)

The average ratio of day program staff to children/ youth in the day program is based on the average number of day program children/youth (Medi-Cal and Non-Medi-Cal) participating in the continuous hours of operation of the day treatment program on that day. Staff providing individual services, including individual therapy to day program children/youth may continue to be counted in the staffing ratio during the time they are in individual therapy in addition to the time they are present and available in the therapeutic milieu. Persons providing Day Treatment Intensive services who do not participate in the entire Day Treatment Intensive session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide day Treatment Intensive services and function in other capacities.

Regarding TBS and Day Treatment Intensive program, the TBS coach may be in the same room and providing TBS services; however, TBS staff cannot be counted in staffing for the Day Treatment program while assigned as the TBS staff member.

Staff requirements will be expanded to require at least one staff person to be present and available to the group in the therapeutic milieu for all scheduled hours of operation. For Day Treatment Intensive, staffing must include at least one staff person whose scope of practice includes psychotherapy.

Persons providing services in Day Treatment Intensive programs serving more than 12 children/youth, shall include at least one person from two of the following staff categories:

1. Physicians
2. Licensed/waivered/registered Psychologists

3. Licensed Clinical Social Workers (LCSW) or related registered professionals (ASW)
4. Marriage and Family Therapists (MFT) or related registered professionals (MFT-Intern [IMF])
5. Registered Nurses (RN)
6. Licensed Vocational Nurses (LVN)

#### Documentation Requirements (Day Treatment Intensive)

Day Treatment Intensive requires a daily progress note on activities and a weekly clinical summary reviewed and signed or co-signed by one of the following Licensed Practitioner of the Healing Arts (LPHA) who is either a staff member in the Day Treatment Intensive program or the person directing the service:

1. Physician
2. Licensed/waivered/registered Psychologist
3. Licensed Clinical Social Worker (LCSW) or related registered professional (ASW)
4. Marriage Family Therapist or related registered professional (MFT-Intern [IMF])
5. Registered Nurse (RN).

#### Attachments:

[MHP 33.A1 Medical Necessity](#)

[MHP 33.A2 Title9 Medical Necessity Criteria](#)

# Medical Necessity For Specialty Mental Health Services That Are The Responsibility Of Mental Health Plans

Must have *all, A, B and C*:

## A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

### Included Diagnosis:

- Pervasive Development Disorders, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia & Other Psychotic Disorder
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identify Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders (related to other included diagnoses).

## B. Impairment Criteria

Must have *one* of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria; Must have *one, 1, 2 or 3*:

- 1 A significant impairment in an important area of life functioning, *or*
- 2 A probability of significant deterioration in an important area of life functioning, *or*
- 3 Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

## C. Intervention Related Criteria

Must have *all, 1, 2 and 3* below:

- 1 The focus of proposed intervention is to address the condition identified in impairment criteria "B" above *and*
- 2 It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), *and*
- 3 The condition would not be responsive to physical health care based treatment.

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EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

### Excluded Diagnosis:

- Mental Retardation
- Learning Disorder
- Motor Skills Disorder
- Communications Disorders
- Autistic Disorder, Other Pervasive Developmental Disorders are included.
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions that may be a focus of clinical attention, except Medication induced Movement Disorders which are included.

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A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

## Medical Necessity Criteria

### **Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services**

#### Section 1830.210

Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),  
(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and  
(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshe.

## Section 1830.205

### Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:

(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Fourth Edition (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition

(G) Mood Disorders, except Mood Disorders due to a General Medical Condition

(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

(A) A significant impairment in an important area of life functioning.

(B) A reasonable probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.



# ATTACHMENT B

HIPAA Notice

Of Privacy

Practices

**NOTICE OF PRIVACY PRACTICES  
FOR PROTECTED HEALTH INFORMATION**  
[45 CFR 164.520]

**Background**

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

**How the Rule Works**

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

#### Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- *Health Plans* must also:
  - ▶ Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - ▶ Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - ▶ Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- *Covered Direct Treatment Providers* must also:

- ▶ Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - ▶ When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - ▶ In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
  - ▶ Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

#### Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

### **Frequently Asked Questions**

To see Privacy Rule FAQs, click the desired link below:

**[FAQs on Notice of Privacy Practices](#)**

**[FAQs on ALL Privacy Rule Topics](#)**

(You can also go to [http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std\\_alp.php](http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php), then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)



Subject: <b>CLIENT RIGHT TO NOTICE OF PRIVACY PRACTICES</b>	Policy No.: <b>PRV 06:00</b>	Original Issue Date: <b>2/23/07</b>	Revision Dates:  <b>6/10,11/5/15</b>
Approved by BHS Director: <i>Signature on File</i>	Supersedes: PRV 18:00 Notice of Privacy Practices	Review Dates:  6/10,11/15	

**POLICY:**

An individual's right to notification of privacy practices forms the cornerstone of Behavioral Health Services (BHS) privacy policies and procedures. This right means clients can learn and understand how BHS protects and discloses their protected health information (PHI). The Notice of Privacy Practices (NPP) is a written document describing, in plain language, BHS privacy practices, including the individual's rights related to his or her PHI. The NPP is revised as needed to ensure compliance with changes in state and federal laws and regulations as well as BHS policy and procedures.

**PURPOSE:**

To comply with HIPAA Privacy Rule (45 C.F.R. Section 164.520)

**DEFINITIONS:**

**Notice of Privacy Practices (NPP)** is a document which has legally required information describing how medical information about a client may be used and disclosed and how a client can get access to this information.

**PROCEDURES:**

- I. Content of Notice:
  - A. A description, including at least one example, of the types and uses of disclosures of
    1. Information BHS is permitted to make for each of the following purposes: treatment, payment, and health care operations. The description includes sufficient detail to place the individual on notice of the uses and disclosures permitted or required by state and federal law.
    2. A description of each of the other purposes (other than treatment, payment or health care operations) for which the provider is permitted or required to use or disclose PHI without the individual's written authorization. The description must include sufficient detail to place the individual on notice of the uses and disclosures permitted or required by state and federal law.

3. A statement that other uses and disclosures are made only with the individual's written authorization and that the individual may revoke this authorization at any time in writing (except to the extent the provider has taken action in reliance on the authorization)
- B. A separate statement is included to alert the client BHS contacts clients to remind them of appointments and to provide information regarding treatment alternatives or other health-related benefits or services that may be of interest to the client.
1. Individual rights:
    - a. Inspect and copy PHI.
    - b. Amend PHI.
    - c. Receive an accounting of disclosures of PHI.
    - d. Request restriction of certain uses and disclosures of information including a statement that the provider is not required to agree to a requested restriction.
    - e. Receive confidential communications of PHI.
    - f. Obtain a paper copy of the notice upon request.
  2. Provider duties:
    - a. Maintain the privacy of PHI and provide individuals with notices of its legal duties and privacy practices.
    - b. Abide by the terms of the notice currently in effect.
  3. Complaints
    - a. Instructions are included for how to file a complaint with the secretary of DHHS and with BHS.
    - b. There is a statement reassuring the individual there will be no retaliation against him or her for filing a complaint.
  4. Contact Information
    - a. The BHS Privacy Officer is listed as the contact person.
    - b. Name, telephone number and address of the Privacy Officer are provided.
    - c. Effective Date
- C. Format
1. Always formatted as a single document and never combined with any other form.
  2. Provided in English and Spanish routinely and in other languages based on client requests.
  3. 12 point font is used.
- D. Dissemination
- The NPP is:

1. Provided to new clients at their first encounter/intake;
2. Available upon request by anyone;
3. Posted in a clear and prominent location at each BHS facility where it is reasonable to expect clients and others to be able to read the notice;
4. Posted on the website and made available electronically through the web site in English and Spanish; and
5. Inmates do not have a right to an NPP.

E. Revisions

1. The Privacy Officer is responsible to promptly revise and distribute the NPP whenever there is a material change to the uses or disclosures, individual's rights, the provider's legal duties or other privacy practices stated in the notice.
2. Except when required by law, a material change to any term of the notice is not implemented prior to the effective date of the notice in which the material change is reflected.
3. The new version is posted and made available upon request. (It is not necessary to mail the new version to individuals who received the prior version.)

F. Acknowledgement

1. Except in emergencies, every effort is made to obtain a written acknowledgement that the individual received the NPP at admission.
2. If the individual refuses to sign an acknowledgement, the intake worker documents that an effort was made to obtain a signature and the reason why the acknowledgement was not obtained.
3. The acknowledgement form is filed in the medical record.

G. Workforce Member Training

1. Training is provided covering the purpose and content of the NPP and each person's role as it relates to it.
2. Training is provided at New Employee Orientation, periodic e-mail reminders, annual HIPAA update training, when revisions are made to policy or procedure and at other times as needed.

H. Documentation

1. The Privacy/Security Officer is responsible for documentation related to the NPP.
2. All versions of the NPP are retained for a minimum 7 years.
3. Relevant information related to the implementation and monitoring of the NPP is documented.

I. Privacy Officer Responsibilities

1. Recommends changes to NPP policy and procedures.



2. Trains workforce members.
  3. Receives and follows up on complaints.
  4. Serves as the primary contact person for workforce members, clients and others regarding the NPP.
  5. Monitors compliance with the NPP and acknowledgement requirements.
  6. Maintains all required documentation related to the NPP.
- J. Workforce Members Responsibilities
1. To understand the NPP and how it applies specifically to their position at BHS.
  2. To report any known or suspected noncompliance of the NPP policy or procedures.

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**Attachments:**

PRV 06:A1 Notice of Privacy Practices – English

PRV 06:A2 Notice of Privacy Practices – Spanish

# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

Effective Date: October 1, 2014

## NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this notice, please contact your provider or call the Madera County Mental Health Plan at (559) 675-7850.

### **Who Will Follow This Notice**

This notice describes the Madera County Behavioral Health Services' privacy practices and that of:

- All employees, staff, and other agency personnel;
- Any student, intern, volunteer, or unlicensed person who might help you while you are here;
- Any health care professional authorized to enter information into your medical chart;
- All facilities and units of the agency.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment or health care operations purposes described in this notice.

### **Our Responsibility**

We understand health information and related services about you is personal and we are strongly committed to protecting your confidential information. We create a record of the care and services you receive at this agency so we can provide you with quality care and comply with certain legal requirements. This notice applies to all of the records of your care generated by this agency, its providers and staff, and those who provide services to you at this agency. It also applies to any records we may have received from your other providers. Other providers may have different policies or notices regarding their use and disclosure of health information created at their offices or facilities.

This notice will tell you about the ways in which we may legally use and disclose your private health information. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure all health information that identifies you is kept private (with certain exceptions);
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- To follow the terms of the notice currently in effect.

## **How We May Use and Disclose Your Health Information**

The following categories describe different ways we use and disclose private health information. For each category of uses or disclosures we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Disclosures At your Request.** We may disclose information when requested by you. This disclosure at your request requires a written authorization by you.
  
- **For Treatment.** We will use your personal health information to provide you treatment and related services including the coordinating and managing your care. For example, we may need to disclose information to a case manager who is responsible for coordinating your care. We may also disclose your health information among our clinicians and other staff (including clinicians other than your therapist or principal clinician) who are involved in your care. This includes psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, case managers, psychiatric technicians, and nurses. For example, our staff may discuss your care at a case conference. We may also disclose information about you to people outside our agency who are or may be involved in your health care such as medical doctors, nurses, technicians, pharmacists, or other behavioral health professionals. For example, we may share information with your primary care physician regarding medications you may be on or to coordinate your care. When you leave our care we may also disclose information to your new provider. Information may also be released in the course of conservatorship proceedings.

If you are receiving services for substance abuse, no information regarding those services will be shared about you with other healthcare providers outside this agency's treatment program without your written permission unless you have a medical emergency or as otherwise required or permitted by law.

- **For Payment.** We may use and disclose health information about you to bill for the treatment and services you receive here and to collect payment from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment or counseling you received here so they will pay us or reimburse you for the services. We may also tell them about treatment or services we plan to provide in order to obtain prior approval or to determine whether your plan will cover the treatment.

If you are receiving services from our substance abuse treatment program, your signed authorization will be obtained before we contact your insurance company or other third party for reimbursement.

- **For Health Care Operations.** We may use and disclose health information about you for our own operations. These uses and disclosures are necessary to run the agency

and to make sure all of our clients receive quality care. For example, we may use health information to review our treatment and services and evaluate the performance of the staff in caring for you. We may also combine information about many clients to help decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to behavioral health care professionals, doctors, nurses, technicians, interns, health care students, and other agency staff for review or learning purposes. We may combine information we have with information from other agencies to compare how we are doing and where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of personal health information so others may use it to study health care and health care delivery without learning who the specific patients are.

- Appointment Reminders. We may use and disclose information to contact you as a reminder you have an appointment for treatment here.
- Treatment Alternatives. We may use and disclose information about you to tell you about or recommend possible treatment options or alternatives that might be of interest to you.
- Health-Related Benefits and Services. We may use and disclose your health information to tell you about health-related benefits or services that might be of interest to you.
- Individuals Involved in Your Care or Payment for Your Care. With your permission, we may release limited health information about you to a friend or family member who is involved in your care or helps pay for your care. For example, if you ask a family member to pick up a medication for you at the clinic or pharmacy, we may tell that person what the medication is and when it will be ready to pick up.
- Research. Under certain circumstances, we may use and disclose information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one treatment to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of personal health information, trying to balance the research needs with patients' need for privacy of their personal information. Before we use or disclose information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for clients with specific mental health needs, as long as the information they review does not leave our agency.
- As Required by Law. We will disclose health information about you when required to do so by federal, state, or local law. For example, if we reasonably suspect child abuse, we are required by law to report it. Or, information may need to be disclosed to

the Department of Health and Human Services to make sure that your rights have not been violated.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person. Any disclosure however, would only be to someone who we believe would be able to prevent the threat or harm from happening.

### **Special Situations**

- **Public Health Activities.** We may disclose health information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report the abuse or neglect of children, elders and dependent adults;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse or neglect.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested. We may disclose information to courts, attorneys and court employees in the course of conservatorship, and certain other judicial or administrative proceedings.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official:
  - in response to a court order, subpoena, warrant, summons or similar process;
  - to report criminal conduct at our facility, or threats of such conduct against our staff or facility;
  - to identify or locate a suspect, fugitive, material witness, certain escapes and certain missing persons;
  - when requested by an officer who lodges a warrant with the facility, and
  - when requested at the time of a patient's involuntary hospitalization.
- **Coroners and Medical Examiners.** We may be required by law to report the death of a

client to a coroner or medical examiner.

- Protection of Elective Constitutional Officers. We may disclose information about you to government law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.
- Inmates. If you are an inmate or ward in a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official if necessary to provide you with healthcare, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.
- Advocacy Groups. We may release information to the statewide protection and advocacy organization if it has a client or client representative's authorization, or for the purposes of certain investigations. We may release mental health information to our Patients' Rights Office if it has a client or client's representative's authorization, or for investigations resulting from reports required by law to be submitted to the Director of Mental Health.
- Department of Justice. We may disclose limited information to the California Department of Justice for movement and identification purposes about certain criminal clients, or regarding persons who may not purchase, possess, or control a firearm or deadly weapon.
- Multidisciplinary Teams. We may disclose information to a multidisciplinary team relevant to the prevention, identification, management, or treatment of an abused child, the child's parents, or an abused elder or dependent adult.
- Senate and Assembly Rules Committees. We may disclose your information to the Senate or Assembly Rules Committee for purpose of legislative investigation
- Other Special Categories of Information. Special legal requirements may apply to the use or disclosure of certain categories of information – e.g., tests for the human immunodeficiency virus (HIV) or treatment and services for alcohol and drug abuse.

### **Your Rights Regarding Private Health Information About You**

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Madera County Behavioral Health Services Medical Records Office. If you request a copy of the information we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request a review of the denial. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. If as a result of the review you are still denied access, you may arrange to have another healthcare professional review your record on your behalf.

Timeline:

- Inspection: We will make your records available for inspection on our premises within 5 working days of receiving your written request.
  - Summary: If you opt for a summary of your health record, it will be provided within 10 working days of receiving your written request or within a maximum of 30 days if we notify you more time is necessary, either because of the length of the record or because you were discharged within the prior 10 days. You will be required to pay fees related to preparing a summary.
  - Mailed Copy: We will mail copies of records within 15 working days after receiving your written request.
- Right to Amend. If you feel that health information we have about you is factually incorrect/wrong or incomplete, you may ask us to amend the error. You have the right to request an amendment for as long as the information is kept by or for us.

To request an amendment, your request must be made in writing and submitted to the Madera County Behavioral Health Services Medical Records Office. In addition, you must provide a reason that supports your request.

We have 60 days to respond to your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is unavailable to make the amendment;
- is not part of the health information kept by or for the facility;
- is not part of the information which you would be permitted to inspect or copy; or
- is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any items or statement in your record you believe is incomplete or incorrect/wrong. If you clearly indicate in writing you want the addendum to be made part of your health record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- Right to Authorize Us to Use or Disclose Your Information. You have the right to authorize us to use or disclose your private health information to other healthcare

providers and/or individuals who are working together to coordinate and provide services to you. This may include community based organizations, school officials, probation, social services, and others. You may also authorize us to disclose protected health information to your attorney, a consumer rights advocate, your health care agent, to a family member, or to anyone else you designate. We have the right to monitor and to approve such requests as allowed and permitted under the law. We must comply with your request that your records be released to your attorney or to a consumer rights advocate who is acting upon your behalf.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made of health information about you other than for our own uses for treatment, payment and health care operations (as those functions are described above) and with other exceptions pursuant to the law.

To request this list of accounting of disclosures, you must submit your request in writing to the Behavioral Health Services Medical Records Office. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time before any costs are incurred.

In addition, we will notify you as required by law if your health information is unlawfully accessed or disclosed.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask we not use or disclose information about a type of therapy you received.

In most cases, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. However, if you pay for treatment wholly out-of-pocket, you may request we not disclose information about that particular treatment to your health plan; we are required to honor that request.

To request restrictions, you must make your request in writing to your provider. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.



To request confidential communications, you must make your request in writing to your provider. We will not ask you for the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of the Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice from your provider or from the Madera County Behavioral Health Services Mental Health Plan. That office is generally open Monday through Friday from 8:00 a.m. to 5:00 p.m. (except holidays).

You may obtain a copy this notice at our website: [www.madera-county.com/behavioralhealth](http://www.madera-county.com/behavioralhealth)

### **Changes to This Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for new services we will offer you a copy of the current notice in effect.

### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint. You may file a complaint with Madera County Behavioral Health Services by contacting:

Sonja Bentley, Compliance/Privacy Officer  
Madera County Behavioral Health Services  
P. O. Box 1288, Madera, CA 93639-1288.  
(559) 673-3508  
OR

You may file a complaint with the Department of Health and Human Services by contacting:

Office of Civil Rights  
US Department of Health and Human Services  
90 7<sup>th</sup> Street, Suite 4 – 100  
San Francisco, CA 94103  
(415) 437-8310; (415) 437-8311 (TDD)  
OR  
[www.dhhs.gov/ocr/privacy/index.html](http://www.dhhs.gov/ocr/privacy/index.html)

**All complaints must be submitted in writing.** *You will not be penalized for filing a complaint.*

**Other Uses of Private Health information**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**ACKNOWLEDGEMENT OF RECEIPT**  
**OF**  
**BHS NOTICE OF PRIVACY PRACTICES**

- I hereby acknowledge receipt of the Madera County Behavioral Health Services Notice of Privacy Practices.
- I have been offered a copy of the Notice of Privacy Practices but do not wish to receive it at this time.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(if not signed by client)

## DEPARTAMENTO DE COMPORTAMIENTO DEL CONDADO DE MADERA

Fecha de Vigencia: 1 de octubre de 2014

### AVISO SOBRE LAS PRÁCTICAS DE PRIVACIDAD

ESTE AVISO DESCRIBE CÓMO SU INFORMACIÓN DE SALUD PRIVADA PUEDE SER UTILIZADA Y REVELADA Y CÓMO USTED PUEDE TENER ACCESO A ELLA. FAVOR DE REVISARLA CON CUIDADO.

Si usted tiene cualquier pregunta respecto a este aviso, favor de comunicarse con su proveedor o llamar al Departamento de Salud Mental del Condado de Madera al (559) 675-7850.

#### **Quiénes Seguirán Este Aviso**

Este aviso describe las prácticas de privacidad del Departamento de Comportamiento del Condado de Madera y las de:

- Todo empleado, miembro del personal y otro personal de esta agencia;
- Cualquier alumno, interno, voluntario, o persona no licenciada que podría ayudarle mientras usted esté aquí;
- Cualquier profesional de salud autorizado para añadir información a su archivo medico;
- Todas las instalaciones y unidades de esta agencia.

Todas estas entidades, sitios y ubicaciones siguen los términos de este aviso. Además, estas entidades, sitios y ubicaciones podrían compartir información de salud entre sí con fines de tratamiento, pagos u operaciones de salud para los propósitos descritos en este aviso.

#### **Nuestra Responsabilidad**

Entendemos que la información de salud y servicios relacionados referente a usted es personal y estamos fuertemente comprometidos a proteger su información confidencial. Nosotros creamos un historial de los cuidados y servicios que usted recibe en esta agencia con el fin de proveerle cuidado de calidad y cumplir con ciertos requisitos legales. Este aviso aplica a todos los datos referentes a su cuidado que son generados por esta agencia, sus proveedores y su personal, y aquellos que le proveen servicios en esta agencia. También aplica a cualquier expediente que pudiéramos haber recibido de sus otros proveedores. Puede que otros proveedores mantengan diferentes normas o avisos respecto a su utilización y revelación de información de salud creada en sus oficinas o instalaciones.

Este aviso le informará en cuanto a las maneras en que podríamos utilizar y revelar su información privada de salud. También describimos sus derechos y ciertas obligaciones que tenemos respecto al uso y la revelación de su información de salud.

La ley nos exige:

- Asegurarnos que toda información de salud que lo identifique se mantenga privada (con ciertas excepciones);
- Darle este aviso sobre nuestros deberes legales y prácticas de privacidad con respecto a su información de salud; y
- Seguir los términos de este aviso actualmente en vigor.

### **Cómo Podríamos Utilizar y Revelar Su Información de Salud**

Las siguientes categorías describen diferentes maneras en que utilizamos y revelamos información de salud privada. Para cada categoría de uso y revelación explicaremos lo que queremos decir y daremos algunos ejemplos. No todos los usos o revelaciones para cada categoría se alistarán. Sin embargo, todas las maneras en que se nos permite utilizar y revelar información caerán en una de las categorías.

- Divulgación a petición suya. Podemos divulgar información cuando usted así lo solicite, para lo cual podría ser necesario que nos otorgara su autorización por escrito.
- Para Tratamiento. Utilizaremos su información de salud personal para proveerle tratamiento y servicios relacionados incluyendo coordinación y manejo de caso. Por ejemplo, podría ser necesario divulgar información al trabajador de caso responsable del manejo de su caso. También podríamos divulgar su información de salud entre nuestros terapeutas y otro personal (incluyendo a terapeutas aparte del suyo) quienes estén involucrados en su cuidado. Esto incluye psiquiatras, psicólogos, trabajadores sociales licenciados, terapeutas de familias o matrimonios, técnicos en psiquiatría, y enfermeras tituladas. Por ejemplo, nuestro personal podría hablar sobre su cuidado en una conferencia de caso. También podríamos divulgar información sobre usted a otros profesionales fuera de esta agencia quienes están o podrían estar involucrados en su cuidado de salud como a doctores médicos, enfermeras, técnicos, farmacistas, u otros profesionales de salud de comportamiento. Por ejemplo, podríamos compartir información con su médico de atención primaria sobre medicamentos que esté tomando o para coordinar su cuidado.

Si usted está recibiendo servicios para el abuso de sustancias, no se compartirá ninguna información sobre usted respecto a tales servicios con otros proveedores de cuidado de salud que no formen parte del programa sin su permiso, a menos que usted sufra una emergencia médica o si de otra manera la ley lo permita o requiera.

- Para Pago. Podemos usar y divulgar su información de salud para cobrarle por el tratamiento y servicios que usted recibe aquí o para coleccionar pago de usted, una compañía de seguros, o un tercero. Por ejemplo, puede que necesitemos darle a su plan médico información respecto a tratamiento o consejería que usted recibió aquí para que ellos nos paguen o le reembolsen a usted por los servicios. Puede que también les informemos sobre algún tratamiento o servicio que

tengamos programado proveerle a usted con el fin de obtener previa autorización o para determinar si su plan médico pagará por el tratamiento. Si usted está recibiendo servicios de nuestro programa de tratamiento para abuso de sustancias, se obtendrá su autorización firmada antes de ponernos en contacto con su compañía de seguros u otro tercero para reembolso.

- Para Funciones de Cuidado de Salud. Puede que utilicemos y revelemos su información de salud para nuestras propias funciones. Estos usos y estas revelaciones son necesarias para manejar la agencia y para asegurar que todos nuestros clientes reciban cuidado de calidad. Por ejemplo, puede que utilicemos información de salud para revisar nuestros tratamientos, servicios y para evaluar la forma en que nuestro personal cuida de usted. También puede que combinemos información médica de muchos clientes para ayudarnos a decidir cuáles servicios adicionales debemos ofrecer, cuáles servicios no son necesarios, y si ciertos tratamientos nuevos son eficaces. Puede que también revelemos información a profesionales en salud de comportamiento, médicos, enfermeras, técnicos, internos, estudiantes de cuidado de salud y otros miembros del personal de la agencia para propósitos de revisión o aprendizaje. Puede que combinemos información que nosotros tengamos con la información de otras agencias para comparar cómo estamos funcionando y dónde podemos mejorar en el cuidado y los servicios que ofrecemos. Puede que removamos los datos que lo identifiquen a usted de este conjunto de información personal de salud para que otros la usen para estudiar el cuidado de salud y cómo hacerlo llegar al paciente, sin revelar quiénes son los pacientes específicos.
- Recordatorios de Citas. Puede que utilicemos y revelemos información para ponernos en contacto con usted para recordarle que tiene una cita para recibir tratamiento aquí.
- Alternativas en Tratamiento. Puede que utilicemos y revelemos información referente a usted para informarle de o recomendarle posibles opciones de tratamiento o alternativas que le puedan interesar.
- Beneficios y Servicios Relacionados al Cuidado de Salud. Puede que utilicemos y revelemos información de salud referente a usted para informarle sobre beneficios y servicios relacionados al cuidado de su salud que le puedan interesar.
- Individuos Involucrados en Su Cuidado o en el Pago Para su Cuidado. Con su permiso, puede que revelemos cierta información de salud referente a usted a un amigo o miembro de su familia que esté involucrado en su cuidado de salud o que ayude a pagar por ello. Por ejemplo, si usted le pide a un miembro de su familia que pase por la farmacia o clínica para conseguir un medicamento, puede que le digamos a tal persona qué es el medicamento y cuándo va a estar listo.
- Investigación. En ciertas circunstancias, podemos utilizar y divulgar su información de salud mental para fines de investigación. Por ejemplo, un proyecto de

investigación puede involucrar la comparación de la salud y recuperación de todos los pacientes que recibieron un tratamiento con los que recibieron otro para la misma condición. Sin embargo, todos los proyectos de investigación son sujetos a un proceso especial de aprobación. Este proceso evalúa un proyecto de investigación propuesto y su uso de la información de salud personal, tratando de equilibrar las necesidades de la investigación con las necesidades de los pacientes en cuanto a la privacidad de su información personal. Antes de utilizar o divulgar información con fines de investigación, el proyecto habrá sido aprobado mediante este proceso de aprobación de investigaciones. Sin embargo, podemos divulgar su información de salud a personas que están preparando la conducción de un proyecto de investigación, por ejemplo, para ayudarles a encontrar pacientes que tengan necesidades de salud mental específicas, siempre que la información de salud mental que consulten no salga esta agencia.

- Como lo Exige la Ley. Divulgaremos su información de salud cuando alguna ley federal, estatal o local nos lo requiera. Por ejemplo, si tenemos una sospecha razonable de que existe algún abuso infantil, la ley nos requiere reportarla. También puede que sea necesario revelar su información al Departamento de Servicios Humanitarios y de Salud para asegurar que sus derechos no se han infringidos.
- Para Evitar una Seria Amenaza a su Salud o Seguridad. Podemos usar y divulgar su información de salud cuando sea necesario para prevenir una amenaza seria a su seguridad y salud, o a la salud y seguridad del público u otra persona. Sin embargo, cualquier revelación sería solamente a alguien que nosotros creyéramos que podría evitar que tal amenaza o daño se realizara.

### **Situaciones Especiales**

- Actividades de Salud Pública. Podemos divulgar su información de salud para realizar actividades de salud pública. Estas actividades pueden incluir, entre otras, las siguientes:
  - para prevenir o controlar enfermedades, lesiones o discapacidades;
  - para reportar el abuso a la negligencia de niños, ancianos o adultos que dependen de otros;
  - para reportar reacciones a medicamentos o problemas con productos;
  - para reportar al público el retiro de productos que quizá estén usando;
  - para notificar al organismo gubernamental apropiado si creemos que un paciente ha sido la víctima de abuso o negligencia.
- Actividades Relacionadas a la Supervisión de Asuntos de Salud. Puede que revelemos información de salud a una agencia encargada de la supervisión de asuntos de salud para actividades que la ley autoriza. Estas actividades de supervisión incluyen, por ejemplo, intervenciones, investigaciones, inspecciones, y la licenciatura. Estas actividades son necesarias para el gobierno poder vigilar el sistema de cuidado de salud, los programas del gobierno, y el cumplir con las leyes del derecho civil.

- Demandas y Disputas. Si usted está envuelto en una demanda o disputa, puede que revelemos información de salud sobre usted en respuesta a una orden jurídica o administrativa. También podemos divulgar su información de salud mental en respuesta a un citatorio, pedido de revelación o a otro acto procesal legítimo de otra de las partes de la disputa, pero únicamente si se ha intentado informarle acerca del pedido (lo cual puede incluir una notificación por escrito para usted) o de obtener una orden que proteja la información solicitada. Podemos divulgar información de salud mental a tribunales, abogados y empleados de juzgados que participen en trámites de adjudicación de tutela y ciertos otros trámites jurídicos o administrativos.
  
- Cumplimiento de la Ley. Puede que revelemos información de salud si nos lo pide un agente de las autoridades:
  - en contestación a una orden jurídica, un citatorio, una orden de detención, una convocatoria o proceso similar;
  - para reportar conducta criminal dentro de nuestras instalaciones, o amenazas de tal conducta contra nuestro personal o nuestras instalaciones;
  - con el fin de identificar o ubicar a un sospechoso, fugitivo, testigo esencial, determinados fugitivos o personas desaparecidas;
  - acerca de un fallecimiento que consideramos que puede ser consecuencia de un delito;
  - cuando lo solicite un funcionario que interponga un mandato judicial ante el establecimiento; y
  - cuando así se solicite en el momento de la hospitalización involuntaria de un paciente.
  
- Médicos Forenses. La ley puede exigir que informemos de la muerte de un paciente a un médico forense o funcionario equivalente.
  
- Protección de Funcionarios Constitucionalmente Electos. Podemos divulgar su información de salud mental a entidades gubernamentales del cumplimiento de la ley, según sea necesario para proteger a funcionarios de nivel federal y estatal constitucionalmente electos y sus familias.
  
- Reclusos. Si usted está preso o recluso en una institución correccional o bajo la custodia de un agente de las autoridades, puede que revelemos información referente a usted a la institución correccional o al agente de las autoridades si es necesario para proveerle a usted cuidados médicos, para proteger su salud y seguridad o las de otros, o para la seguridad de la institución correccional.
  
- Grupos de Propugnación. Podemos divulgar información de salud mental a la organización de defensa y protección estatal si tenemos la autorización del paciente o de su representante o con fines de ciertas investigaciones. Podemos divulgar información de salud mental a la Oficina del Condado de Derechos de los



Pacientes si tenemos la autorización del paciente o su representante o para investigaciones que se produzcan de informes que por ley se deben presentar al Director de Salud Mental.

- Departamento de Justicia. Podemos divulgar información limitada al Departamento de Justicia de California con fines de traslado e identificación de ciertos pacientes criminales o acerca de personas que tienen prohibido comprar, tener o controlar una arma de fuego o letal.
- Equipos de Personal Multidisciplinario. Podemos divulgar información de salud mental a un equipo de personal multidisciplinario que sea pertinente para la prevención, identificación, control o tratamiento de un menor maltratado, los padres de dichos menores o una persona de edad avanzada o adulta a cargo maltratada.
- Comités de Normas de la Asamblea o del Senado. Podemos divulgar su información de salud mental al Comité de Normas de la Asamblea o del Senado con fines de investigación legislativa.
- Otras Categorías Especiales de Información. Hay ciertos requisitos jurídicos especiales que podrían aplicarse al uso o la divulgación de ciertas categorías de información, como por ejemplo, resultados de los análisis de detección del virus de la inmunodeficiencia humana (VIH) y el tratamiento o los servicios para alcoholismo y drogadicción.

### **Sus Derechos Respecto a Información de Salud Privada Sobre Usted**

Usted tiene los siguientes derechos respecto a información de salud que conservamos sobre usted:

- Derecho a Inspeccionar y Copiar. Usted tiene el derecho de examinar y copiar información de salud que usted pueda utilizar para tomar decisiones sobre su cuidado.
- Para examinar y copiar información de salud que pueda utilizar para tomar decisiones sobre usted, usted tiene que presentar su solicitud por escrito a la Oficina de Registros Médicos Departamento de Salud Mental del Condado de Madera. Si usted pide una copia de la información quizás le cobremos una cuota por el costo de las copias, envío, y otras provisiones asociadas con su solicitud.

Quizás, en ciertas circunstancias muy limitadas, se le negará su solicitud para examinar y copiar. Si se le niega acceso a información de salud que usted haya solicitado, usted puede solicitar una revisión de tal negación. Otro profesional licenciado en cuidado de salud, escogido por las instalaciones, revisara su solicitud y la negación de esta. La persona que conducirá el reviso no será la persona que denegó su solicitud. Nosotros cumpliremos con el resultado del reviso. Si como resultado de la revisión aun se le niega acceso, usted puede convenir que otro profesional de cuidado de salud revise de su parte su registro.

Línea de Tiempo:

- Inspección: Pondremos los archivos a su disposición dentro de nuestro establecimiento para su inspección dentro de 5 días hábiles de haber recibido la solicitud escrita.
  - Resumen: Si opta por un resumen de su archivo de salud, este se le hará disponible dentro de 10 días hábiles de haber recibido la solicitud escrita o dentro de un máximo de 30 días si le notificamos que más tiempo es necesario, ya sea debido al tamaño del archivo o debido a que su caso ha sido cerrado en los últimos diez días. Se le requerirá hacer un pago relacionado con la preparación de un resumen.
  - Copia Mandada por Correo: Mandaremos copias de archivos por correo dentro de 15 días después de haber recibido una solicitud escrita.
- Derecho a Corregir. Si usted siente que la información de salud que tenemos sobre usted está fácticamente incorrecta o incompleta, usted puede solicitar que corrijamos el error. Usted tiene el derecho de solicitar una corrección durante todo el tiempo que guardemos o tengamos la información.

Para solicitar una corrección, su solicitud tiene que hacerse por escrito y presentarla a la Oficina de Registros Médicos Departamento de Salud Mental del Condado de Madera. Adicionalmente, necesitará proveernos una razón para apoyar su solicitud.

Tenemos 60 días para responder a su solicitud. Puede que neguemos su solicitud de corrección si no está por escrito o no incluye una razón que apoye su solicitud. Adicionalmente, puede que neguemos su solicitud si usted solicita que corrijamos información que:

- no se originó por nosotros, a menos que la persona o entidad que originó la información no esté;
- disponible para hacer la corrección;
- no es parte de la información de salud guardada por o para estas instalaciones;
- no es parte de la información que a usted se le permite examinar o copiar; o
- no es exacta y completa.

Aunque neguemos su solicitud de corrección, usted tiene el derecho a presentar un addendum por escrito, sin exceder 250 palabras, con respecto a cualquier punto o declaración de su archivo que usted considere incompleto o incorrecto. Si usted indica claramente por escrito que quiere que el addendum se haga parte de su archivo de salud, lo añadiremos a su archivo y lo incluiremos en cualquier divulgación del punto o declaración que usted considere incompleta o incorrecta.

- Derecho de Autorización Para Utilizar o Revelar Su Información. Usted tiene el derecho de autorizarnos para utilizar o revelar su información de salud privada a otros proveedores de cuidado de salud y/o a individuos que están trabajando unidamente para coordinar y proveerle servicios a usted. Esto pueda que incluya a

organizaciones en la comunidad, funcionarios escolares, probación, servicios sociales, y otros. Usted también puede autorizarnos para revelar información de salud, protegida a su abogado, defensor de los derechos del consumidor, su agente de cuidado de salud, miembro de su familia, o a cualquier otra persona a quien usted haya designado. Tenemos el derecho de verificar y aprobar tales solicitudes como se permita bajo la ley. Tenemos el deber de cumplir con su solicitud de relevar sus registros a su abogado o al defensor de los derechos del consumidor que esté actuando de su parte.

- Derecho a Una Lista de Revelaciones. Usted tiene el derecho a solicitar un “informe de divulgaciones”. Este informe es una lista de las divulgaciones que efectuamos de su información de salud aparte del uso que le demos para fines de tratamiento, pagos y gestiones administrativas de atención médica (según dichas funciones se describen anteriormente), y según otras excepciones conforme a la ley.

Para solicitar una lista o informe de las divulgaciones, debe presentar una solicitud por escrito a la Oficina de Registros Médicos del Departamento de Salud Mental del Condado de Madera. Su petición debe indicar un plazo de tiempo que no exceda seis años y no puede incluir fechas anteriores al 14 de Abril de 2003. Su petición debe indicar en qué forma quiere usted su lista (por ejemplo, un documento escrito o por vía electrónica). La primera lista que usted pida dentro de un plazo de doce meses será gratis. Puede que le cobremos por el costo de proveerle listas adicionales. Le notificaremos del costo envuelto y usted puede decidir retirar o modificar su petición en cualquier momento antes de incurrir gasto alguno.

Además, le notificaremos, según lo requerido por la ley, si la información sobre su salud es obtenida o revelada ilícitamente.

- Derecho de Solicitar Restricciones. Usted tiene el derecho de solicitar una restricción o limitación en la información de salud que utilizamos o divulgamos acerca de usted para fines de tratamiento, pagos o gestiones administrativas de atención médica. Usted también tiene el derecho a solicitar un límite en la información que divulgamos acerca de usted a una persona que participe en su atención o para el cobro de la misma, como por ejemplo, un familiar o amigo. Por ejemplo, usted puede solicitar que no utilicemos o divulguemos información acerca de un tipo de terapia a la que se sometió.

No tenemos obligación de concederle su pedido. Si decidimos conceder su pedido, cumpliremos con su solicitud a menos que la información sea necesaria para brindarle tratamiento de emergencia. Sin embargo, si usted por tratamiento de su propio bolsillo, usted puede solicitar que no divulguemos información sobre ese particular tratamiento a su plan de salud; se nos requiere honrar esa solicitud.

Para solicitar restricciones, usted tiene que presentar su solicitud por escrito a su proveedor. En su solicitud usted tendrá que dejarnos saber cuál es la información que usted quiere que limitemos, ya sea que usted quiera limitar nuestro uso, revelación o ambos, y a quién quiere usted que apliquen las limitaciones.

- **Derecho de Solicitar Comunicación Confidencial.** Usted tiene el derecho de solicitar que nos comuniquemos con usted de cierta forma o en cierto lugar sobre asuntos de salud. Por ejemplo, usted puede pedir que nos pongamos en contacto con usted solamente en su lugar de empleo o por correo.

Para solicitar comunicación confidencial, usted tiene que presentar su solicitud por escrito a su proveedor. No le preguntaremos la razón de su solicitud. Cumpliremos con toda solicitud razonable. Su solicitud tiene que especificar cómo o cuándo usted desea que nos pongamos en contacto con usted.

- **Derecho de Obtener una Copia de Papel de este Aviso.** Usted tiene el derecho de obtener una copia de papel de este aviso. Usted puede pedirnos una copia de esta notificación en cualquier momento. Aunque usted haya concordado en recibir esta notificación electrónicamente, aún tiene el derecho de recibir una copia de papel de este aviso.

Usted podrá obtener una copia de esta notificación de su proveedor o del Plan de Salud Mental del Departamento de Salud Mental del Condado de Madera. Generalmente, esta oficina abre sus puertas de lunes a viernes de 8:00 a.m. a 5:00 p.m. (excepto días feriados).

Puede obtener una copia de este informe en nuestra sede en la red: [www.madera-county.com/behavioralhealth](http://www.madera-county.com/behavioralhealth)

### **Cambios a esta Notificación**

Reservamos el derecho de hacer cambios a esta notificación. Reservamos el derecho de hacer vigente la notificación modificada o cambiada respecto a información de salud que ya tengamos sobre usted, asimismo, cualquier información que recibamos en el futuro. Pondremos una copia vigente de la notificación en nuestras instalaciones. En la primera página en la parte superior a mano derecha la notificación incluirá la fecha de vigencia. Adicionalmente, cada vez que usted se registre para servicios nuevos, le ofreceremos una copia de la notificación en vigencia.

### **Quejas**

Si usted cree que sus derechos de privacidad han sido infringidos, usted puede presentar una queja.- Usted puede entablar un reclamo con El Departamento de Comportamiento y Salud Mental del condado de Madera al ponerse en contacto con:

Sonja Bentley, Compliance/Privacy Officer  
Madera County Behavioral Health Services  
P.O. Box 1288, Madera, CA 93639-1288.

(559) 673-3508

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Puede Entablar un reclamo con El Departamento de Salud y Servicios Humanos al ponerse en contacto con:

Office of Civil Rights  
US Department of Health and Human Services  
50 United Nations Plaza – Room 322  
San Francisco CA 94102  
(415) 437-8310; (415) 437-8311 (TDD)

○

[www.dhhs.gov/ocr/privacy/index.html](http://www.dhhs.gov/ocr/privacy/index.html)

**Toda queja debe ser presentada por escrito.** *No se le penalizara por presentar una queja.*

### **Otros Usos de Información de Salud**

Otros usos o revelaciones de información de salud no protegidas por esta notificación o por las leyes que a nosotros aplican, se harán solo con su permiso por escrito. Si usted nos provee permiso para utilizar o revelar información de salud sobre usted, podrá revocar en cualquier tiempo ese permiso por escrito. Si usted cancela su permiso, no revelaremos información de salud sobre usted por las razones protegidas un su autorización por escrito. Queda entendido que no podemos retraer ninguna revelación que ya hayamos hecho con su permiso, y que nos es requerido mantener registros del cuidado que ya hemos provisto.

**RECONOCIMIENTO DE HABER RECIBIDO EL AVISO**  
**SOBRE**  
**PRÁCTICAS DE PRIVACIDAD DE BHS**

- Con la presente reconozco el haber recibido el Aviso Sobre Prácticas de Privacidad del Departamento de Comportamiento del Condado de Madera.
- Se me ha ofrecido una copia del Aviso Sobre Prácticas de Privacidad, pero no deseo recibirla ahora.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_

Nombre en Letra de Molde: \_\_\_\_\_ Parentesco: \_\_\_\_\_  
(Si no firmada por el/la cliente)

# ATTACHMENT C

## Chart Review Policy

&

## Procedure

QMP 10.00



Subject: <b>NETWORK PROVIDER CHART REVIEW</b>	Policy No.: <b>QMP 10.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates: 10-04-06, 9-2-09, 10-30-09, <b>10-16-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 10-04-06, 9-2-09, 10-30-09, <b>10-16-15</b>	

**POLICY:**

At least annually, the Madera County Mental Health Plan (MHP) will review one chart and up to ten percent (10%) of all Madera County Medi-Cal beneficiary charts of each Network Provider.

**PURPOSE:**

To assure provision of high quality outpatient services through network providers.

**PROCEDURE:**

- I. Each year the Managed Care Coordinator, or designee, will conduct an on-site review of one to ten percent (10%) of the Madera County Mental Health Plan referral charts of each credentialed Network Provider.
- II. The Network Provider will :
  - A. Provide access to all Madera County Medi-Cal beneficiary charts.
  - B. Assist in coordinating an area for the review.
  - C. Cooperate with the Managed Care Coordinator, or designee, and the recommendations offered.
- III. The Managed Care Coordinator, or designee, will:
  - A. Notify the Network Provider at least three weeks in advance of the scheduled review.
  - B. Assign a number to the reviewed chart and keep a list of names and numbers in a locked file in the MHP office.
  - C. Fill out the Internal Chart Review form (QMP 10.A1).
  - D. Notify the Network Provider in writing of the commendations and recommendations of the Interagency Quality Improvement Committee (IQIC) within two weeks of the review (See QMP 10.A2 Quality Improvement Review form).
  - E. Maintain strict confidentiality of information and chart:



1. No communication related to the review shall be discussed with persons outside Quality Management or the MHP.
  2. Names of clients and treating providers shall not be used in minutes or reports.
  3. Confidential information about clients, treatment providers, or reviewers shall not be disclosed or issued unless authorized by the local Behavioral Health Services Director or designee.
  4. Violation of any of these ethical codes shall be dealt with appropriately.
  5. Feedback on the review will be given to the IQIC.
- IV. This policy and any subsequent revisions shall be approved by the Quality Management Committee (QMC).

Attachments:

[QMP 10.A1 Internal Chart Review Form](#)  
[QMP 10.A2 Quality Improvement Review](#)

MADERA COUNTY MENTAL HEALTH PLAN QMP 10.A1

Internal Chart Review – For the Audit Period \_\_\_\_\_ Date of Review \_\_\_\_\_

Chart # \_\_\_\_\_ DOB \_\_\_\_\_

Head of Case \_\_\_\_\_ Reviewed by: \_\_\_\_\_

MEDICAL NECESSITY	COMPLIANCE			COMMENTS
	YES	NO	NA	
1. Medi-Cal covered five-axis diagnosis using DSM-IV TR.				DMH REQUIREMENT. Disallowance of entire treatment episode if treatment continued beyond the initial assessment for an excluded diagnosis.
2. It is clearly documented that the beneficiary, as the result of a mental disorder, has specific impairments, a probability of significant deterioration in an important area of life function, or for youth, a probability that the child/youth will not progress developmentally.				DMH REQUIREMENT. Disallowance of entire treatment episode if not found.
3. The proposed intervention(s) focuses on reducing impairments, preventing deterioration of functioning, or allowing developmentally appropriate progress.				DMH REQUIREMENT. Disallowance if not present.
4. There is an expectation that the proposed interventions will do, at least, one of the following: Diminish the impairment, prevent deterioration of functioning, allow developmental progress, and if under age 21, correct or ameliorate the condition.				DMH REQUIREMENT. Disallowance if not present.
<b>Comments/Corrections:</b>				
<b>Date of Follow-up and Completion:</b>				
<b>ASSESSMENT—the following documentation components are present:</b>				
5. Relevant physical health conditions are identified and updated as appropriate				DMH REQUIREMENT. Corrective action if not found.
6. Presenting problems or relevant conditions which affect the consumer’s physical health and mental status, including baselines				DMH REQUIREMENT. Corrective action if not found.
7. Consumer strengths to achieve therapeutic goals				DMH REQUIREMENT. Corrective action if not found.
8. Special status situations including suicidal/homicidal risks and grave disability are noted and updated.				DMH REQUIREMENT. Corrective action if not found.

MADERA COUNTY MENTAL HEALTH PLAN QMP 10.A1

Internal Chart Review – For the Audit Period \_\_\_\_\_ Date of Review \_\_\_\_\_

Chart # \_\_\_\_\_ DOB \_\_\_\_\_

Head of Case \_\_\_\_\_ Reviewed by: \_\_\_\_\_

9. Current medications, dosages, refill dates, lab tests, and informed consent for medication				DMH REQUIREMENT. Corrective action if not found.
10. Client self report of allergies and adverse reactions to medications or lack of known allergies/sensitivities				DMH REQUIREMENT. Corrective action if not found.
11. Past mental health history including treatment, providers, interventions, consultation, and relevant family information				DMH REQUIREMENT. Corrective action if not found.
12. Prenatal and perinatal events and developmental history for children/adolescents				DMH REQUIREMENT. Corrective action if not found.
13. Past or present use of tobacco, alcohol, caffeine, over the counter, and illicit drugs				DMH REQUIREMENT. Corrective action if not found.
14. Mental status exam				DMH REQUIREMENT. Corrective action if not found.
15. Diagnosis is consistent with the presenting problems, history, mental status evaluation and other assessment data.				DMH REQUIREMENT. Corrective action if not found.
16. Assessment updated when clinically appropriate.				DMH REQUIREMENT. Corrective action if not found.
17. Consumer was asked whether he/she had an Advance Directive and information was provided.				DMH REQUIREMENT. Corrective action if not found.
<b>Comments/Corrections:</b>				
<b>Date of Follow-up and Completion:</b>				
<b>PLAN OF CARE</b>				
18. Plan of Care is updated at least annually and covers the present treatment period.				<b>DMH REQUIREMENT. Disallowance of entire treatment episode if not found.</b>
19. Consumer's or legal guardian's signature is present or there is a written explanation if it is absent.				<b>DMH REQUIREMENT. Disallowance of entire treatment episode if not found.</b>
20. Plan objectives are behaviorally specific, observable or quantifiable and are consistent with the diagnosis.				DMH REQUIREMENT. Corrective action if not found.
21. Plan identifies proposed duration of intervention and treatment.				DMH REQUIREMENT. Corrective

MADERA COUNTY MENTAL HEALTH PLAN QMP 10.A1

Internal Chart Review – For the Audit Period \_\_\_\_\_ Date of Review \_\_\_\_\_

Chart # \_\_\_\_\_ DOB \_\_\_\_\_

Head of Case \_\_\_\_\_ Reviewed by: \_\_\_\_\_

				action if not found.
22. Plan of Care is signed by the MHP representative and co-signed when necessary.				DMH REQUIREMENT. Corrective action if not found.
23. Plan of Care and proposed interventions are consistent with diagnosis and treatment goals.				DMH REQUIREMENT. Corrective action if not found.
24. A copy of the POC is offered to the consumer and this is documented.				Per Department policy. Corrective action if not found.
<b>Comments/Corrections:</b>				
<b>Date of Follow-up and Completion:</b>				
<b>PROGRESS NOTES consistently document:</b>				
25. The date, time spent, and type of services provided.				<b>DMH REQUIREMENT. Disallowance if not present.</b>
26. The time claimed is equal to the time documented.				<b>DMH REQUIREMENT. Disallowance if not present.</b>
27. Progress note indicates service is provided in an eligible setting (not an IMD, jail, or other lockout setting.)				<b>DMH REQUIREMENT. Disallowance if not present.</b>
28. If note is for a group activity, time is properly apportioned to all clients present.				<b>DMH REQUIREMENT. Disallowance if not present.</b>
29. Signature(s) (or electronic equivalent) of person providing the service is present (with co-signatures if required).				<b>DMH REQUIREMENT. Disallowance if not present.</b>
30. Note indicates service was not solely for transportation, clerical, payee related, or for a missed appointment.				<b>DMH REQUIREMENT. Disallowance if not present.</b>
31. Medical necessity for continued treatment. Medical necessity is demonstrated by continued symptoms and impairment which impacts daily social and community functioning.				<b>DMH REQUIREMENT. Disallowance of further treatment beyond when medically necessary.</b>
32. Interventions and relevant clinical decisions aimed at reducing the symptoms and impairments identified on the POC.				DMH REQUIREMENT. Corrective action if not found.
33. Staff interventions and consumer response to life-threatening conditions, i.e.; suicidal/homicidal ideation and grave disability.				DMH REQUIREMENT. Corrective action if not found.

MADERA COUNTY MENTAL HEALTH PLAN QMP 10.A1

Internal Chart Review – For the Audit Period \_\_\_\_\_ Date of Review \_\_\_\_\_

Chart # \_\_\_\_\_ DOB \_\_\_\_\_

Head of Case \_\_\_\_\_ Reviewed by: \_\_\_\_\_

34. Continued active participation in treatment by the beneficiary and his/her family.				DMH REQUIREMENT. Corrective action if not found.
35. Progress or lack of progress toward treatment goals.				DMH REQUIREMENT. Corrective action if not found.
36. Evidence of collaboration and referrals to community resources or other agencies when appropriate				DMH REQUIREMENT. ( Title 9 1810.310) Corrective action if not found.
37. Linking beneficiary to culturally-specific and/or linguistic services when appropriate				DMH REQUIREMENT. (Title 9 1810.410) Corrective action if not found.
38. Consumer was offered a choice of provider, e.g., male, female, culture or language specific, etc.				DMH REQUIREMENT. (Title 9 1830.225) Corrective action if not found.
39. Correspondence is in the consumer's primary language.				Per Department policy. Corrective action if not found.
40. Discharge summary or plan for follow-up care when appropriate				DMH REQUIREMENT. Corrective action if not found.
<b>Comments/Corrections:</b>				
<b>Date of Follow-up and Completion:</b>				
<b>TYPE OF SERVICE CONTACT is accurately documented:</b>				
41. Effort to contact the beneficiary after missed appointments				DMH REQUIREMENT. Corrective action if not found.
42. Individual and family therapy notes show a service that focuses primarily on symptom reduction for an individual or family group.				Title 9 REQUIREMENT. Plan of correction if notes are not specific. May be reason for disallowance.
43. Group therapy notes show a service that focuses on symptom reduction and is provided to multiple consumers in one session.				Title 9 REQUIREMENT. Plan of correction if notes are not specific. May be reason for disallowance.
44. Plan Development notes show a service activity which consists of development and approval of the consumer's plan, and/or monitoring of the consumer's progress				Title 9 REQUIREMENT. Plan of correction if notes are not specific. May be reason for disallowance.
45. Case management linkage and consultation notes show consumer was linked, assisted, monitored, or advocated for by staff per POC.				Title 9 REQUIREMENT. Plan of correction if notes are not specific.

MADERA COUNTY MENTAL HEALTH PLAN QMP 10.A1

Internal Chart Review – For the Audit Period \_\_\_\_\_ Date of Review \_\_\_\_\_

Chart # \_\_\_\_\_ DOB \_\_\_\_\_

Head of Case \_\_\_\_\_ Reviewed by: \_\_\_\_\_

				May be reason for disallowance.
46. Case management/placement notes show consumer was offered assistance in locating and securing an appropriate living environment or funding per POC.				Title 9 REQUIREMENT. Plan of correction if notes are not specific. May be reason for disallowance.
47. Individual rehab or Group rehab notes show consumer was offered assistance, training, counseling, support, or encouragement per POC.				Title 9 REQUIREMENT. Plan of correction if notes are not specific. May be reason for disallowance.
48. Crisis Intervention notes show consumer's condition required (and received) a more timely response than a regularly scheduled visit.				Title 9 REQUIREMENT. Plan of correction if notes are not specific. May be reason for disallowance.
49. Collateral notes show contact with the consumer's significant support person(s) including consultation and training to assist in better utilization of services and understanding of the consumer's mental illness per POC.				Title 9 REQUIREMENT. Plan of correction if notes are not specific. May be reason for disallowance.
<b>Comments/Corrections:</b>				
<b>Date of Follow-up and Completion:</b>				
<b>OVERALL QUESTIONS</b>				
50. Mandated reporting to CPS or APS is documented if appropriate.				DMH REQUIREMENT. Corrective action if not found.
51. Provider is working within scope of practice, documented throughout chart.				DMH REQUIREMENT. Corrective action if not found.
<b>Comments/Corrections:</b>				
<b>Date of Follow-up and Completion:</b>				
<b>Date of Completion of Any Outstanding Issues:</b>				
<b>Was information relayed to Division Manager/QA and Data Management?    YES            NO</b>				

MADERA COUNTY MENTAL HEALTH PLAN QMP 10.A1

Internal Chart Review – For the Audit Period \_\_\_\_\_ Date of Review \_\_\_\_\_

Chart # \_\_\_\_\_ DOB \_\_\_\_\_

Head of Case \_\_\_\_\_ Reviewed by: \_\_\_\_\_

INTAKE DOCUMENTATION		Select One:	YES	NO	N/A	COMMENTS
<i>Copy of the following is present :</i>						
1.	Original signed Consent for Treatment and a new signed Consent for Treatment form for each voluntary episode of inpatient hospitalization, voluntary crisis stabilization and prior to starting outpatient services.		<input type="checkbox"/>	<input type="checkbox"/>		California Family Code, Sections 6920-21, 6924 (as cited in BHS P&P MR 04:00)
2.	Signed Limits of Confidentiality Statement		<input type="checkbox"/>	<input type="checkbox"/>		Title 42, Sections 2.1 thru 2.67-1, Code of Federal Regulations. (consumers entitled to right of confidentiality)
3.	Signed Notice of Privacy Practice		<input type="checkbox"/>	<input type="checkbox"/>		HIPPA requirement; BHS Requirement P&P PRV 18:00, Sect.I, D, 1.
4.	Signed internal authorization to exchange information		<input type="checkbox"/>	<input type="checkbox"/>		BHS Requirement P&P PRV 20:00, Sect. III, A, 1.
5.	Medi-Cal card		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DMH Revenue Manual, Sect. 2.3.02
6.	All other insurance cards		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DMH Revenue Manual, Sect. 2.3.02
7.	Current Financial Review		<input type="checkbox"/>	<input type="checkbox"/>		DMH Revenue Manual, Sect. 2.3.01
8.	Court Order, if ward of the court		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BHS Requirement P&P CLN 13:00
<p><u>Intake Documentation Criteria:</u> All items listed above must be marked either "yes" or "n/a" to meet criteria.</p> <p style="text-align: right;"><b>Intake Documentation criteria met?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>						

ORGANIZATION		Select One:	YES	NO	COMMENTS
1.	Documentation filed in date order		<input type="checkbox"/>	<input type="checkbox"/>	BHS Requirement P&P MR 03:00, Sect. I, A.
2.	Documentation filed in the correct location (tab)		<input type="checkbox"/>	<input type="checkbox"/>	BHS MR standard chart set-up requirements?
3.	Chart is free of post-it notes and loose papers		<input type="checkbox"/>	<input type="checkbox"/>	BHS Requirement P&P MR 01:00, Sect. IV, G, 1.
<p><u>Organization Criteria:</u> All items listed above must be marked "yes" to meet criteria.</p> <p style="text-align: right;"><b>Organization criteria met?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					

<p><u>Clerical Review Criteria:</u> All intake documentation criteria and organization criteria must be checked "yes" or "N/A" to meet clerical review.</p> <p style="text-align: right;"><b>Clerical Review criteria met?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Additional Comments:	
Reviewer:	Signature / Date:

**QMP 10.A2**

**Madera County Mental Health Plan  
Quality Improvement Review**

Chart # \_\_\_\_\_

Network Provider: \_\_\_\_\_  
\_\_\_\_\_

Date:

Reason for Review: Annual [ ]      24 visits or more [ ]      12 visits in 6 months [ ]

**MANAGED CARE:**

- 1. Completion of Re-authorization adequate?      YES [ ] NI [ ] NO [ ]  
\_\_\_\_\_
- 2. Was Re-authorization Request submitted  
prior to Screening "End Date" or prior to  
visits ending?      YES [ ] NI [ ] NO [ ]  
\_\_\_\_\_
- 3. Progress toward previous treatment goals?      YES [ ] NI [ ] NO [ ]  
\_\_\_\_\_
- 4. Justification for service extension?      YES [ ] NI [ ] NO [ ]  
\_\_\_\_\_
- 5. Provider and client signatures?      YES [ ] NI [ ] NO [ ]  
\_\_\_\_\_
- 6. Client's name or ID number on each page?      YES [ ] NI [ ] NO [ ]  
\_\_\_\_\_
- 7. Signed copy of NPP in chart?      YES [ ] NI [ ] NO [ ]  
\_\_\_\_\_





# ATTACHMENT D

## Clinical Chart Documentation

Authorization/Reauthorization/Network Provider

MHP 20.00



Subject: <b>MHP NETWORK PROVIDER CHART REVIEW</b>	Policy No.: <b>MHP 20.00</b>	Original Issue Date: <b>12-06-12</b>	Revision Dates:  08-18-14, <b>09-25-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates:  08-18-14, <b>09-25-15</b>	

**POLICY:**

Any client that has received services through a network provider will have their documentation reviewed at the time of billing.

**PURPOSE:**

To assure provision of appropriate utilization of outpatient services through network providers.

**PROCEDURE:**

- A. Any client that has received services from a network provider will be reviewed. At An MHP clinician will conduct an on-site review of such charts of each credentialed Network Provider.
- B. The Network Provider will :
  1. Provide access to all Madera County Medi-Cal beneficiary charts.
  2. Assist in coordinating an area for the review.
  3. Cooperate with the MHP clinician, or designee, and the recommendations offered.
- C. The MHP clinician or designee, will:
  1. Notify the Network Provider at least three weeks in advance of the scheduled review.
  2. Fill out the Network Provider Review Form.
  3. Notify the Network Provider in writing of the recommendations of the reviewer.
  4. Maintain strict confidentiality of information and chart:
    - a. No communication related to the review shall be discussed with persons outside the MHP.
    - b. Names of clients and treating providers shall not be used in minutes or reports.
    - c. Confidential information about clients, treatment providers, or reviewers shall not be disclosed or issued unless authorized by the local Behavioral Health Services Director or designee.
    - d. Violation of any of these ethical codes by the MHP Clinician or designee shall be dealt with appropriately.
  5. A need for a correction during a review will require a Plan of Correction within 30 days from the date of the notification letter from MHP.

Note: See Also Quality Management policy QMP 10:00 Network Provider Chart Review

Attachments:

[MHP 20.A1 Demographic Form](#)

[MHP 20.A2 Network Provider Assessment](#)

**MADERA COUNTY  
MENTAL HEALTH PLAN  
209 E. 7<sup>TH</sup> Street  
P.O. BOX 1288  
MADERA CA 93638  
(559) 673-3508  
(559) 675-7758**

Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_  
\_\_\_\_\_

The Madera County Mental Health Plan has authorized you to provide the following services:

Client Name: \_\_\_\_\_

Client I.D. No.: \_\_\_\_\_

Authorized HCPC/CPT  
Codes: \_\_\_\_\_

No. of Sessions: \_\_\_\_\_

Auth. Start Date: \_\_\_\_\_

Auth. Expiration Date: \_\_\_\_\_

Please note that the Expiration Date is the last date on which this service authorization can be used. After this date, the authorization will be automatically cancelled, even if all authorized sessions have not been used.

All payments are subject to the member's continued Medi-Cal eligibility, Mental Health Plan policy and reimbursement schedules.

If additional care or visits are required, you must contact the Mental Health Plan at 1-888-275-9779 (toll free) or (559) 673-3508 in Madera City to arrange further authorized visits. We cannot reimburse services that have not been preauthorized.

If you have any questions, please call the Mental Health Plan at the above numbers.

Sincerely,

\_\_\_\_\_  
Managed Care Clinician

Madera County Behavioral Health Services  
P. O. Box 1288 / Madera, CA 93639-1288  
209 E. 7<sup>th</sup> Street, Madera, CA 93637  
(559)673-3508  
(559)675-7758 (fax)

## Service Authorization Request For Providers Only

Client's Name (Last, First, Middle)	DOB	Age	CIN or SSN
Provider			Phone Number
Address			Fax Number
Submitted to MHP			Date Submitted to MHP

Initial Authorization for "Client Assessment" only

Initial Authorization  
(Required documents: "Client Assessment" and "Client Plan")

Re-Authorization  
(Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

Annual Re-Authorization  
(Submit "Client Assessment Update" and "Client Plan" consistent with MHP's frequency requirements)

(Please note: The MHP may request clarifying information/documentation to process your request for any of the above)

Mental Health Services Requested	Frequency of Service(s) (Indicate How many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (Initial approved service)
Evaluation and Management (Office or Other Outpatient Facility)	____ Per <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Authorization				
Individual Psychotherapy	____ Per <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Authorization				
Group Psychotherapy	____ Per <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Authorization				
Family Psychotherapy	____ Per <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Authorization				
Other	____ Per <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Authorization				

Explain why this service level is necessary

Client Name:

Record/Identification Number:

Madera County Behavioral Health Services  
P. O. Box 1288 / Madera, CA 93639-1288  
209 E. 7<sup>th</sup> Street, Madera, CA 93637  
(559)673-3508  
(559)675-7758 (fax)

**CLIENT TREATMENT PLAN FORM  
PROVIDER**

(MHP Use Only) Authorization #: _____		
Code	# Visits	Authorized Period
		From:                      To:
		From:                      To:
Signature: _____		Date: _____

Date of this Client Plan:

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age Today: \_\_\_\_\_

SSN: \_\_\_\_\_ CIN: \_\_\_\_\_ Chart/Identification Number \_\_\_\_\_

**Other Coordinated Services/Agencies Involved (with contacts if known):**  None Known

1. Agency: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Agency: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

3. Agency: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Treatment Goals**

Specific, observable and/or quantifiable goals (include the current baseline)	Modalities and Interventions	Within what time frame (Duration)

I participated in the development of this plan and was offered a copy

\_\_\_\_\_  
Client Signature\*                                      Date                                      Caregiver Signature                                      Date

\_\_\_\_\_  
Provider Signature                                      License                                      Date:

\*Child/Youth refuses or is unavailable to sign, please explain the refusal or unavailability here:



## CHILD & ADOLESCENT NEEDS and STRENGTHS ASSESSMENT (California CANS-50)

**Assessment Type:**       Initial     Subsequent     Annual     Discharge     Administrative Close

**KEY for Child Behavioral / Emotional Needs:**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**CHILD BEHAVIORAL / EMOTIONAL NEEDS**

- |                                 |                         |                         |                         |                         |
|---------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 1. Psychosis (Thought Disorder) | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 2. Impulsivity / Hyperactivity  | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Depression                   | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 4. Anxiety                      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 5. Oppositional                 | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 6. Conduct                      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 7. Anger Control                | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 8. Substance Use                | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 9. Adjustment to Trauma         | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Life Domain Functioning:**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**LIFE DOMAIN FUNCTIONING**

- |                                  |                         |                         |                         |                         |
|----------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 10. Family Functioning           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 11. Living Situation             | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 12. Social Functioning           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 13. Developmental / Intellectual | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 14. Decision-Making              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 15. School Behavior              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 16. School Achievement           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 17. School Attendance            | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 18. Medical / Physical           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 19. Sexual Development           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 20. Sleep                        | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Risk Behaviors:**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**RISK BEHAVIORS**

- |  |                         |                         |                         |                         |
|--|-------------------------|-------------------------|-------------------------|-------------------------|
| 21. Suicide Risk                         | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 22. Non-Suicidal Self-Injurious Behavior | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 23. Other Self-Harm (Recklessness)       | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 24. Danger to Others                     | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 25. Sexual Aggression                    | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 26. Delinquent Behavior                  | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 27. Runaway                              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 28. Intentional Misbehavior              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Cultural Factors**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**CULTURAL FACTORS**

- |                            |                         |                         |                         |                         |
|----------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 29. Language               | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 30. Traditions and Rituals | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 31. Cultural Stress        | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Strengths Domain**

- |                          |                     |
|--------------------------|---------------------|
| 0 = Centerpiece strength | 1 = Useful strength |
| 2 = Identified strength  | 3 = No evidence     |

**STRENGTHS DOMAIN**

- |                           |                         |                         |                         |                         |
|---------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 32. Family Strengths      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 33. Interpersonal         | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 34. Educational Setting   | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 35. Talents / Interests   | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 36. Spiritual / Religious | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 37. Cultural Identity     | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 38. Community Life        | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 39. Natural Supports      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 40. Resiliency            | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Caregiver Resources and Needs**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

Youth has no known caregiver. (Skip Caregiver Resources and Needs Domain)

If Yes, Name: **Short Text Response**

**CAREGIVER RESOURCES and NEEDS**

- |                            |                       |   |                       |   |                       |   |                       |   |
|----------------------------|-----------------------|---|-----------------------|---|-----------------------|---|-----------------------|---|
| 41a. Supervision           | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 42a. Involvement with Care | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 43a. Knowledge             | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 44a. Social Resources      | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 45a. Residential Stability | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 46a. Medical / Physical    | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 47a. Mental Health         | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 48a. Substance Abuse       | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 49a. Developmental         | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 50a. Safety                | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |

**Signature of Assessor:**

Name: Staff Name      Date: 06/21/2018      Time: 1:41 PM      Electronic  
Electronically Signed

**Signature of Supervisor:**

Name: Staff Name      Date: 06/21/2018      Time: 1:41 PM      Electronic  
Electronically Signed

## CHILD & ADOLESCENT NEEDS and STRENGTHS ASSESSMENT (California CANS-50)

**Assessment Type:**       Initial     Subsequent     Annual     Discharge     Administrative Close

**KEY for Child Behavioral / Emotional Needs:**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**CHILD BEHAVIORAL / EMOTIONAL NEEDS**

- |                                 |                         |                         |                         |                         |
|---------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 1. Psychosis (Thought Disorder) | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 2. Impulsivity / Hyperactivity  | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Depression                   | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 4. Anxiety                      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 5. Oppositional                 | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 6. Conduct                      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 7. Anger Control                | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 8. Substance Use                | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 9. Adjustment to Trauma         | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Life Domain Functioning:**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**LIFE DOMAIN FUNCTIONING**

- |                                  |                         |                         |                         |                         |
|----------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 10. Family Functioning           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 11. Living Situation             | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 12. Social Functioning           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 13. Developmental / Intellectual | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 14. Decision-Making              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 15. School Behavior              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 16. School Achievement           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 17. School Attendance            | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 18. Medical / Physical           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 19. Sexual Development           | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 20. Sleep                        | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Risk Behaviors:**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**RISK BEHAVIORS**

- |  |                         |                         |                         |                         |
|--|-------------------------|-------------------------|-------------------------|-------------------------|
| 21. Suicide Risk                         | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 22. Non-Suicidal Self-Injurious Behavior | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 23. Other Self-Harm (Recklessness)       | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 24. Danger to Others                     | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 25. Sexual Aggression                    | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 26. Delinquent Behavior                  | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 27. Runaway                              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 28. Intentional Misbehavior              | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Cultural Factors**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

**CULTURAL FACTORS**

- |                            |                         |                         |                         |                         |
|----------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 29. Language               | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 30. Traditions and Rituals | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 31. Cultural Stress        | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Strengths Domain**

- |                          |                     |
|--------------------------|---------------------|
| 0 = Centerpiece strength | 1 = Useful strength |
| 2 = Identified strength  | 3 = No evidence     |

**STRENGTHS DOMAIN**

- |                           |                         |                         |                         |                         |
|---------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 32. Family Strengths      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 33. Interpersonal         | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 34. Educational Setting   | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 35. Talents / Interests   | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 36. Spiritual / Religious | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 37. Cultural Identity     | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 38. Community Life        | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 39. Natural Supports      | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 40. Resiliency            | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

**KEY for Caregiver Resources and Needs**

- 0 = no evidence
- 1 = history or suspicion, monitor
- 2 = interferes with functioning; action needed
- 3 = disabling, dangerous; immediate or intensive action needed

Youth has no known caregiver. (Skip Caregiver Resources and Needs Domain)

If Yes, Name: **Short Text Response**

**CAREGIVER RESOURCES and NEEDS**

- |                            |                       |   |                       |   |                       |   |                       |   |
|----------------------------|-----------------------|---|-----------------------|---|-----------------------|---|-----------------------|---|
| 41a. Supervision           | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 42a. Involvement with Care | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 43a. Knowledge             | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 44a. Social Resources      | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 45a. Residential Stability | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 46a. Medical / Physical    | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 47a. Mental Health         | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 48a. Substance Abuse       | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 49a. Developmental         | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |
| 50a. Safety                | <input type="radio"/> | 0 | <input type="radio"/> | 1 | <input type="radio"/> | 2 | <input type="radio"/> | 3 |

**Signature of Assessor:**

Name: Staff Name  
Electronically Signed

Date: 06/21/2018

Time: 1:39 PM

Electronic

**Signature of Supervisor:**

Name: Staff Name  
Electronically Signed

Date: 06/21/2018

Time: 1:39 PM

Electronic

Client Name:

Record/Identification Number:

Madera County Behavioral Health Services  
P. O. Box 1288 / Madera, CA 93639-1288  
209 E. 7<sup>th</sup> Street, Madera, CA 93637  
(559)673-3508  
(559)675-7758 (fax)

**ASSESSMENT/AUTHORIZATION FORM  
PROVIDER**

(MHP Use Only) Authorization #: _____		
Code	# Visits	Authorized Period
		From: _____ To: _____
		From: _____ To: _____
Signature: _____		Date: _____

Name: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ DOB \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Medi-Cal #: \_\_\_\_\_ MHP CLIENT #: \_\_\_\_\_

Ethnicity (How does the client identify): \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Language Spoken at Assessment: \_\_\_\_\_ Interpreter Yes  No  Who? \_\_\_\_\_

Primary Caregiver: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Caregiver is the Legal Guardian? Yes  No  If No:

Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Parents: Same as caregiver/legal guardian above? Yes  No  If no:

Mother: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if known): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if known): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Siblings:

\_\_\_\_\_  At Home  Foster Placement  Unknown/neither  Other \_\_\_\_\_

\_\_\_\_\_  At Home  Foster Placement  Unknown/neither  Other \_\_\_\_\_

Client Name:

Record/Identification Number:

Additional Siblings (include birth order if known)

---

---

**STRENGTHS AND RESOURCES: Check and describe all known client strengths and resources in achieving Client Plan goals. Complete as appropriate.**

**Skills, Interests and Desires of Client:**

**Interpersonal:** \_\_\_\_\_

**Creative:** \_\_\_\_\_

**Academic:** \_\_\_\_\_

**Athletic:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Family:**

**Availability:** \_\_\_\_\_

**Involvement:** \_\_\_\_\_

**Skills and Interests:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Community/Social Supports for Client/Family:**

**Positive Peer/Adult Relationships:** \_\_\_\_\_

**School, Job or Volunteer Activities:** \_\_\_\_\_



Client Name:

Record/Identification Number:

**Access to Leisure Activities:** \_\_\_\_\_

**Cultural Activities:** \_\_\_\_\_

**Spiritual Activities:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**PRESENTING PROBLEM/SYMPTOMS:** (As stated by client/guardian):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF PRESENTING PROBLEM:** e.g.(Precipitating events/stressors, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS TREATMENT:** (Please check all that apply):

Outpatient Chemical Dependency       Outpatient Psychotherapy       Self-Help Group

Inpatient Chemical Dependency       Psychotropic Medication Management       None

Use of traditional or alternative healing practices (describe with results below

Neurological Testing      Date if known \_\_\_\_\_ Examiner if known: \_\_\_\_\_

Psychological Testing      Date if known \_\_\_\_\_ Examiner if known \_\_\_\_\_

Other \_\_\_\_\_

If "yes" to any of the above, please give dates & place of service:

\_\_\_\_\_  
\_\_\_\_\_

Previous crisis contact?  Yes  No      If yes, number of crisis services without hospitalization in the past 6 months?  0       1       2       3 or more

Previous psychiatric hospitalization? Number of psychiatric hospitalizations in past 6 months

0       1       2 or more

Client Name:

Record/Identification Number:

Most recent date and hospital \_\_\_\_\_

Comments: Include earliest symptoms, age of onset, other support/stressors at time of onset, family understanding of the problem, response to treatment, other potential contributing factors, relevant family history and **any family mental health illness history**.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SYMPTOM CHECKLIST**

Check the "Ever" box if symptom was ever present.  
Also check the "6 months" box if symptom was present in the past 6 months.

**Depression**  None

Ever	6 Months		Ever	6 Months	
<input type="checkbox"/>	<input type="checkbox"/>	Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Behavior
<input type="checkbox"/>	<input type="checkbox"/>	Tearful	<input type="checkbox"/>	<input type="checkbox"/>	Irritable, easily annoyed
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest of pleasure	<input type="checkbox"/>	<input type="checkbox"/>	Often feels angry
<input type="checkbox"/>	<input type="checkbox"/>	Isolative or withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal ideation
<input type="checkbox"/>	<input type="checkbox"/>	Hopeless and/or helpless	<input type="checkbox"/>	<input type="checkbox"/>	Over-reactive (quick to anger)
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Excessively happy or silly
<input type="checkbox"/>	<input type="checkbox"/>	Worthlessness, shame or guilt	<input type="checkbox"/>	<input type="checkbox"/>	Labile (sudden mood shifts)
<input type="checkbox"/>	<input type="checkbox"/>	Bored	<input type="checkbox"/>	<input type="checkbox"/>	Distinct mood cycles
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of non-suicidal self-harm	<input type="checkbox"/>	<input type="checkbox"/>	Episodes of excess energy, insomnia, and euphoria or rage
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts			
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

**Anxiety**  None

Ever	6 Months		Ever	6 Months	
<input type="checkbox"/>	<input type="checkbox"/>	Anxious mood	<input type="checkbox"/>	<input type="checkbox"/>	Avoids talk or reminders of trauma
<input type="checkbox"/>	<input type="checkbox"/>	Separation anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hyper-vigilance or excessive startle
<input type="checkbox"/>	<input type="checkbox"/>	Feels tense or stressed	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	Agoraphobia
<input type="checkbox"/>	<input type="checkbox"/>	Fears or phobias	<input type="checkbox"/>	<input type="checkbox"/>	Dissociation
<input type="checkbox"/>	<input type="checkbox"/>	Intrusive memories	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions or compulsions
<input type="checkbox"/>	<input type="checkbox"/>	Flashbacks (trauma re-experience)			
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

**Sleep, Appetite and Elimination**  None

Ever 6 Months

- Initial insomnia  
  Middle insomnia  
  Late insomnia  
  Sleeps excessively  
  Nighttime fears  
  Frequent nightmares  
  Night terrors  
  Excessive appetite

  Other: \_\_\_\_\_

Ever 6 Months

- Poor Appetite  
  Rapid weight gain  
  Weight loss (unintentional)  
  Excessive weight loss (intentional)  
  Bed wetting  
  Daytime enuresis  
  Encopresis

**Thought and Perception**  None

Ever 6 Months

- Difficulty concentrating  
  Auditory hallucinations  
  Delusions  
  Disorganized thought process  
  Bizarre behavior

  Other: \_\_\_\_\_

Ever 6 Months

- Visual hallucinations  
  Other hallucinations  
  Perceptual distortions other than hallucinations  
  Irrational or odd but not delusional thoughts (e.g., of persecution)

**Activity, Attention & Impulse**  None

Ever 6 Months

- Overactive or fidgety  
  Slowed or lethargic  
  Short attention span  
  Easily distracted

  Other: \_\_\_\_\_

Ever 6 Months

- Difficulty completing tasks  
  Talks excessively  
  Impulsive (act without thinking)

**Conduct**  None

Ever 6 Months

- Defiant, uncooperative, oppositional  
  Frequent lying  
  Blames others for own misbehavior  
  Controlling, bossy or manipulative  
  Breaks rules  
  Provokes  
  Property destruction  
  Physical aggression toward others  
  Impulsive, reactive aggression

  Other: \_\_\_\_\_

Ever 6 Months

- Threatens, bullies or intimidates  
  Runaways  
  Cruel to animals  
  Truancy  
  Breaking into car or building  
  Stealing  
  Vandalism, tagging/graffiti  
  Gang involvement  
  Fire-setting

Client Name:

Record/Identification Number:

**Attachment**  None

- Ever 6 Months
- Poor eye contact
- Disinterest in relationships
- Difficulty making relationships
- Clingy

- Ever 6 Months
- Physically intrusive
- Resistant to being touched
- Overly attached to objects

Other: \_\_\_\_\_

**Sexuality and Gender**  None

- Ever 6 Months
- Sexualized behavior
- Inappropriate or high-risk sexual beh.
- Forced sexual contact—Victim
- Forced sexual contact—Perpetrator
- Forced sexual contact—Perpetrator

- Ever 6 Months
- Gender preference conflict
- Gender identity conflict
- Inappropriate sexual comments

Other: \_\_\_\_\_

**Neuro-Cognitive**  None

- Ever 6 Months
- Low intellectual functioning
- Learning disorder
- Speech or language delay/disorder

- Ever 6 Months
- Motor delay
- Head injury

Other: \_\_\_\_\_

Comment on the most prominent checked symptoms that need additional information:

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**Substance Use/Abuse**  
 Answer the following questions about all current drug and alcohol use. List applicable drug(s) for items marked "yes"

Type of Substance	Prenatal Exposure	Age at First Use	Current Substance Use					
			None/Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Client-Perceived Problem
<input type="checkbox"/> Not Applicable (comments required)	None/Unknown		None/Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Client-Perceived Problem
<input type="checkbox"/> Alcohol	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Amphetamines (Speed/Uppers, Crank, Ritalin)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cocaine/Crack	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Opiates (Heroin, Opium, Methadone)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hallucinogens (LSD, Mushrooms, Peyote, Ecstasy)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sleeping Pills, Pain Killers, Valium or Similar	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PCP (Phencyclidine) or Designer Drugs (GHB)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Inhalants (Paint, Gas, Glue, Aerosols)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Marijuana/Hashish	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Methamphetamines	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tobacco/Nicotine	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Caffeine (Energy Drinks, Sodas, Coffee, etc.)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Over the Counter: specify in comments below	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other Substance(s): specify in comments below	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does the client report receiving any alcohol and drug services:

Yes, from this provider

Yes, from a different provider

No

Client Name:

Record/Identification Number:

Comment on any co-occurring abuse/use as they relate to mental health symptoms and behaviors:

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<b><u>Mental Status Examination</u></b>				
Note cultural and age factors for descriptors when applicable				
<b><u>Appearance</u></b>	<input type="checkbox"/> Older than stated <input type="checkbox"/> Younger than stated <input type="checkbox"/> Eccentric	<input type="checkbox"/> Meticulous, <input type="checkbox"/> Appropriate grooming/dress for age/culture	<input type="checkbox"/> Seductive <input type="checkbox"/> Unique features <input type="checkbox"/> Poor hygiene	Describe:
<b><u>Eye Contact</u></b>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Describe:
<b><u>Speech</u></b>	<input type="checkbox"/> Normal for age/situation <input type="checkbox"/> Soft <input type="checkbox"/> Loud <input type="checkbox"/> Overly talkative <input type="checkbox"/> Brief responses	<input type="checkbox"/> Non-verbal <input type="checkbox"/> Rapid <input type="checkbox"/> Pressured <input type="checkbox"/> Rambling <input type="checkbox"/> Monotone	<input type="checkbox"/> Excessive Profanity <input type="checkbox"/> Slurred <input type="checkbox"/> Stammer/Stutter <input type="checkbox"/> Vocal Tic <input type="checkbox"/> Other speech difficulty	Describe:
<b><u>Attitude</u></b>	<input type="checkbox"/> Responsive <input type="checkbox"/> Engaging <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative	<input type="checkbox"/> Superficial <input type="checkbox"/> Guarded/distant <input type="checkbox"/> Provocative/limit testing <input type="checkbox"/> Manipulative/deceitful	<input type="checkbox"/> Angry/hostile <input type="checkbox"/> Shy/timid <input type="checkbox"/> Dramatic <input type="checkbox"/> Demanding/Insistent	Describe:
				Describe:

Client Name:

Record/Identification Number:

<p><b><u>Behavior/</u></b> <b><u>Motor</u></b> <b><u>Activity</u></b></p>	<p><input type="checkbox"/> Normal for age/situation</p> <p><input type="checkbox"/> Slowed</p> <p><input type="checkbox"/> Overactive/restless</p>	<p><input type="checkbox"/> Impulsive</p> <p><input type="checkbox"/> Agitated</p> <p><input type="checkbox"/> Unusual mannerism</p>	<p><input type="checkbox"/> Tremor</p> <p><input type="checkbox"/> Other involuntary movement</p>	
<p><b><u>Mood</u></b></p>	<p><input type="checkbox"/> Happy</p> <p><input type="checkbox"/> Sad</p>	<p><input type="checkbox"/> Irritable or Angry</p> <p><input type="checkbox"/> Bored</p>	<p><input type="checkbox"/> Anxious</p> <p><input type="checkbox"/> Fearful</p>	<p>Describe:</p>
<p><b><u>Affect</u></b></p>	<p><input type="checkbox"/> Euthymic (normal/appropriate)</p> <p><input type="checkbox"/> Sad</p> <p><input type="checkbox"/> Tearful</p> <p><input type="checkbox"/> Overly happy</p> <p><input type="checkbox"/> Irritable</p>	<p><input type="checkbox"/> Angry</p> <p><input type="checkbox"/> Silly</p> <p><input type="checkbox"/> Anxious</p> <p><input type="checkbox"/> Fearful</p> <p><input type="checkbox"/> Bored</p>	<p><input type="checkbox"/> Labile (rapidly shifting)</p> <p><input type="checkbox"/> Flat, blunted, constricted</p> <p><input type="checkbox"/> Incongruent with topic or thoughts</p>	<p>Describe:</p>
<p><b><u>Perceptions</u></b></p>	<p><input type="checkbox"/> Normal</p>	<p><input type="checkbox"/> Hallucinations</p> <p style="padding-left: 20px;"><input type="checkbox"/> Auditory</p> <p style="padding-left: 20px;"><input type="checkbox"/> Visual</p> <p style="padding-left: 20px;"><input type="checkbox"/> Other</p>	<p><input type="checkbox"/> Other perceptual distortion</p>	<p>Describe:</p>
<p><b><u>Delusions</u></b></p>	<p><input type="checkbox"/> None</p>	<p><input type="checkbox"/> Persecutory</p>	<p><input type="checkbox"/> Grandiose</p>	<p>Describe:</p>
<p><b><u>Thought</u></b> <b><u>Form/</u></b> <b><u>Process</u></b></p>	<p><input type="checkbox"/> Linear and rational</p> <p><input type="checkbox"/> Racing</p>	<p><input type="checkbox"/> Disorganized or loose</p>	<p><input type="checkbox"/> Pervasive</p>	<p>Describe:</p>



<p><b><u>Thought Content</u></b></p>	<p><input type="checkbox"/> Normal <input type="checkbox"/> Delusions <input type="checkbox"/> Obsessions</p>	<p><input type="checkbox"/> Excessive preoccupation <input type="checkbox"/> Other involuntary movement</p>	<p><input type="checkbox"/> Unusual, non-delusional ideations (suspicious, etc.)</p>	<p>Describe:</p>
<p><b><u>Thoughts of Harming Self or Others</u></b></p>	<p><input type="checkbox"/> None <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Suicidal intent</p>	<p><input type="checkbox"/> Thoughts or intent of non-lethal self-injury</p>	<p><input type="checkbox"/> Unusual, non-delusional ideations (suspicious, etc.)</p>	<p>Describe:</p>
<p><b><u>Sensorium</u></b></p>	<p>Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Situation</p> <p>Memory intact for: <input type="checkbox"/> Immediate <input type="checkbox"/> Recent <input type="checkbox"/> Remote</p>	<p>Alertness: <input type="checkbox"/> Alert <input type="checkbox"/> Clouded/ confused <input type="checkbox"/> Other</p> <p>Attention: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p>	<p>Intellectual functioning: <input type="checkbox"/> Average or higher <input type="checkbox"/> Below average</p> <p>Insight/Judgment <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p>	<p>Describe:</p>

**Cultural Factors**

Explain how the client's cultural factors, including those previously described, impact current functioning and the treatment plan. Include immigration, acculturation, sexual orientation, and other significant factors in your explanation.

Client Name:

Record/Identification Number:

**Social Factors**

Explain how the client's social factors, including those previously described, impact current functioning and the treatment plan. Include living situation, daily activities and other significant factors in your explanation.

**Functional Impairment**

Assess the Impact of the client's impairment in the following areas

**Home:**

**School:**

**Community:**

**Work:**

**Family Relationships:**

**Peer Relationships:**

Is there significant impairment in an important area of life functioning?  Yes  No

Probability of significant deterioration in an important area of life functioning?  Yes  No

(Child only) Has a mental disorder which can be corrected or ameliorated?  Yes  No

<b>Developmental Status</b>			
Categories	Within Normal Limits	Unknown	Concerns/Issues (describe the specific concern or issue)
Parental Risk Factors: i.e., mental health issues, substance/physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive Functioning: i.e., Developmental delay, learning disability, making academic progress	<input type="checkbox"/>	<input type="checkbox"/>	
Sensory Functioning: i.e., Visual or auditory deficits, other sensory deficits	<input type="checkbox"/>	<input type="checkbox"/>	
Fine and Gross Motor Skills: i.e., Motor deficits, delay in acquiring skills	<input type="checkbox"/>	<input type="checkbox"/>	
Early Childhood: i.e., Prenatal care, delivery complications, neglect or abuse, separation anxiety	<input type="checkbox"/>	<input type="checkbox"/>	

Client Name:

Record/Identification Number:

Middle Childhood: i.e., Problems with peers and/or siblings, age appropriate behavior, problems at school	<input type="checkbox"/>	<input type="checkbox"/>	
Adolescence: i.e., Sexual/gender issues, truancy, illegal behavior, substance/alcohol use (including nicotine)	<input type="checkbox"/>	<input type="checkbox"/>	
Other:			
<b><u>Current Medications</u></b>			
If known, include drug names, dosages, when prescribed and who prescribed them. Document any experienced side effects and/or compliance issues			
Current medications, including psychiatric, if known:			
Past medications, including psychiatric ,if known:			
Supplements/Vitamins:			

<b><u>Medical History</u></b>			
Current Primary Medical Care Provider:			
Address:		Phone:	
Date of Last Physical Exam:	<input type="checkbox"/> Unknown	<input type="checkbox"/> No—Explain below	
Date of Last Dental Exam:	<input type="checkbox"/> Unknown	<input type="checkbox"/> No—Explain below	
Are there any health concerns (medical illness, medical symptoms)?	<input type="checkbox"/> Unknown/ None Reported	<input type="checkbox"/> No	<input type="checkbox"/> Yes—Explain below
Non-Medication Allergies (food, pollen, bee sting, etc?)	<input type="checkbox"/> Unknown/ None Reported	<input type="checkbox"/> No	<input type="checkbox"/> Yes—Explain below
Medication Allergies (list type)	<input type="checkbox"/> Unknown/ None Reported	<input type="checkbox"/> No	<input type="checkbox"/> Yes—Explain below
Has the child or caregiver reported any of the following problems/experiences? (check all that apply)			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Surgery of any kind. Explain Below	
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Thyroid Problem	
<input type="checkbox"/> Convulsions or Seizure	<input type="checkbox"/> Immune System Problems	<input type="checkbox"/> Tuberculosis (TB)	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Problems or Hepatitis	<input type="checkbox"/> Obesity	
<input type="checkbox"/> Exposure to Toxic Lead Levels	<input type="checkbox"/> Motor or Movement Problems	<input type="checkbox"/> Weight Gain or Loss, Explain Below	
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Urinary Tract or Kidney Problems	<input type="checkbox"/> Eating Disorder	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Serious Rash or Other Skin Problems	<input type="checkbox"/> Appetite Changes	
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Speech or Language Problems. Explain Below	
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Miscarriage	Vision Problems	
<input type="checkbox"/> Sexually Transmitted Disease (STD)	<input type="checkbox"/> Enuresis	<input type="checkbox"/> Encopresis	
<input type="checkbox"/> Other			

Client Name:

Record/Identification Number:

Comments:

Additional clarifying formulation information as needed. Please document any additional comments or information.

Client Name:

Record/Identification Number:

**DSM-IV CODE AND DIAGNOSIS:**

			<u>Primary Diagnosis</u>	<u>Secondary Diagnosis</u>
Axis I	_____	_____	[ ]	[ ]
	_____	_____	[ ]	[ ]
Axis II	_____	_____	[ ]	[ ]
	_____	_____	[ ]	[ ]
Axis III	_____			
Axis IV	_____			
Axis V	_____			

Current GAF:

\_\_\_\_\_

Diagnosing

LPHA: \_\_\_\_\_ Lic/Reg: \_\_\_\_\_ Date: \_\_\_\_\_

LPHA Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

LPHA Signature: \_\_\_\_\_ Lic/Reg: \_\_\_\_\_

Notice of Privacy Practices Offered to Client/Primary Caregiver?  Yes  No

Revised: 02-06-13

Madera County Behavioral Health Services  
 P. O. Box 1288 / Madera, CA 93639-1288  
 209 E. 7<sup>th</sup> Street, Madera, CA 93637  
 (559)673-3508  
 (559)675-7758 (fax)

**ASSESSMENT UPDATE/AUTHORIZATION  
 FORM  
 PROVIDER**

(MHP Use Only) Authorization #: _____		
Code	# Visits	Authorized Period
		From:                      To:
		From:                      To:
Signature: _____		Date: _____

Date of this Assessment Update: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age Today: \_\_\_\_\_

SSN; \_\_\_\_\_ CIN: \_\_\_\_\_ Chart/Identification Number \_\_\_\_\_

**Please describe any changes to the following areas since the most recent Client Assessment dated:**

Primary Caregiver: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Resources (Interests, family, community, school and peers, etc.)  No Change

Presenting Problems:  No Change

Symptoms (mood, anxiety, thought, perception, attention, sexuality, gender, etc):  No Change

Substance Abuse:  No Change



Mental Status Exam:

No Change

Relevant Physical Health Conditions:

No Change

Cultural Factors:

No Change

Social Factors:

No Change

Developmental Status:

No Change

Medications:

No Change

Coordinated Services/Agencies:

No Change

Functional Impairment (home, school/education, community, work, family/peers relationships):  No Change

1. Significant Impairment in an important area of life functioning?  Yes  No  
If yes, describe in space below

2. Probability of significant deterioration in an important area of life functioning?  Yes  No

3. (Child Only) Has a mental disorder which can be corrected or ameliorated?  Yes  No

Diagnosis  No Change

I:

II:

III:

IV:

V: GAF: Past Year: Current Year:

Additional Comments (Optional):

LPHA Printed Name:

Date:

LPHA Signature:

Lic:

Client Signature:

Date:

## MADERA COUNTY BEHAVIORAL HEALTH SERVICES MENTAL HEALTH DISCHARGE SUMMARY

Presenting problem (description of why client is seeking services now: include impact/impairment on social, work and/or academic functioning, current stressors and/or precipitating events):

\_\_\_\_\_

Treatment or services provided:

If other, specify

Response to service provided:

- Worse                       Unchanged                       Minimal Improvement  
 Moderate Improvement       Marked Improvement           Unknown

List any other medications not included above:

\_\_\_\_\_

Reason for discharge

Additional comments relating to the above:

\_\_\_\_\_

Date of discharge

**Signature of Staff Completing Form:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  Yes  No

**Signature of Staff Entering Information (If Different from Above):**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  Yes  No  N/A

Form WIZ46MH; Version 2.00; 6/24/10

**MADERA COUNTY BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH CLIENT TRANSFER**

Transfer from

Transfer to

Reason for transfer:

\_\_\_\_\_

Other relevant information:

\_\_\_\_\_

**Signature of Staff Completing Form:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  Yes  No

**Signature of Staff Receiving Transfer:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  Yes  No

**Signature of Staff Entering Information (If Different from Above):**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  Yes  No  N/A

Form WIZ45MH; 2.00; 6/24/10

# ATTACHMENT E

## Mental Health Plan

### Billing Forms

MHP 32.00



**MADERA  
COUNTY  
BHS**

**BEHAVIORAL HEALTH SERVICES  
POLICY/PROCEDURE**

Subject: <b>NETWORK PROVIDER BILLING</b>	Policy No.: <b>MHP 32.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates: 1-13-04, 9-18-07, 11-16-07, <b>09-25-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 1-13-04, 9-18-07, 11-16-07, <b>09-25-15</b>	

**POLICY:**

Network providers shall be paid promptly for authorized services to Medi-Cal beneficiaries.

**PURPOSE:**

To insure that billings for mental health services are submitted, verified and paid in a timely manner.

**PROCEDURE:**

- A. The network provider may submit billing forms to the Madera County Mental Health Plan (MHP) for all Madera County beneficiaries who received pre-authorized services during the previous calendar month.
  - 1. A separate form is required for each beneficiary served.
- B. Payment requests for outpatient services shall be made using an MHP claim form (attached) or HCFA 1500.
- C. Payment requests for inpatient services will be made on UB 92 (attached).
- D. Billing forms shall be sent to:
  - Madera County Mental Health Plan
  - P. O. Box 1288
  - Madera, CA 93639-1288
- E. Claims must be submitted within thirty (30) days of the close of the month when services were provided.
- F. Payment will be authorized for valid claims for outpatient mental health services if:
  - 1. Services were pre-authorized by the Mental Health Plan.
  - 2. Services were delivered by a contract provider and were in accordance with contract agreements.
  - 3. Beneficiary was eligible for Medi-Cal reimbursement when services were provided.
- G. The following will apply when Medi-Cal is the payer of last resort:

1. Share of Cost

- a. Depending on a beneficiary's monthly income, Medi-Cal may require that the individual/family meet a share of cost before Medi-Cal will reimburse for covered, authorized services. The provider must bill the beneficiary for any unmet share of cost before requesting payment from the Mental Health Plan (MHP).
- b. When submitting a Medi-Cal claim for a beneficiary with a Share of Cost, the provider must attach copies of receipts indicating the individual has met the share of cost requirement for the month of services in claim. If the provider is collecting the share of cost from the beneficiary, the provider should complete a receipt for the money received.
  - i. The receipt should include the following: Provider name and title, client and /or guardian name, client birth date, amount received, applicable dates of service.

2. Third Party Insurance

- a. When a beneficiary has private health insurance in addition to Medi-Cal, the following applies:
  - i. The provider must bill the third party payer before requesting payment from MHP,
  - ii. Within thirty (30) days of receipt, the provider must attach a copy of the third party payer denial letter or Explanation of Benefits (EOB) indicating the amount reimbursed by the third party payer,
  - iii. MHP will only reimburse the difference of the approved network provider service rates and the payment amount received from the primary payer less any remaining share of cost. The total reimbursement from all payers shall not exceed the MHP service rate. The provider does not need preauthorization from MHP.

H. Reimbursement rates are included in provider contracts.

I. Payment will be mailed to providers within twenty (20) working days of receipt and verification of valid claims.

Attachments:

[MHP 32.A1 HCFA 1500](#)

[MHP 32.A2 UB92](#)

1

2		3 PATIENT CONTROL NO.				4 TYPE OF BILL	
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV. D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11

12 PATIENT NAME												13 PATIENT ADDRESS											
-----------------	--	--	--	--	--	--	--	--	--	--	--	--------------------	--	--	--	--	--	--	--	--	--	--	--

14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION			21 D HR	22 STAT	23 MEDICAL RECORD NO.			CONDITION CODES			31			
				18 HR	19 TYPE	20 SRC						24	25	26	27	28	29	30

32 OCCURRENCE DATE	33 CODE	34 OCCURRENCE DATE	34 CODE	35 OCCURRENCE DATE	35 CODE	36 CODE	OCCURRENCE SPAN FROM		THROUGH	37
										A
										B
										C

38			39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
			a	.		.		.
			b	.		.		.
			c	.		.		.
			d	.		.		.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1					.	.	
2					.	.	
3					.	.	
4					.	.	
5					.	.	
6					.	.	
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18					.	.	
19					.	.	
20					.	.	
21					.	.	
22					.	.	
23					.	.	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
				.	.	
				.	.	
				.	.	

**DUE FROM PATIENT** ▶

57	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES			74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
				71 CODE	72 CODE	73 CODE					

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		
			C		D		83 OTHER PHYS. ID
					E		
							OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	51



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA									
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)									
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE						
ZIP CODE			TELEPHONE (Include Area Code) ( )		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE			TELEPHONE (Include Area Code) ( )						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____					DATE _____					SIGNED _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
					17b. NPI _____														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER									
2. _____ 4. _____																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #							
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	30. BALANCE DUE \$						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ( )									
SIGNED _____					DATE _____					a. _____		b. _____	a. _____	b. _____					

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

# MADERA COUNTY MENTAL HEALTH PLAN

## Billing Form

Provider Number:

MHP Client ID#:                      Authorization #

You may use this form for up to twelve authorized services.

Billable Services:

Date of Service (mm/dd/yy)	HCPC/CPT Code	Time	Rate Billed	Share of Cost Received	Primary Insurance Pmt	MHP USE ONLY
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
OT		In Minutes	\$0.00	\$0.00	\$0.00	
<b>TOTAL DUE</b>						

Provider Information:

Name:

Mailing Address:

Phone #: ( ) -

Fax #: ( ) -

I attest that the above claim is true and correct; that no part has been previously paid; and that the amount is justly due. I understand that claims must be submitted within thirty (30) days after the close of the month when services were provided.

OT

Signature of Claimant



# ATTACHMENT F

## Provider Complaint & Appeal Process

MHP 34.00



Subject: <b>PROVIDER COMPLAINT AND APPEAL PROCESS</b>	Policy No.: <b>MHP 34.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates:  1-30-04, 8-22-07, <b>09-25-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates:  1-30-04, 8-22-07, <b>09-25-15</b>	

**POLICY:**

Providers have the right to access the provider appeal process at any time before, during or after the provider problem resolution process has begun, when the complaint concerns a denied or modified request for a Mental Health Plan (MHP) payment authorization or the processing or payment of a provider's claim to MHP.

**PURPOSE:**

To define and inform providers of the process to register a complaint and appeal a denial or modification for payment.

**PROCEDURE:**

Good provider relations are essential to the effective delivery of mental health services. The following describes the process by which providers may address their complaints and appeals to the Madera County MHP for resolution.

- I. Definitions
  - A. Services: inpatient or outpatient Medi-Cal mental health services.
  - B. Complaint: a statement registered by a provider regarding a problem that can be resolved informally.
  - C. Non-Contracting Provider: a mental health provider who does not have a contract with MHP but may do business with MHP for specific reasons (e.g., provision of emergency, out-of-area or one-time client care).
  - D. Provider: a mental health provider who has a contract with MHP to provide services to Medi-Cal beneficiaries.
  - E. Mental Health Plan (MHP): responsible for the administration of Medi-Cal mental health services in Madera County.
- II. Informal Complaint Process
  - A. Provider complaints may address one or more of the following:
    1. Lack or level of payment for an authorized or emergency claim.
    2. Delay of payments

3. Lack of information or cooperation by MHP staff.
  4. Disagreement by the provider with utilization review decisions made by MHP staff.
  5. A dispute with MHP regarding interpretations of provider action which are reasons for contract terminations.
  6. Other issues as determined by the provider.
- B. A provider may present a complaint to the Managed Care Coordinator by telephone, in person or in writing.
1. The Managed Care Coordinator will attempt to resolve the complaint. Suggested solutions will be provided to the complainant within two weeks from receipt of the complaint.
  2. If the provider is not satisfied with the response, the provider may file an appeal under the circumstances listed in section III.

### III. Appeals: Formal Problem Resolution Process

A provider has the right to access the provider appeal process at any time before, during or after the provider problem resolution process has begun, when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a providers claim to MHP.

#### A. Denial of Authorization for Services

1. A provider may file a written appeal concerning the denial for authorization of specialty mental health services directly to the Behavioral Health Services Director, or designee.
2. The written appeal shall be submitted to the Behavioral Health Services Director, or designee, within thirty (30) calendar days of the postmark date of the notification of the denial.
3. The appeal shall be reviewed and a decision made by the Behavioral Health Services Director, or designee, and other qualified staff as assigned by the Behavioral Health Services Director, or designee.
  - a. MHP shall use personnel not involved in the initial decision to respond to the provider's appeal.
4. The Behavioral Health Services Director, or designee, will have thirty (30) days from the post mark or fax date of receipt of the appeal to complete an evaluation of the appeal.
5. The provider will be notified in writing if the appeal is upheld or there is a proposed resolution (partial authorization of services or payment) or no basis is found for altering the original decision.
6. This formal process may also be utilized by any residential treatment program provider. MHP will respond within 48

hours of receipt of all required materials.

B. Denial of Claim Payments

1. Providers who receive payment directly from EDS may file a written appeal concerning the denial or delay of claim payments for specialty mental health services directly to the fiscal intermediary (EDS). The fiscal intermediary will have thirty (30) days from the post mark or fax date of receipt of the appeal to respond in writing to the provider.
2. Providers who receive payment directly from MHP may file a written appeal concerning the denial or delay of claim payments directly to the Behavioral Health Services Director, or designee.
3. The written appeal shall be submitted to the Behavioral Health Services Director, or designee, within thirty (30) calendar days of the postmark date of the notification of denial or delay of claim payments.
4. The Behavioral Health Services Director, or designee, shall have ten (10) working days from the post mark or fax date of receipt of the appeal to complete an evaluation of the appeal.
5. The appeal shall be reviewed and a decision made by the Behavioral Health Services Director, or designee, and other qualified staff as assigned by the Behavioral Health Services Director, or designee. Personnel not involved in the initial denial decision will be used to respond to the provider's appeal.
6. The provider will be notified in writing if the appeal is upheld, if there is a proposed resolution (i.e., partial payment) or no basis is found for altering the original decision.
7. If the provider appeal is upheld or partial payment is approved, the Behavioral Health Services Director, or designee, will have fifteen (15) working days to process the claim for payment to the provider.
8. The Behavioral Health Services Director, or designee, shall maintain a log of all MHP Formal Problem Resolution Requests and decisions, including disposition of the problems, which shall be submitted monthly to the County Mental Health Quality Improvement Committee.
9. The Formal Problem Resolution Log information shall include a method for identifying the provider, date of receipt, nature of the problem, time period allowed for resolution, party responsible for addressing the problem, date for resolution or disposition of the problem.
  - a. These records will be open to review by the State Department of Health Care Services and the Federal

oversight agency.

- b. The Log shall document the resolution of the problem within 30 calendar days of its receipt, or the reason why it could not be resolved.
- 10. The formal problem resolution process may be utilized by any residential treatment program provider. MHP will respond within 48 hours of receipt of all required materials.
- 11. MHP may file an appeal concerning the processing or payment of its claim for services paid through the Short-Doyle/Medi-Cal system to the Department of Mental Health.
- C. The contact person for all beneficiary and provider problems and appeals is:

**Mental Health Plan Supervisor**

**Madera County Behavioral Health Services**

**P. O. Box 1288**

**Madera, CA 93639-1288**

**(559) 675-7850; FAX (559) 675-7758**





Subject: <b>PSYCHIATRIC HOSPITAL COMPLAINT AND APPEAL PROCESS</b>	Policy No.: <b>MHP 49.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates:  09-06-12, <b>09-25-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates:  09-06-12, <b>09-25-15</b>	

**POLICY:**

Psychiatric hospitals contracting with Madera County Behavioral Health Services (BHS) will have access to a complaint and appeal process.

**PURPOSE:**

To insure good provider relations between psychiatric hospitals and BHS.

**PROCEDURE:** Problem Complaint Process.

1. A Psychiatric hospital may file a complaint regarding one or more of the following:
    - a. Lack of information from BHS staff.
    - b. Disrespect or lack of cooperation from BHS staff.
    - c. A dispute regarding interpretations of hospital action which are reasons for contract termination.
    - d. Other reasons as determined by the provider.
  2. A provider may present a complaint to the Managed Care Coordinator by telephone, in person or in writing.
    - a. The Managed Care Coordinator will attempt to resolve the complaint. Suggested solutions will be provided to the complainant within two weeks from receipt of the complaint.
    - b. If the provider is not satisfied with the response, the provider may file an appeal with the Psychiatric Hospital Contract Coordinator.
- A. Provider Appeal Process.

Good provider relations are essential to the effective delivery of mental health services. Providers may address their complaints and appeals to the Madera County MHP for quick and easy resolution. Providers have the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP.

1. A psychiatric inpatient hospital may appeal a denied request for

reimbursement of psychiatric inpatient hospital services to the Madera County Psychiatric Hospital Contract Coordinator. The written appeal must reach the Psychiatric Hospital Contract Coordinator within ninety (90) calendar days of the post mark (or fax) date of notification of the non-approval of payment.

2. The Madera County Psychiatric Hospital Contract Coordinator shall have sixty (60) calendar days from the post mark (or fax) date of the receipt of the appeal to inform the hospital in writing of the decision and its basis.
  - a. If no basis is found for altering the decision or a remedy is not within the purview of the Psychiatric Hospital Contract Coordinator, the hospital shall be notified of its right to submit the appeal to the State Department of Health Care Services (DHCS).
  - b. If the Psychiatric Hospital Contract Coordinator does not respond within sixty (60) calendar days, the hospital has the right to appeal directly to DHCS.
  - c. If the Psychiatric Hospital Contract Coordinator upholds the hospital's appeal, the Psychiatric Hospital Contract Coordinator shall have fourteen (14) calendar days from the date of receipt of the hospital's revised request for payment to approve the payment authorization document or to take corrective action.
  - d. If the hospital chooses to appeal the Psychiatric Hospital Contract Coordinator's denial to DHCS, it shall do so within 30 calendar days from the date of the Psychiatric Hospital Contract Coordinator's written decision.
3. DHCS shall have two calendar months from the receipt of the appeal to notify, in writing, the hospital and the Psychiatric Hospital Contract Coordinator of its decision and its basis.
  - a. If DHCS does not respond within 60 calendar days from the post mark or fax date of receipt of the appeal, the hospital may consider the appeal to have been denied.
  - b. If DHCS upholds the hospital's appeal, the Psychiatric Hospital Contract Coordinator has fourteen calendar days from the post mark or fax date of receipt of the hospital's revised request for payment to approve the payment authorization document or to take corrective action.
  - c. A provider (psychiatric inpatient hospital) may file an appeal concerning the processing or payment of a claim directly to the fiscal intermediary. The fiscal intermediary shall respond in writing to the provider within 60 calendar days of the post mark or fax date of receipt of the appeal.

# ATTACHMENT G

## Reporting Unusual Occurrences

QMP 12.00



Subject: <b>REPORTING UNUSUAL OCCURENCES</b>	Policy No.: <b>QMP 12.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates: 1-14-04, 11-05-09, 03-30-10 <b>10-14-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 1-14-04, 11-05-09, 03-30-10 <b>10-14-15</b>	

**AUTHORITY:**

Section 784.15, Unusual Occurrences, California Code of Regulations; Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statues of 1994: Sections 5675 and 5768 Welfare and Institutions Code.

**POLICY:**

Madera County Behavioral Health Services (BHS) shall notify the State Department of Mental Health (DMH) of all unusual occurrences as soon as possible after becoming aware of the event. Unusual occurrences are defined as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and events that jeopardize the welfare, safety or health of clients, staff, and/or members of the community.

**PURPOSE:**

To provide a mechanism for immediate notification to the DMH in compliance with State regulations.

**PROCEDURE:**

- A. Staff or network providers who witness any incident or unusual occurrence are required to verbally report the event as soon as possible to the BHS Director and submit a written report within one working day.
- B. The BHS Director, or designee, will provide notification to State Department of Health Care Services (DHCS) via telephone or email within 24 hours of becoming aware of the occurrence.
- C. The BHS Director, or designee, will send a report by certified U.S. mail to DHCS within five (5) calendar days of notification of the unusual occurrence.
- D. The written report will include the following:
  1. Description of the event, including outcome.
  2. Staff/Provider's investigation and conclusions about the event.
  3. A list of persons directly involved or who have direct knowledge of the event.
  4. The report will be sent to:

Program Oversight and Compliance Branch-Mental Health  
Mental Health Services Division  
Department of Health Care Services  
P.O. Box 997413, MS 2703  
Sacramento, CA 95899-7413

Ph 916-319-0985  
Fax 916-324-9435

DHCS retains the right to independently investigate unusual occurrences and to expect the cooperation of Staff/Providers.

Attachments:

[QMP 12.A1 Reporting Unusual Occurrences/Incident Form](#)



# BEHAVIORAL HEALTH SERVICES

## REPORT OF UNUSUAL OCCURRENCE/INCIDENT

1. INCIDENT DATE:	2. INCIDENT TIME:
3. PERSON(S) INVOLVED IN INCIDENT:	
4. ADDRESS OR LOCATION OF INCIDENT:	
5. PERSON REPORTING INCIDENT:	
6. TYPE OF INCIDENT:	
7. WITNESS(ES):	
8. INCIDENT DESCRIPTION (Be as specific as possible. Include names, addresses, times, dates, injuries, damages):	
9. PLANNED FOLLOW-UP:	
..... 10. Signature	..... Date
11. SUPERVISOR'S SIGNATURE	
..... Signature	..... Date

REVIEWED BY QUALITY MANAGEMENT COORDINATOR \_\_\_\_\_

DATE \_\_\_\_\_

REVIEWED BY DIRECTOR \_\_\_\_\_

DATE \_\_\_\_\_

# ATTACHMENT H

Consumer

Death/Suicide

QMP 13.00



Subject: <b>CONSUMER DEATH SUICIDE</b>	Policy No.: <b>QMP 13.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates: 1-14-04, 9-4-09, 10-30-09, <b>10-14-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 1-14-04, 9-4-09, 10-30-09, <b>10-14-15</b>	

**POLICY:**

Behavioral Health Services Administration will be notified immediately when a death of a consumer or recent consumer occurs.

**PURPOSE:**

To assure timely notification of Behavioral Health Services Administration of any consumer death no matter what the cause of death.

**PROCEDURE:**

- I. Notification of Behavioral Health Services Director.
  - A. When staff members of the Madera County Behavioral Health Services become aware of a death of a consumer, they will notify their immediate supervisor who will telephone the Behavioral Health Services Director or designee. In the case of a Network Provider consumer's death, the Network Provider will call the Director or designee.
  - B. The facts related to the death will be documented and sent to the Director within 24 hours. The report will include, as applicable:
    1. Name.
    2. Birth date.
    3. Pertinent information related to the death and events surrounding the death.
    4. Plans for outreach efforts with family or friends of the decedent, including consumer peers.
    5. Plans/identified concerns related to preventing other occurrences, e.g., "copycat" suicides.
    6. Plans for debriefing with involved staff and description of other unmet needs.
  - C. The Director, or designee, will notify the Medical Records Supervisor, or designee, who will immediately seal the decedent's medical record.



1. Access to the sealed chart will be given to only the Behavioral Health Services Director or designee.
2. No additional information will be placed in the chart after it is sealed.

II. Psychological Autopsy

- A. As soon as the Coroner's Report is received, if death is deemed a suicide or homicide, a psychological autopsy will be scheduled with the Interagency Quality Improvement Committee (see QMP 11:00).

# ATTACHMENT I

## Provider Satisfaction Survey

## MADERA COUNTY MENTAL HEALTH PLAN PROVIDER SATISFACTION SURVEY

Please check the appropriate box based on your experience with Madera County Mental Health Plan.

Question/Comments	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. My invoices are processed in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					
2. I am satisfied with the paperwork that is required by MHP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					
3. I am satisfied with the authorization process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					
4. I receive helpful, appropriate feedback from the MHP and Quality Management regarding site and chart reviews.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					
5. If I have a problem, I know whom to contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					
6. I am satisfied with the Madera County MHP's utilization management system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					
7. Referrals from the MHP are appropriate for my setting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____					
Other Comments: _____					

# ATTACHMENT J

Consumer

Satisfaction

Survey

QMP 24.00



Subject: <b>CONSUMER SATISFACTION SURVEYS</b>	Policy No.: <b>QMP 24.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates: 10-18-06,11-14-07,9-4-09, 10-30-09, <b>10-14-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 10-18-06,11-14-07,9-4-09, <b>10-30-09</b>	

**POLICY:**

Madera County Behavioral Health Services (BHS) will seek continuous improvement of mental health services provided to Madera County residents and Medi-Cal beneficiaries.

**PURPOSE:**

To develop a way to receive feedback from consumers regarding services they received.

**PROCEDURE:**

- A. The Performance Outcome & Quality Improvement Survey (POQI) will be administered to outpatient consumers, as required by the State Department of Mental Health (DMH), following instructions provided by DMH.
  - 1. The Quality Management Coordinator, or designee, will coordinate the administration of the POQI with the program manager/supervisor at each site.
  - 2. When results are released by DMH, a written summary and oral presentation will be provided to outpatient consumer providers and the Madera County Mental Health Board. The Mental Health Board will review the summary and provide written comment to the California Mental Health Planning Council.
- B. Survey forms for hospitalized beneficiaries and Network Provider consumers will be developed by Quality Management Committee members with input from consumers.
  - 1. Any client or Quality Management Committee member may make suggestions regarding the content of the form.
  - 2. The Quality Management Committee will approve a final version of the survey form.
  - 3. Prior to discharge, a survey and self-addressed return envelope will be offered to beneficiaries admitted to a hospital by a BHS Hospital Liaison, or designee.
    - a. Surveys received from hospital patients will be returned to and date stamped upon receipt by the Quality Management Coordinator, or designee.

- b. The Quality Management Coordinator, or designee, will compile returned surveys on a quarterly basis and report results to the Interagency Quality Improvement Committee (IQIC).
    - c. The Quality Management Coordinator, or designee, will inform the applicable hospitals of the results of the surveys.
  - 4. Annually, the Quality Management Administrative Assistant, or designee, will mail Consumer Satisfaction surveys directly to Network Provider consumers, along with a stamped, self-addressed return envelope.
    - a. All Network Providers will give a survey to clients at the end of their sessions. Surveys should be completed outside the office setting and returned in the self-addressed, stamped envelope.
    - b. All Network Provider Consumer Surveys will be returned to the Quality Management Coordinator, or designee, for compilation and summary.
    - c. The Quality Management Coordinator, or designee, will inform Network Providers of the results of the survey.
    - d. The Quality Management Coordinator, or designee, will report results to the IQIC.
- C. Surveys requesting demographic data, such as, ethnicity, gender and age will be culturally sensitive, including questions about culture, language and lifestyle.
- D. Surveys will be in all threshold languages.
- E. Survey statistics will be shared with the appropriate Quality Improvement Committee.
- F. Survey information will be summarized for the Quality Management Committee.
- G. Original surveys will be kept in a locked file in the office of the Quality Management Coordinator, or designee.
- H. When surveys contain comments in the nature of a grievance, consumers will be contacted to determine if they wish to file a grievance. This will occur only if the consumer indicates on the survey that permission to contact is granted and provides enough optional identifying information.
- I. Any trends noted through surveys will be reported to the appropriate Quality Improvement Committee for program recommendation.
  - 1. Program recommendations will be made to appropriate program managers/supervisors.
- J. Summaries of the surveys will be forwarded to the Quality Management Committee for approval.

# ATTACHMENT K

## Site Certification Form

### for Mental Health

as of 8-8 -2013

## SITE CERTIFICATION

As of 08.08.13 this is the most current document.

For possible updates please see the link:

[http://www.dhcs.ca.gov/services/MH/Documents/Cert\\_Re-Cert%20PROTOCOL \(ver.%202007 03 2012\) Updated 8-8-2013 \(PDF view\).pdf](http://www.dhcs.ca.gov/services/MH/Documents/Cert_Re-Cert%20PROTOCOL%20(ver.%202007%2003%202012)%20Updated%208-8-2013%20(PDF%20view).pdf)

Or Call MHP at (559) 673-3508



# ATTACHMENT L

## Quality Management

### Committee

QMP 8



Subject: <b>QUALITY MANAGEMENT COMMITTEES</b>	Policy No.: <b>QMP 8.00</b>	Original Issue Date: <b>10-01-03</b>	Revision Dates: 10-27-04, 11-2-07, 9-2-09, 10-30-09, <b>09-25-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 10-27-04, 11-2-07, 9-2-09, 10-30-09, 09-25-15	

**POLICY:**

The Director of Madera County Behavioral Health Services (BHS) will appoint a Quality Management Committee to oversee the Quality Improvement (QI) and Quality Management (QM) Activities of the Mental Health Plan (MHP).

**PURPOSE:**

To develop procedures for structuring the Quality Management Committee that will be responsive to oversee MHP QM and QI activities.

**PROCEDURE:**

- A. The BHS Director will appoint members of the Quality Management Committee (QMC), consisting of:
  - 1. Quality Management Committee Chair (Department Director or designee)
  - 2. Quality Management Committee Co-Chair (designated to act as Chair in Director's/designee's absence, may be a member listed below)
  - 3. Division Managers
  - 4. Medical Director, or designee
  - 5. Quality Management Coordinator
  - 6. Mental Health Plan Supervisor
  - 7. Clinical Staff Representative(s)
  - 8. Clerical Staff Representative(s)
  - 9. Compliance Officer/Data Manager, or designee
  - 10. Patient's Rights Advocate
  - 11. Client/Family Representatives
  - 12. Network/Group/Organizational Provider Representatives

13. Other appropriate members representing the community, faith based organizations, community providers, Behavioral Health Board members, etc.
- B. The Quality Management Committee members will reflect the ethnic and geographic diversity of the County whenever possible.
- C. The Quality Management Committee activities include:
1. Monitoring service provided by Madera County Behavioral Health Services for the purpose of making recommendations for improving service delivery
    - a. Recommending policy decisions.
    - b. Review information related to credentialing
    - c. Review accessibility of services within the service area
      - i. Twenty-four hour responsiveness
      - ii. Timeliness for routine schedule appointments
      - iii. Timeliness for urgent and crisis services
      - iv. After-hours services
  2. Recommending studies for Quality Management Committees
  3. Review and evaluate results of Quality Improvement (QI) activities
    - a. Performance Improvement Projects (PIPs)
    - b. Other Departmental Improvement Initiatives
  4. Institute needed QI and QM actions and ensure follow up on planned actions
- D. Document QI and QM Committee decisions and actions taken
- i. Dated and signed minutes of all meetings will be maintained.
5. (meeting minutes)
  6. Collect and analyze data to measure against goals or prioritize areas of improvement
  7. Monitor client and family member feedback
    - a. Reviewing and evaluating
      - i. Consumer Satisfaction Surveys, Grievances, Appeals, Suggestions, Fair Hearings, Requests for Change of Providers
      - ii. Broadly share results with internal and external stakeholders
  8. Clinical record review results
  9. Projects related to coordination of care with Primary Care and other health and human services agencies serving the same clients

10. Reviewing compliance with cultural and linguistic competence requirements
  - a. Review Cultural Competence Plan, goals, etc.
  - b. Review of efforts to ensure provider cultural responsiveness to ethnic and underserved populations
  - c. Review staff linguistic capacity to serve target populations
  - d. Promoting and ensuring cultural competence be fully integrated into all relevant Committee recommendations.
- E. The Quality Management Committee will meet quarterly.
- F. The Interagency Quality Improvement Committee (IQIC) Subcommittee
  - a. This committee focuses on inpatient and crisis services and will review and evaluate Inpatient and Network and Network Provider services, Client Satisfaction Surveys, Client Grievances, Appeals, and Suggestions.
  - b. Attendees: Quality Management Coordinator, Adult Service Representative, Children's Service Representative, Supervising Clinician, MHP Clinician, Psychiatrist, Hospital Liaison, Staff Clinician, MHP Administrative Assistant
    - i. Review inpatient charts retrospectively, that meet one or more of the following quality management indicators:
      1. Lengths of stay one day or less
      2. Lengths of stay 14 days or more
      3. Three or more admissions within six months
      4. Readmissions within 30 days or less
      5. Other Quality of care concerns
    - ii. Discuss the review of at least one chart or up to ten percent (10%) of all Madera County Behavioral Health Services (MCBHS) client charts of each Network Provider annually (see Network Provider chart Review Policy and Procedures).
    - iii. Review all County homicides and suicide, maintaining statistics on demographics (See Policy and Procedure on Homicide and Suicide Review)
    - iv. The committee will conduct a trend analysis for re-occurring issues that occur for multiple clients and discuss options for addressing these systems issues as utilization management and quality management
      1. Committee recommendations related to utilization and quality management will be documented, tracked overtime, and reported to the QMC until the issues have been resolved or reduced to an acceptable level.

- v. This committee will meet monthly.
- vi. Confidentiality will be maintained for client cases reviewed.
- vii. Dated and signed minutes of all meetings will be maintained.

c. Outpatient Services Quality Management Committee (OSQMC)

- i. Attendees include the Managed Care Coordinator, MHP Administrative Assistant, Medical Records Representative, Adult and Children's Service Case Manager, Adult and Children's services Clinician, Juvenile Justice Clinician, MHP Clinician, and a Supervising Clinician
- ii. The committee reviews and discusses:
- iii. Program charts for compliance with quality standards for procedures and goals for service delivery (Former Policy and Procedure for Chart Review)
  - 1. Reviews a sample of all charts (medical records) to assess compliance with documentation standards (see Policy and Procedure MR 03:00 and QMP Chart Review)
  - 2. Reviews a sample of charts from all clinicians at least annually.
  - 3. Plan of Correction will be prepared when necessary and forward to the specified provider and that provider's supervisor.
  - 4. The statistics and trends from the completed charts will be compiled and reported to the Quality Management Committee for review and recommendations

G. Charts can be referred by staff, clients or Patients' Rights Advocate

- a. Incidents related to suicides or homicides of MCBHS clients (see Policy and Procedure for Homicide and Suicide Review)
- b. Charts referred by the Behavioral Health Service Director
- c. Quality indicators of MCBHS' programs
- d. Peer Presentation (see Policy and Procedure on Peer Review)
- e. Department forms (see Policy and Procedure on Department Forms)
- f. Department Complaints, Grievances, Suggestions, Consumer Satisfaction Surveys (see Policy and Procedure for each)

H. The subcommittees will submit quarterly summaries of their meetings to the QMC.

# ATTACHMENT M

## Interagency Quality

### Committee

QMP 9.00



Subject: <b>INTERAGENCY QUALITY IMPROVEMENT COMMITTEE</b>	Policy No.: <b>QMP 9.00</b>	Original Issue Date: <b>09-25-15</b>	Revision Dates: 10-25-06, 09-02-09, 10-30-09, <b>09-25-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 10-25-06, 09-02-09, 10-30-09, <b>09-25-15</b>	

**POLICY:**

The goal of the Madera County Mental Health Plan (MHP) is the continuous improvement of mental health services provided to Madera County residents and Medi-Cal beneficiaries. Cultural competence is considered fundamental to quality services and must be embedded in all quality improvement initiatives.

**PURPOSE:**

To develop procedures for structuring Interagency Quality Improvement Committee (IQIC) activities that will assure that the Mental Health Plan provides quality services in inpatient and Network Provider settings.

**PROCEDURE:**

- I. The Behavioral Health Services Interagency Quality Improvement Committee shall be comprised of the following individuals appointed by the Behavioral Health Services Director:
  - A. Quality Management Coordinator, or designee
  - B. Adult Services Representative
  - C. Children’s Services Representative
  - D. Supervising Clinician
  - E. MHP Clinician
  - F. Psychiatrist
  - G. Hospital Liaison
  - H. Staff Clinician
  - I. MHP Administrative Assistant
- II. IQIC activities shall include:
  - A. Review and evaluate Inpatient and Network Provider: Consumer

Satisfaction Surveys, Consumer Grievances, Appeals, and Suggestions.

- B. Review inpatient charts, retrospectively, that meet one or more of the following quality indicators:
    - 1. Length of stay one day or less.
    - 2. Length of stay 14 days or more.
    - 3. Three or more admissions within six months.
    - 4. Readmitted in 30 days or less.
    - 5. Quality of care concerns.
  - C. Discuss the review of at least one chart or up to ten percent (10%) of all Madera County beneficiary charts of each Network Provider annually (See Policy QMP 10:00).
  - D. Review all County homicides and suicides, maintaining statistics on demographics (See Policy QMP 11:00).
  - E. Review and discuss any matter referred to IQIC by the Behavioral Health Services Director and make recommendations.
  - F. The committee will conduct trend analysis for re-occurring issues that occur for multiple clients and discuss options for addressing these systems issues as utilization management and quality improvement.
  - G. Committee recommendations related to utilization management and quality improvement will be documented and tracked over time until the identified issue have been resolved or reduced to an acceptable level. Issues pertaining to inpatient facilities, network providers, etc., will be reviewed with them to obtain a satisfactory resolution.
- III. The Interagency Quality Improvement Committee will meet monthly.
  - IV. Confidentiality will be maintained in all IQIC matters.
  - V. Dated and signed minutes of all Interagency Quality Improvement Committee meetings will be maintained.



# ATTACHMENT N

## GUIDES/INFORMATIONAL BROCHURES/FORMS

Consumer/Beneficiary Rights &  
Problem Solving Resolution Guide.

Formal Grievance

Services Guide

## CLIENT RIGHTS

Madera County mental health clients are entitled to:

- ◆ Respectful treatment with consideration for privacy by all Behavioral Health Services staff.
- ◆ Service provided in a safe environment.
- ◆ Receive information on treatment options.
- ◆ Request and receive a copy of medical records and request corrections.
- ◆ Participate in decisions regarding health care including the right to refuse treatment.
- ◆ Request a change in the level of care, change of provider, and a second opinion regarding any treatment issue.
- ◆ Be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

<b>Mental Health Plan</b>	<b>(559) 673-3508</b>
<b>Toll free</b>	<b>(888) 275-9779</b>
<b>Patients' Rights Advocate</b>	<b>(559) 673-3508 Ext. 1267</b>
<b>Toll free</b>	<b>(888) 275-9779</b>
<b>State Ombudsman</b>	<b>(800) 896-4042</b>
<b>TTY</b>	<b>(800) 896-2512</b>
<b>Email</b>	<b>MHOmbudsman@dhcs.ca.gov</b>
<b>Relay Services (English/Spanish)</b>	<b>711</b>
<b>Speech to Speech</b>	<b>(866) 288-1909</b>

### Behavioral Health Director

Dennis Koch, MPA  
(559) 673-3508  
Toll free (888) 275-9779  
TTY (800) 735-2929

# CLIENT RIGHTS AND PROBLEM RESOLUTION GUIDE



## MADERA COUNTY BEHAVIORAL HEALTH SERVICES

Please ask receptionist about your **right to free language assistance** services as well as alternative formats of this brochure. If you have **physical limitations**, we will help you find available, appropriate and accessible services.

## GRIEVANCES

When a mental health client has a problem or grievance regarding mental health services, we encourage him/her to discuss those concerns with their therapist or program staff. They may also talk to the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779; or call the Patients' Rights Advocate at (559) 673-3508 ext. 1267 or the California Department of Mental Health Ombudsman at (800) 896-4042, or TTY (800) 896-2512 or email [MHombudsman@dhcs.ca.gov](mailto:MHombudsman@dhcs.ca.gov).

If you are unable to resolve a concern about any aspect of service, you may at any time, for any reason file a grievance with the Quality Management Coordinator. A grievance may be filed verbally by calling (559) 673-3508 or (888) 275-9779, or by completing a Grievance Form. Formal Grievance forms and pre-addressed envelopes are available in the reception area of all clinics and provider offices. Grievance forms are also available on the County website, [madera-county.com](http://madera-county.com). The completed Grievance Form may be given to the Patients' Rights Advocate, mailed in the envelope provided, or mailed to the following address:

Madera County  
Behavioral Health Services  
Mental Health Plan  
P.O. Box 1288  
Madera, CA 93639-1288



The Quality Management Coordinator will notify you within five working days that your grievance has been received. A written response notifying you of the final resolution will be sent within sixty calendar days.

You may designate someone to act on your behalf at any time. The Patients' Rights Advocate may be contacted at (559) 673-3508 ext. 1267 to assist in resolving grievances.

## APPEALS

If you wish to appeal an "Action" by the Mental Health Plan, you may call the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779 – toll free. An "Action" is when the MHP:

- Denies or limits authorization of a requested service.
- Reduces, suspends, or terminates a previously authorized service.
- Denies, in whole or in part, payment for a service.
- Fails to act within the timeframes for disposition of Standard Grievances, the resolution of Standard Appeals, or the resolution of Expedited Appeals.
- Fails to provide services in a timely manner, as determined by the MHP.

An Expedited Appeal may be used when a decision must be made quickly to protect the beneficiary's life, health, or ability to function at a maximum level

Beneficiaries may request a State Fair Hearing after the Appeal process has been completed. You may contact the Patients' Rights Advocate or the State Ombudsman listed below to assist in filing for a State Fair Hearing. All State Fair Hearing decisions are final.

***YOUR MENTAL HEALTH SERVICES WILL NOT BE AFFECTED IN ANY WAY BY FILING A GRIEVANCE OR APPEAL, OR REQUESTING A STATE FAIR HEARING.***

## SUGGESTIONS

Client suggestions are important in providing quality, effective services. Providers have (green) Suggestion Forms in service areas. Client suggestions are welcome and can be placed in designated boxes or given directly to a staff member or Patients' Rights Advocate.

## DERECHOS DEL CLIENTE

Cientes de Servicios de Salud de Comportamiento del Condado de Madera tienen derecho a:

- ◆ Ser tratados con respeto y consideración a privacidad por todo el personal de salud mental.
- ◆ Recibir servicio en un ambiente seguro.
- ◆ Recibir información sobre opciones de tratamiento.
- ◆ Solicitar y recibir una copia de expedientes médicos y solicitar correcciones.
- ◆ Participar en decisiones con respecto a cuidado médico incluyendo el derecho a rechazar tratamiento.
- ◆ Pedir un cambio en el nivel de cuidado, un cambio de proveedor, y una segunda opinión con respecto a cualquier asunto de tratamiento.
- ◆ Derecho a estar libre del uso de restricciones o aislamiento como medio de coerción, disciplina, conveniencia o represalias.

<b>Plan De Salud Mental</b>	<b>(559) 673-3508</b>
<b>Línea Gratuita</b>	<b>(888) 275-9779</b>
<b>Representante de Derechos del Cliente</b>	<b>(559) 673-3508 x. 1267</b> <b>(888) 275-9779</b>
<b>Mediador Estatal</b>	<b>(800) 896-4042</b>
<b>TTY</b>	<b>(800) 896-2512</b>
<b>Email</b>	<b>MHOmbudsman@chcs.ca.gov</b>
<b>Servicios de Relevó</b>	<b>Marque 711</b>
<b>Voz a Voz</b>	<b>(866) 288-4151</b>

### Director de Salud Mental

Dennis Koch, MPA  
(559) 673-3508  
Llamada Gratis (888) 275-9779  
TTY (800) 855-3000

# DERECHOS DEL CLIENTE Y GUÍA DE RESOLUCIÓN DE PROBLEMAS



## SERVICIOS DE SALUD DE COMPORTAMIENTO CONDADO DE MADERA

Por favor pregunte a recepcionista sobre su **derecho** a servicios gratuitos de **asistencia en su idioma** y formatos alternativos de este panfleto. Si tiene **limitaciones físicas**, le ayudaremos a encontrar servicios disponibles, apropiados y accesibles.

## QUEJAS

Cuando un cliente de Servicios de Salud de Comportamiento tiene un problema o una queja acerca de los servicios de salud mental, le animamos que hable sobre la situación con su terapeuta o el personal del programa. También pueden hablar con el Coordinador de Manejo de Calidad al (559) 673-3508 o (888) 275-9779 o llame al Representante de Derechos del Cliente al (559) 673-3508 x. 1267 o al Mediador del Departamento de Servicios de Salud de California al (800) 896-4042 o TTY (800) 896-2512 o correo electrónico MHombudsman@dhcs.ca.gov.

Si no puede resolver algún asunto sobre cualquier aspecto de servicio, usted puede presentar una queja al Coordinador de Manejo de Calidad cuando así lo desee y por cualquier razón. Puede presentar una queja verbal al llamar al (559) 673-3508 o (888) 275-9779 o al llenar un Formulario de Queja Formal. Formularios de Queja Formal y sobres rotulados están disponibles en el área de recepción en todas las clínicas y oficinas. El formulario también está disponible en nuestro sitio de web madera-county.com. El formulario de Queja Formal puede entregarse al Representante del Cliente, mandarse por correo en el sobre rotulado o mandarse por correo al siguiente domicilio:

Servicios de Salud de Comportamiento  
Coordinador de Manejo de Calidad  
P.O. Box 1288  
Madera, CA 93639-1288



El Coordinador de Manejo de Calidad le notificará dentro de 5 días de trabajo que su queja ha sido recibida. Una respuesta escrita notificándole sobre la resolución final le será enviada dentro de sesenta días de calendario.

Puede asignar a un representante para que actúe por usted si así usted lo desea. El Representante de Derechos del Paciente puede ser llamado al (559) 673-3508 x. 1267 para asistirle en resolver la queja.

## APELACIÓN

Si usted desea apelar una “Acción” al Plan de Salud Mental, puede llamar al Coordinador de Manejo de Calidad al (559) 673-3508 o (888) 275-9779 – llamada gratis. Una “Acción” es cuando el Plan de Salud Mental:

- Le niega o limita la autorización de un servicio solicitado.
- Reduce, suspende, o termina un servicio previamente autorizado.
- Niega, por completo o en parte, pago por un servicio.
- Falla en actuar dentro de la marca del tiempo para la disposición de quejas estándares, la resolución de apelación estándar, o la resolución de apelación apresurada.
- Falla en proporcionar servicios de una manera oportuna, según lo determinado por el Plan de Salud Mental.

Una apelación apresurada puede ser utilizada cuando una decisión se debe tomar rápidamente para proteger la vida, salud, o la capacidad de función a un nivel máximo.

Clientes tienen el derecho de solicitar una audiencia Justa del Estado después que el proceso de Apelación haya sido completado. Usted puede ponerse en contacto con el Representante de los Derechos del Cliente o al Mediador del Estado indicado abajo para asistirle a programar una Audiencia Justa del Estado. Todas las decisiones de la Audiencia Justa del Estado son finales.

***SUS SERVICIOS DE SALUD MENTAL NO SERÁN AFECTADOS DE NINGUNA MANERA AL PRESENTAR UNA QUEJA, APELACIÓN, O UNA AUDIENCIA JUSTA DEL ESTADO.***

## SUGERENCIAS

Sugerencias y opiniones de clientes son una parte importante para proveer cuidado efectivo y de calidad. Proveedores tienen Formas de Sugerencias (verde) en áreas de servicios. Sugerencias de clientes son bienvenidas y se pueden entregar directamente al miembro de personal o al Representante del Cliente.

**If you need assistance completing this form please contact:**

**Quality Management Coordinator**

(559) 673-3508  
(888) 275-9779

**Patients' Rights Advocate**

(559) 673-3508 x. 1267  
(888) 275-9779

**Compliance Officer**

(559) 673-3508 x 1311

**State Ombudsman**

(800) 896-4042  
TTY (800) 896-2512  
Email: MHOmbudsman@dhcs.ca.gov

Please return this completed form to the receptionist or mail in the self-addressed envelope to:

**Madera County Behavioral Health Services**

Mental Health Plan  
P.O. Box 1288  
Madera, CA 93639

# GRIEVANCE FORM



## MADERA COUNTY BEHAVIORAL HEALTH SERVICES

TTY (800) 735-2929  
Cal Relay Dial 711  
Speech to Speech (866) 288-1909

**Behavioral Health Director**

Dennis Koch, MPA  
(559) 673-3508  
Toll free (888) 275-9779

Please ask receptionist about your **right to free language assistance** services as well as alternative formats of this brochure. If you have **physical limitations**, we will help you find available, appropriate and accessible services.

**MADERA COUNTY BEHAVIORAL HEALTH SERVICES  
CLIENT GRIEVANCE FORM**

- Grievances may be filed using this form, writing a letter, or submitted verbally, in person or by telephone.
- For assistance completing this form or to verbally report a complaint, you may get help from your therapist, the Program Supervisor, or those listed on the back of this form.
- To submit this form or a letter, you may give it to the receptionist or return in a self-addressed envelope we provide.
- You may designate someone to act on your behalf.
- The grievance process is confidential and applicable privacy laws followed.
- Your services at Madera County Behavioral Health will **NOT** be affected or change in any way if you file a grievance.
- You will be kept informed of the status of your grievance.

**Please print or write clearly.**

Name: \_\_\_\_\_ Birth Date \_\_\_\_\_ Date: \_\_\_\_\_

Name of Legal Guardian if on behalf of a minor: \_\_\_\_\_ Relationship: \_\_\_\_\_

How may we contact you?:  Mail Address: \_\_\_\_\_

Telephone/Number(s): \_\_\_\_\_ May we leave message?  Yes  No

Your Current Service Location  7<sup>th</sup> Street  Pine Street  Chowchilla  Oakhurst  NA

Write a description of the events-be as specific as possible including full names of persons involved, witnesses (if any) and dates and time of incidents. You may use additional paper.

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Have you tried to resolve the issue before?  No  Yes. Describe what you tried and the outcome.

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What would you like to have happen to resolve this grievance? \_\_\_\_\_

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The Quality Management (QM) Coordinator oversees the resolution process ensuring your grievance is addressed in 60 days. You or the QM Coordinator may request an extension of the timeline up to 14 calendar days; a decision maker is designated who is neutral and has clinical expertise; you must sign release forms for persons involved in solving the grievance; you may file an appeal for a State Fair Hearing if the process does not meet the specified timelines or you are dissatisfied with the outcome.

I understand that the Mental Health Plan staff will be authorized to contact any involved provider in order to resolve my grievance. The Mental Health Plan staff will also be authorized to discuss any and all information that shall be needed to evaluate and resolve this grievance.

\_\_\_\_\_  
Date Signature of person completing Form  
**ORIGINAL TO QUALITY MANAGEMENT COORDINATOR**

**Si necesita asistencia para completar esta forma por favor contacte a:**

**Coordinador de Servicios de Calidad**

(559) 673-3508  
(888) 275-9779

**Representante de Derechos del Cliente**

(559) 673-3508  
(888) 275-9779

**Oficial de Privacidad**

(559) 673-3508

**Mediador Estatal**

(800) 896-4042  
TTY (800) 896-2512  
Email: MHOmbudsman@dhcs.ca.gov

# FORMULARIO DE QUEJA



## SERVICIOS DE SALUD DE COMPORTAMIENTO CONDADO DE MADERA

Favor de entregar esta forma a la recepcionista o mande por correo en el sobre rotulado a:

**Servicios de Salud de Comportamiento del Condado de Madera**  
Plan de Salud Mental  
P.O. Box 1288  
Madera, CA 93639

Por favor pregunte a recepcionista sobre su **derecho** a servicios gratuitos de **asistencia en su idioma** y formatos alternativos de este panfleto. Si tiene **limitaciones físicas**, le ayudaremos a encontrar servicios disponibles, apropiados y accesibles.



# SERVICIOS DE COMPORTAMIENTO DEL CONDADO DE MADERA

## FORMULARIO DE QUEJA DEL CLIENTE

- Se puede presentar una queja al usar este formulario, escribir una carta, o verbalmente en persona o por teléfono.
- Para asistencia al llenar este formulario o para reportar una queja verbalmente, usted puede acudir a su terapeuta, el supervisor de programa, o a las personas listadas al reverso.
- Para presentar este formulario o una carta, d selala a la recepcionista o m ndela en el sobre rotulado prove do.
- Puede designar a otra persona para que actu  en su nombre.
- El proceso de queja es confidencial y se siguen las reglas de privacidad aplicables.
- Sus servicios del Dpto. de Salud de Comportamiento **NO** se ver n afectados de ninguna manera al presentar una queja.
- Se le mantendr  informado sobre el estatus de su queja.

Nombre: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_ Fecha: \_\_\_\_\_

Nombre de Guardi n Legal si es por un menor: \_\_\_\_\_ Parentesco: \_\_\_\_\_

 C mo podemos contactarle?:  Correo Domicilio: \_\_\_\_\_

Tel fono/N mero(s): \_\_\_\_\_  Podemos dejar mensaje?  S   No

✓ Lugar(es) donde recibe servicio  7<sup>th</sup> Street  Pine Street  Chowchilla  Oakhurst  NA

Describa los eventos-sea lo m s espec fico posible incluyendo nombres completos de personas involucradas, testigos (si hay) fechas y hora de incidentes. Puede usar m s papel.

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 Ha intentado resolver este asunto antes?  No  S . Describa lo que trato y el resultado. \_\_\_\_\_

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 Qu  le gustar a que ocurriera para resolver esta queja? \_\_\_\_\_

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El Coordinador de Calidad de Manejo (QM) supervisa la resoluci n del proceso asegurando que se responda a su queja dentro de 60 d as. Usted o el Coordinador de QM puede pedir una extensi n de hasta 14 d as de calendario; se designa una persona neutral con experiencia cl nica para tomar la decisi n; usted debe firmar formularios de autorizaci n para personas involucradas en la resoluci n de la queja; usted puede presentar una apelaci n para una Audiencia Estatal Justa si el proceso no cumple con las fechas de limite especificadas o si usted no est  de acuerdo con los resultados.

Yo entiendo que los empleados de Servicios de Comportamiento (BHS) estar n autorizados para ponerse en contacto con cualquier proveedor de servicios involucrado para resolver mi queja. Los empleados de Servicios de Comportamiento tambi n estar n autorizados para compartir parte y/o toda la informaci n necesaria para evaluar y resolver esta queja.

\_\_\_\_\_ Fecha

\_\_\_\_\_ Firma de Persona Llenando este Formulario

**WELCOME**  
**RESIDENTS OF MADERA**  
**COUNTY**

A variety of mental health services and programs are available to mental health clients in Madera County. Madera County Behavioral Health Services provides a continuum of services to children, youth, adults, and their families at three locations as well as with contracted private therapists in the community. A list of mental health providers is available upon request.

**SCREENING AND REFERRAL**

Services may be accessed by calling the Mental Health Plan (MHP) at the number listed below. Callers will speak to a licensed mental health clinician who will provide a referral to the most appropriate programs and/or services.

Madera County      (559) 673-3508  
Toll free              (888) 275-9779

**CHILDREN'S SERVICES**

- Assessment is a thorough analysis of the history and current status of an individual's mental, emotional, and behavioral concerns. Cultural issues and history are also identified. The assessment is used to determine what mental health services are needed.
  
- Individual, family, and group counseling/therapy are provided to persons who would benefit.
  
- Psychiatric services evaluate and

monitor individuals who need and are willing to take psychotropic medication.

- Dual Diagnosis groups are available for adolescents who have both a mental health and substance related diagnosis.
  
- Case Management services are offered to help families and individuals connect with community resources.
  
- Therapeutic Behavioral Services (TBS) are available for children/youth up to age 21 who are full scope Medi-Cal beneficiaries. TBS is one-on-one therapeutic contact between a mental health provider and a beneficiary for a specified brief time period designed to maintain the child's or youth's residential placement and prevent psychiatric hospitalization by resolving target behaviors and achieving short-term goals.
  
- There is a collaborative program between Madera County Behavioral Health Services, Madera County Department of Social Services, Madera County Public Health Department, and Madera County Office of Education. The program offers assessment and comprehensive treatment for children in out-of-home placement.
  
- Juvenile Justice Programs provide individual, group, and family counseling for youth who are court ordered through the Probation Department or referred by the School

Attendance Review Board.

**ADULT SERVICES**

- Assessment is a thorough analysis of the history and current status of the individual's mental, emotional, and behavioral concerns. Pertinent cultural issues and history are also identified. The assessment is used to determine what mental health services are needed.
  
- Individual, family, and group counseling/therapy are provided to persons who would benefit.
  
- Case management helps consumers find and connect with resources to solve and alleviate everyday living problems.
  
- Intensive case management helps individuals stabilize and improve their ability to function and prevent possible hospitalization.
  
- Psychiatric services evaluate and monitor individuals who need and are willing to take psychotropic medication.
  
- Dual Diagnosis treatment is provided for individuals who have both a mental health and a substance related diagnosis.
  
- Intensive treatment and prevention services are also available through the Mental Health Services Act funding. These include peer/family member support services available through Hope House in Madera and the Mountain Wellness Center in Oakhurst. Contact

the Mental Health Plan for more information.

**PSYCHIATRIC EMERGENCY**  
**TEAM**

- Emergency services are available 24 hours a day, 7 days a week for individuals who are potentially a danger to themselves or others, or for those who are gravely disabled due to a mental illness. An immediate assessment is provided to determine if psychiatric hospitalization or other care is required.

**SUGGESTIONS**

Suggestions and opinions are an important part of providing good care. Please give us this feedback by calling the Mental Health Plan at (559) 673-3508 or (888) 275-9779 or using the suggestion boxes in the waiting rooms of Behavioral Health Services programs.

**MADERA COUNTY**  
**BEHAVIORAL HEALTH**  
**SERVICES**

**(559) 673-3508**  
**TOLL FREE (888) 275-9779**  
**TTY (800) 735-2929**

**Cal Relay Services**  
**(English & Spanish)**  
**Dial 711**

**English Speech to Speech**  
**866-288-1909**  
**Spanish Speech to Speech**  
**866-288-4151**

## **GRIEVANCE PROCEDURE**

We encourage you to discuss concerns about mental health services with your therapist or program staff. You may also talk to the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779; or call the Patients' Rights Advocate at (559) 673-3508 ext. 1267 or (888) 275-9779; or the California Department of Health Care Ombudsman at (800) 896-4042; or TTY (800) 896-2512 or email [MHombudsman@dhcs.ca.gov](mailto:MHombudsman@dhcs.ca.gov).

If you are unable to resolve a concern about any aspect of service, you may at any time, for any reason file a grievance with the Quality Management Coordinator. A grievance may be filed verbally by calling (559) 673-3508 or (888) 275-9779, or by completing a Grievance Form. Formal Grievance forms and pre-addressed envelopes are available in the reception area of all clinics and provider offices. Grievance forms are also available on the County website <http://maderacounty.com>

You may designate someone to act on your behalf at any time. A consumer representative is also available to assist you by calling (559) 673-3508 or (888) 275-9779.

The Patients' Rights Advocate may be contacted at (559) 673-3508 ext. 1267 to assist in resolving grievances.

## **APPEAL PROCEDURE**

If you wish to appeal an "Action" by the Mental Health Plan, you may call the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779 – toll free. An "Action" is when the MHP:

- Denies or limits authorization of a requested service.
- Reduces, suspends, or terminates a previously authorized service.
- Denies, in whole or in part, payment for a service.
- Fails to act within the timeframes for

disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

- Fails to provide services in a timely manner, as determined by the MHP.

An Expedited Appeal may be used when a decision must be made quickly to protect the beneficiary's life, health, or ability to function at a maximum level

Beneficiaries have a right to request a State Fair Hearing after the Appeal process has been completed. You may contact the Patient's Rights Advocate or the State Ombudsman listed below to assist in filing for a State Fair Hearing. All State Fair Hearing decisions are final.

**YOUR MENTAL HEALTH SERVICES WILL NOT BE AFFECTED IN ANY WAY, NOR WILL YOU BE SUBJECT TO ANY PENALTY, BY FILING A GRIEVANCE OR AN APPEAL.**

## **Oakhurst Counseling Center (OCC)**

49774 Road 426, #D,

Oakhurst (559) 683-4809

## **Pine Recovery Center (PRC)**

117 N. R. Street, Suite 101,

Madera, CA (559) 662-0527

**BHS, CRC, OCC and PRC are open for beneficiaries with scheduled appointments and emergency walk-ins 8:00 a.m. to 5:00 p.m., Monday through Friday.**

**TOLL FREE (888) 275-9779**

**TTY (800) 735-2929**

**Cal Relay Services**

**(English & Spanish)**

**Dial 711**

**English Speech to Speech**

**866-288-1909**

**Spanish Speech to Speech**

**866-288-4151**

Please ask receptionist about your **right to free language assistance** services as well as alternative formats of this brochure. If you have **physical limitations**, we will help you find available, appropriate and accessible services.

## **MADERA COUNTY BEHAVIORAL HEALTH SERVICES**

### **SERVICES GUIDE**

**P. O. Box 1288 /**

**Madera, CA 93639-1288**

**209 E. 7<sup>th</sup> St. / Madera, CA 93638**



### **24-HOUR PHONE LINES**

**Emergency Psychiatric Services**

**Madera County (559) 673-3508**

**Toll Free (888) 275-9779**

**Screening and Referral for Services**

**Madera County (559) 673-3508**

**Toll Free (888) 275-9779**

### **WHERE TO GET MENTAL HEALTH SERVICES**

**Behavioral Health Services (BHS)**

**209 E. 7<sup>th</sup> Street,**

**Madera (559) 673-3508**

**Chowchilla Recovery Center (CRC)**

**215 S. 4<sup>th</sup> St.,**

**Chowchilla, CA (559) 665-2947**

## **BIENVENIDOS RESIDENTES DEL CONDADO DE MADERA**

Una variedad de servicios de salud mental y programas están disponibles para clientes de salud mental del Condado de Madera. El Departamento de Servicios de Comportamiento del Condado de Madera proporciona servicios continuos para niños, jóvenes, adultos y sus familias en tres ubicaciones con terapeutas privados contratados en la comunidad. Una lista de proveedores de salud mental está disponible al solicitarla.

### **CONSULTA Y REFERENCIA**

Puede acceder servicios al llamar al Plan de Salud Mental (MHP) a los números indicados abajo. Hablará con un consejero de salud mental licenciado quien lo referirá al programa y/o servicios más apropiados.

Condado de Madera (559) 673-3508  
Línea Gratuita (888) 275-9779

### **SERVICIOS PARA NIÑOS**

- Una evaluación es un análisis completo sobre la historia y el estado de salud mental, emocional, y de comportamiento preocupante. Cuestiones culturales e historia también son identificados. La evaluación se usa para determinar qué servicios de salud mental son necesarios.
- Terapia/consejería individual, de familia y en grupo son proporcionados a personas que podría beneficiar.

- Servicios psiquiátricos evalúan y monitorean a individuos que necesiten y quieran tomar Grupos de diagnóstico dual están disponibles para adolescentes que tienen una diagnosis relacionada con salud mental y abuso de sustancias.
- Servicios de manejo de caso son ofrecidos para ayudar a familias y a individuos a conectarse con recursos en la comunidad.
- Servicios terapéuticos de comportamiento (TBS) están disponibles para niños/jóvenes menores de 21 años con Medí-Cal. TBS es terapia entre el proveedor de salud mental y el beneficiario por un periodo de tiempo específico breve, diseñado para mantener vivienda en casa hogar y prevenir hospitalización psiquiátrica al resolver problemas de comportamiento y lograr metas a tiempo corto.
- Existe un programa colaborativo entre el Departamento de Salud de Comportamiento, el Departamento de Servicios Sociales del Condado de Madera, el Departamento de Salud del Condado de Madera, y la Oficina de Educación del Condado de Madera. El programa ofrece asesoramiento y tratamiento comprensivo para niños que se encuentran en colocación fuera del hogar.
- Programas de Justicia Juvenil proporcionan consejería individual, en grupo y consejería familiar para jóvenes que son mandados por el Departamento de Libertad Condicional por medio de la corte o referidos por la mesa de revisión de asistencia escolar.

## **SERVICIOS PARA ADULTOS**

- Asesoramiento es un análisis completo sobre la historia y el estado de salud mental, emocional y de comportamiento preocupante. Asuntos culturales e historial pertinente también son identificados. El asesoramiento determina los servicios de salud mental necesarios.
- Terapia individual, familiar y en grupo son proporcionados a personas que podría beneficiar.
- Manejo de caso ayuda a clientes a encontrar y a conectarse con recursos para resolver y aliviar problemas de la vida cotidiana.
- Manejo de caso intensivo ayuda a individuos a estabilizar y mejorar su habilidad de funcionamiento y prevenir una posible hospitalización.
- Servicios psiquiátricos evalúan y monitorean a individuos que necesiten y quieran tomar medicamento psicotrópico.
- Tratamiento de diagnóstico dual es proporcionado a individuos que tengan diagnosis relacionadas con salud mental y abuso de sustancias.
- Servicios de tratamiento intensivo y prevención están disponibles por medio de fondos del Acta de Servicios de Salud Mental. Estos incluyen servicios de apoyo entre compañeros/familiar en Hope House en Madera y en el Centro Mountain Wellness en Oakhurst. Contacte al Plan de Salud Mental para más información.

## **EQUIPO PSIQUIÁTRICO DE EMERGENCIA**

Servicios de emergencia están disponibles las 24 horas del día, 7 días de la semana a personas que poseen peligro a sí mismos o a otros; y para personas que estén gravemente discapacitados debido a una enfermedad mental. Un asesoramiento inmediato es proporcionado para determinar si hospitalización psiquiátrica u otro cuidado es requerido.

### **SUGERENCIAS**

Sugerencias y opiniones son una parte importante para proporcionar un buen cuidado. Por favor denos su opinión al llamar al Plan De Salud Mental al (559) 673-3508 o (888) 275-9779 o al utilizar las cajas de sugerencia en las áreas de recepción de las oficinas del Departamento de Salud de Comportamiento del Condado de Madera.

### **SERVICIOS DE SALUD DE COMPORTAMIENTO CONDADO DE MADERA**

**(559) 673-3508  
LLAMADA GRATIS (888) 275-9779  
TTY Español (800) 855 3000**

**Relevo de California  
(en Español)  
marcar el 711**

**Voz a Voz en Español  
866-288-4151**

## PROCEDIMIENTO DE QUEJA

Le animamos a que hable sobre sus inquietudes sobre los servicios de salud mental con su terapeuta o el personal del programa. Usted también puede platicar con el Coordinador de Manejo de Calidad al (559) 673-3508 o (888) 275-9779 o llame al Representante de Derechos del Cliente al (559) 673-3508 ext. 1267 o al Mediador Estatal al (800) 896-4042 o TTY (800) 896-2512 o correo electrónico MHombudsman@dhcs.ca.gov.

Si no se resuelve su asunto en relación a cualquier aspecto de servicio, usted puede, por cualquier razón, hacer una queja formal con el Coordinador de Manejo de Calidad. Puede presentar una queja verbalmente al llamar al (559) 673-3508 o (888) 275-9779 o al completar un formulario de Queja Formal. Formularios de Queja Formal y sobres dirigidos están disponibles en el área de recepción de todas las clínicas y oficinas. Formularios también están disponibles en nuestro sitio de web <http://madera-county.com>.

Puede asignar a un representante que actué en su nombre si así lo desea. Un representante de clientes también está disponible para asistirle al llamar al (559) 673-3508 o (888) 275-9779.

El Representante de Derechos del Cliente puede ser contactado al (559) 673-3508 ext. 1267 para asistirle en resolver la queja.

## PROCEDIMIENTO DE APELACIÓN

Si usted desea pedir una “Acción” al

Plan de Salud Mental, puede llamar al Coordinador del Manejo de Calidad al (559) 673-3508 o (888) 275-9779 – llamada gratis. Una “Acción” es cuando el Plan de Salud Mental:

- Le niega o limita la autorización de un servicio solicitado.
- Reduce, suspende, o da por terminado un servicio previamente autorizado.
- Niega, por completo o en parte, pago por un servicio.
- Falla en actuar dentro del lapso indicado para la disposición de quejas estándares, la resolución de apelaciones estándares, o la resolución de apelaciones apresuradas.
- Falla en proporcionar servicios de una manera oportuna, según lo determinado por el Plan de Salud Mental.

Una Apelación Apresurada puede ser utilizada cuando una decisión se debe tomar rápidamente para proteger la vida, salud, o la capacidad de funcionar a un nivel máximo de los beneficiarios.

Clientes tienen el derecho a solicitar una Audiencia Justa del Estado después que el proceso de Apelación se haya completado. Usted puede ponerse en contacto con el Abogado de los Derechos del Paciente o al Mediador del Estado para asistirle a programar una Audiencia Justa del Estado. Todas las decisiones de la Audiencia Justa del Estado son finales.

Centro de Consejería, Oakhurst (OCC)  
49774 Road 426, #D, (559) 683-4809

Centro de Recuperación Pine (PRC)  
117 N. R. Street, Suite 101, Madera, CA (559) 662-0527

**BHS, CRC, OCC y PRC están abiertos para beneficiarios con cita o sin cita previa en caso de emergencia de 8:00 a.m. - 5:00 p.m., de lunes a viernes.**

**SUS SERVICIOS DE SALUD MENTAL NO SERÁN AFECTADOS DE NINGUNA MANERA, NI SE LE IMPONDRÁ ALGÚN PENALTI AL ENTREGAR UNA QUEJA O UNA APELACIÓN.**

Por favor pregunte a recepcionista sobre su **derecho** a servicios gratuitos de **asistencia en su idioma** y formatos alternativos de este panfleto. Si tiene **limitaciones físicas**, le ayudaremos a encontrar servicios disponibles, apropiados y accesibles.

**MADERA COUNTY  
SERVICIOS DE SALUD DE  
COMPORTAMIENTO  
CONDADO DE MADERA**

**GUÍA DE SERVICIOS  
P. O. Box 1288 /  
Madera, CA 93639-1288  
209 E. 7<sup>th</sup> St. / Madera, CA 93638**



## LÍNEAS TELEFÓNICAS DE 24-HORAS

**Servicios de Psiquiatría de  
Emergencia  
Ciudad De Madera (559) 673-3508  
Línea Gratuita (888) 275-9779**

**Servicios de Detección y Consulta  
Condado de Madera (559) 673-3508  
Línea Gratuita (888) 275-9779**

**DONDE PUEDE RECIBIR  
SERVICIOS DE SALUD MENTAL**

**Servicios de Salud de Comportamiento  
(BHS)  
209 E. 7th St., (559) 673-3508**

**Centro de Recuperación Chowchilla  
(CRC)  
215 S 4<sup>th</sup> St., (559) 665-2947**

# ATTACHMENT O

Denial of  
authorization for  
requested services



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## DENIAL OF AUTHORIZATION FOR REQUESTED SERVICES

### Notice of Adverse Benefit Determination About Your Treatment Request

Date Client ID# Client DOB

**Beneficiary's Name**  
Address  
City, State Zip

**Treating Provider's Name**  
Address  
City, State Zip

**RE:** Service requested

Name of requestor (Client or Provider) has asked Madera County Mental Health Plan (MHP) to approve *Service requested* (Ex. Assessment). This request is denied. The reason for the denial is **DELETE ALL THIS TEXT BEFORE PRINTING IT IS ONLY FOR YOU TO REFERENCE**. Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call the MHP at 559-673-3508 or (888) 275-9779.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter or before the date the MHP says services will be stopped or reduced.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP between 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number (800) 735-2929, between 8:00 a.m. to 5:00 p.m. for help.



If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the MHP by calling (559) 673-3508 or (888) 275-9779.

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice





# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## NEGACIÓN DE AUTORIZACIÓN DE SERVICIOS SOLICITADOS

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

Date

Client ID#

Client DOB

Beneficiary's Name  
Address  
City, State Zip

Treating Provider's Name  
Address  
City, State Zip

**RE:** *Service requested*

*Name of requestor* ha pedido al Plan de Salud Mental (MHP) que apruebe *Service requested*. Esta solicitud es negada. La razón de la negación es **DELETE ALL THIS TEXT BEFORE PRINTING IT IS ONLY FOR YOU TO REFERENCE**. Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

Puede pedir copias gratuitas de toda la información utilizada para hacer esta decisión. Esto incluye una copia de la guía, protocolo, o criterio que usamos al tomar nuestra decisión. Para pedir esto, por favor llame a MHP al (559) 673-3508.

Si usted está recibiendo servicios actualmente y quiere seguir recibiendo servicios mientras decidimos sobre su queja, debe pedir una apelación a más tardar 10 días de la fecha de esta carta o antes de la fecha que el Plan indica que cesarán o reducirán sus servicios.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: NOABD "Sus Derechos"  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice

# ATTACHMENT P

Denial of Payment  
for a Service  
Rendered by a  
Provider



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## DENIAL OF PAYMENT FOR A SERVICE RENDERED BY PROVIDER

### Notice of Adverse Benefit Determination About Your Treatment Request

Date	Client ID#	Client DOB
<i>Beneficiary's Name</i>	<i>Treating Provider's Name</i>	
<i>Address</i>	<i>Address</i>	
<i>City, State Zip</i>	<i>City, State Zip</i>	

**RE:** *Service requested*

Name of requesting provider has asked the Madera County Mental Health Plan (MHP) to approve payment for the following service, which you already received: *Service requested*. The MHP has denied your provider's request for payment. The reason for the denial is **DELETE ALL THIS TEXT BEFORE PRINTING IT IS ONLY FOR YOU TO REFERENCE**. Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

**Please note: this is not a bill for the service. You are not required to pay for the services you received.**

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call the MHP at 559-673-3508 or (888) 275-9779.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number (800) 735-2929, between 8:00 a.m. to 5:00 p.m. for help.

If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the MHP by calling 559-673-3508 or (888) 275-9779.

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
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MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## NEGACIÓN DE PAGO POR SERVICIO YA PROPORCIONADOS POR PROVEEDOR

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

<i>Date</i>	<i>Client ID#</i>	<i>Client DOB</i>
<i>Beneficiary's Name</i>	<i>Treating Provider's Name</i>	
<i>Address</i>	<i>Address</i>	
<i>City, State Zip</i>	<i>City, State Zip</i>	

**RE:** *Service requested*

*Name of requesting provider* ha pedido al Plan de Salud Mental (MHP) que apruebe pago para los siguientes servicios, los cuales usted ya ha recibido: *Service requested*. El Plan ha negado la petición de pago de su proveedor. La razón de la negación es **DELETE ALL THIS TEXT BEFORE PRINTING IT IS ONLY FOR YOU TO REFERENCE**. *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.*

**Por favor note: esta no es una factura por servicios. No se le requiere pagar por los servicios que ha recibido.**

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

Puede pedir copias gratuitas de toda la información utilizada para hacer esta decisión. Esto incluye una copia de la guía, protocolo, o criterio que usamos al tomar nuestra decisión. Para pedir esto, por favor llame a MHP al (559) 673-3508.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: NOABD "Sus Derechos"  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice

# ATTACHMENT Q

## Delivery System





# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

**DENNIS P. KOCH, MPA**  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## DELIVERY SYSTEM – MEDICAL NECESSITY

### Notice of Adverse Benefit Determination About Your Treatment Request

Date Client ID# Client DOB

**Beneficiary's Name**  
Address  
City, State Zip

**Treating Provider's Name**  
Address  
City, State Zip

**RE:** Service requested

This notice lets you know that the Madera County Mental Health Plan (MHP) has determined that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services. *This determination is based on:*

- Your mental health diagnosis as identified by the assessment is not covered by the Mental Health Plan (Title 9, CCR, Section 1830.205(b)(1));*
- Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the Mental Health Plan (Title 9, CCR, Section 1830.205(b)(2))*
- The specialty mental health services available from the mental Health Plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B));*
- Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).*

Although you do not qualify for specialty mental health services, you may be able to receive non-specialty mental health services from *your Health Plan or physical health care provider (CalViva, Anthem Blue Cross) or your physical health provider*. You can call them at the number provided on the back of your insurance card or provided by your health care provider.

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal

help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed “Your Rights” information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call the MHP at (559) 673-3508 or (888) 275-9779.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your mental health plan says services will be stopped or reduced.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP between 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number (800) 735-2929, between 8:00 a.m. to 5:00 p.m. for help.

**If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the MHP by calling (559) 673-3508 or (888) 275-9779.**

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosures: NOABD “Your Rights”  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

**DENNIS P. KOCH, MPA**  
**DIRECTOR OF BEHAVIORAL HEALTH SERVICES**  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## SISTEMA DE ADMINISTRACIÓN – NECESIDAD MÉDICA

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

Date Client ID# Client DOB

Beneficiary's Name  
Address  
City, State Zip

Treating Provider's Name  
Address  
City, State Zip

**RE:** Service requested

Este aviso le informa que el Plan de Salud Mental (MHP) ha determinado que su condición de salud mental no satisface los requisitos del criterio de necesidad médica para calificar para servicios especializados de salud mental. *Esta decisión está basada en:*

- Su diagnosis de la salud mental como identificó por el avalúo no se cubre por el plan de la salud mental (Título 9, CCR, Sección 1830,205 (b) (1)).
- Su condición de salud mental no causa problemas para usted en su vida diaria que sean bastante serios para hacerlo elegible por especialidad de servicios del plan de salud mental (Título 9, CCR, Sección 1830,205 (b) (2)).
- La especialidad de servicios de salud mental disponible del plan de salud mental es probable no ayudarlo a mantener o mejorar su condición de salud mental (Título 9, CCR, Sección 1830,205 (b) (3) (Un) y (B)).
- Su condición de salud mental respondería a tratamiento por un proveedor de cuidado de la salud física (Título 9, CCR, 1830,205 (b) (3) (C)). .

Aunque no califica para servicios especializados de salud mental, puede recibir servicios de salud mental no-especializados de *Su Plan de Salud (CalViva, Anthem Blue Cross)* o su proveedor de salud. Puede llamarles al número proporcionado al revés de su tarjeta de seguro médico o al número proporcionado por su proveedor.

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación.

Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

Puede pedir copias gratuitas de toda la información utilizada para hacer esta decisión. Esto incluye una copia de la guía, protocolo, o criterio que usamos al tomar nuestra decisión. Para pedir esto, por favor llame a MHP al (559) 673-3508.

Si usted está recibiendo servicios actualmente y quiere seguir recibiendo servicios mientras decidimos sobre su queja, debe pedir una apelación a más tardar 10 días de la fecha de esta carta o antes de la fecha que el Plan indica que cesarán o reducirán sus servicios.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

**Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.**

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: NOABD "Sus Derechos"  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice

# ATTACHMENT R

## Modification of Requested Services



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

**DENNIS P. KOCH, MPA**  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## MODIFICATION OF REQUESTED SERVICES

### Notice of Adverse Benefit Determination About Your Treatment Request

Date

Client ID#

Client DOB

***Beneficiary's Name***

*Address*

*City, State Zip*

***Treating Provider's Name***

*Address*

*City, State Zip*

**RE:** *Service requested*

*Name of requestor* has asked the Madera County Mental Health Plan (MHP) to approve *Service requested*. We cannot approve this treatment as requested. This is because **DELETE ALL THIS TEXT BEFORE PRINTING IT IS ONLY FOR YOU TO REFERENCE**. Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

We will instead approve the following treatment: *Service or service length approved*.

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call the MHP at 559-673-3508 or (888) 275-9779.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your mental health plan says services will be stopped or reduced.

The MHP can help you with any questions you have about this notice. For help, you may call MHP between 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number (800) 735-2929, between 8:00 a.m. to 5:00 p.m. for help.

If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the MHP by calling (559) 673-3508 or (888) 275-9779.

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

**DENNIS P. KOCH, MPA**  
**DIRECTOR OF BEHAVIORAL HEALTH SERVICES**  
**MENTAL HEALTH DIRECTOR**  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

**P.O. BOX 1288**  
**MADERA, CA 93639-1288**  
**PHONE (559) 673-3508 TTY (800) 735-2922**  
**CONFIDENTIAL FAX (559) 661-2818**

## MODIFICACIÓN DE SERVICIOS SOLICITADOS

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

*Date*

*Client ID#*

*Client DOB*

*Beneficiary's Name*  
*Address*  
*City, State Zip*

*Treating Provider's Name*  
*Address*  
*City, State Zip*

**RE:** *Service requested*

*Name of requestor* ha pedido al Plan de Salud Mental (MHP) que apruebe *Service requested*. No podemos aprobar esta solicitud de tratamiento como solicitada. Esto es debido a **DELETE ALL THIS TEXT BEFORE PRINTING IT IS ONLY FOR YOU TO REFERENCE**. Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.

En su lugar aprobamos el siguiente tratamiento: *Service or service length approved*.

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

Puede pedir copias gratuitas de toda la información utilizada para hacer esta decisión. Esto incluye una copia de la guía, protocolo, o criterio que usamos al tomar nuestra decisión. Para pedir esto, por favor llame a MHP al (559) 673-3508.

Si usted está recibiendo servicios actualmente y quiere seguir recibiendo servicios mientras decidimos sobre su queja, debe pedir una apelación a más tardar 10 días de la fecha de esta carta o antes de la fecha que el Plan indica que cesarán o reducirán sus servicios.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar



u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: NOABD "Sus Derechos"  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice

# ATTACHMENT S

Termination of a

Previously

Authorized Service



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## TERMINATION OF A PREVIOUSLY AUTHORIZED SERVICE

### Notice of Adverse Benefit Determination About Your Treatment Request

Date

Client ID#

Client DOB

**Beneficiary's Name**

Address

City, State Zip

**Treating Provider's Name**

Address

City, State Zip

**RE:** Service requested

You are currently receiving Service to be terminated. Unless you contact me by enter date I will assume you are no longer interested in receiving this treatment and your chart will be closed to further treatment. Beginning on termination date we will no longer approve this treatment. This is because you did not meet the Madera County Behavioral Health Treatment Compliance Agreement as follows:

- Client no longer meets medical necessity due to:
  - Your mental health diagnosis as identified by the assessment is not covered by the Mental Health Plan (Title 9, CCR, Section 1830.205(b)(1));
  - Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the Mental Health Plan (Title 9, CCR, Section 1830.205(b)(2))
  - The specialty mental health services available from the mental Health Plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B));
  - Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C))
- You moved out of Madera County, or are no longer a Madera County Medi-Cal beneficiary,
- You have not been seen for over 90 days.
- You have missed three (3) consecutive appointments.
- You no longer meet target population criteria and are stable.
- You do not participate in the treatment planning process with the primary provider clinician.

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call the Madera County Mental Health Plan (MHP) at (559) 673-3508 or (888) 275-9779.

If you want to keep getting this service while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your plan says services will be stopped or reduced, listed above.

This notice does not affect any of your other Medi-Cal services.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP between 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number 800-735-2929, between 8:00 a.m. to 5:00 p.m. for help.

**If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the MHP by calling (559) 673-3508 or (888) 275-9779.**

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

*Signature Block*

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## TERMINACIÓN DE SERVICIO PREVIAMENTE AUTORIZADO

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

Date

Client ID#

Client DOB

Beneficiary's Name  
Address  
City, State Zip

Treating Provider's Name  
Address  
City, State Zip

**RE:** Service requested

Actualmente usted está recibiendo Service to be terminated. A menos que me contacte antes del enter date asumiré que ya no está interesado/a en recibir este tratamiento y si caso se cerrará para tratamiento adicional. A partir del termination date no seguiremos aprobando este tratamiento. Esto es debido a que no cumplió con el Acuerdo de Cumplimiento de Tratamiento del Departamento de Servicios de Salud de Comportamiento del Condado de Madera como indicado:

- Usted ya no cumple con los criterios de necesidad médica debido a:
- Su diagnóstico de la salud mental como identificó por el avalúo no se cubre por el plan de la salud mental (Título 9, CCR, Sección 1830,205 (b) (1));
  - Su condición de salud mental no causa problemas para usted en su vida diaria que sean bastante serios para hacerlo elegible por especialidad de servicios del plan de salud mental (Título 9, CCR, Sección 1830,205 (b) (2));
  - La especialidad de servicios de salud mental disponible del plan de salud mental es probable no ayudarlo a mantener o mejorar su condición de salud mental (Título 9, CCR, Sección 1830,205 (b) (3) (Un) y (B));
  - Su condición de salud mental respondería a tratamiento por un proveedor de cuidado de la salud física (Título 9, CCR, 1830,205 (b) (3) (C)).
- Usted se mudó fuera del Condado de Madera, o ya no es beneficiario de Medi-Cal en el Condado de Madera,
- Usted no se ha presentado para servicios en más de 90 días.
- Usted no se ha presentado a más de tres (3) citas seguidas.
- Usted ya no cumple los criterios de población beneficiaria o está estable.
- Usted no participa en el proceso de planificación de tratamiento con su proveedor clínico principal.

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información “Sus Derechos” adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información “Sus Derechos” adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

Puede pedir copias gratuitas de toda la información utilizada para hacer esta decisión. Esto incluye una copia de la guía, protocolo, o criterio que usamos al tomar nuestra decisión. Para pedir esto, por favor llame a MHP al (559) 673-3508.

Si usted está recibiendo servicios actualmente y quiere seguir recibiendo servicios mientras decidimos sobre su queja, debe pedir una apelación a más tardar 10 días de la fecha de esta carta o antes de la fecha que el Plan indica que cesaran o reducirán sus servicios.

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

**Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.**

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador ‘Ombudsman’ Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

#### *Signature Block*

Adjunto: NOABD “Sus Derechos”  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD “Your Rights”  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice

# ATTACHMENT T

## Delay in Processing Authorization of Services



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

**DENNIS P. KOCH, MPA**  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## DELAY IN PROCESSING AUTHORIZATION OF SERVICES

### Notice of Adverse Benefit Determination About Your Treatment Request

<i>Date</i>	<i>Client ID#</i>	<i>Client DOB</i>
<i>Beneficiary's Name</i>	<i>Treating Provider's Name</i>	
<i>Address</i>	<i>Address</i>	
<i>City, State Zip</i>	<i>City, State Zip</i>	

**RE:** *Service requested*

*You or your provider (Name of requesting provider)* has asked the Madera County Mental Health Plan (MHP) to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf on *date requested*. The MHP has not yet made a decision about the request.

We apologize for the delay in processing this request. We are working on your request and will provide *you or your provider (Name of requesting provider)* with a decision as soon as possible.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP between 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number 800-735-2929, between 8:00 a.m. to 5:00 p.m. for help.

If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact MHP by calling (559) 673-3508 or (888) 275-9779.



If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR

- ALCOHOL/DRUG PROGRAM ADMINISTRATOR

P.O. BOX 1288  
MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## RETRAZO DE PROCESAMIENTO DE AUTORIZACIÓN PARA SERVICIOS

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

*Date*

*Client ID#*

*Client DOB*

*Beneficiary's Name*  
*Address*  
*City, State Zip*

*Treating Provider's Name*  
*Address*  
*City, State Zip*

**RE:** *Service requested*

*You or your provider (Name of requesting provider)* ha pedido al Plan de Salud Mental (MHP) obtener o aprobar *Service requested*. Nuestros registros demuestran que usted solicitó servicio(s), o que alguien solicitó servicio en su nombre el *date requested*. MHP aún no ha tomado una decisión sobre su solicitud.

Nos disculpamos por la tardanza en procesar su solicitud. Estamos trabajando en su solicitud y le proporcionaremos a *you or your provider (Name of requesting provider)* una decisión lo más pronto posible.

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: NOABD "Sus Derechos"  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice

# ATTACHMENT U

Failure to Provide

Timely Access to

Services



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

**DENNIS P. KOCH, MPA**  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

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MADERA, CA 93639-1288  
PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## FAILURE TO PROVIDE TIMELY ACCESS TO SERVICES

### Notice of Adverse Benefit Determination About Your Treatment Request

Date Client ID# Client DOB

**Beneficiary's Name**  
Address  
City, State Zip

**Treating Provider's Name**  
Address  
City, State Zip

**RE:** Service requested

You or your provider [Name of requesting provider] has asked the Madera County Mental Health Plan (MHP) to obtain or approve *Service requested*. The MHP has not provided services within *number of* working days. Our records show that you requested service(s), or service(s) were requested on your behalf on *date requested*.

We apologize for the delay in providing timely services. We are working on your request and will provide you with *Service requested* soon.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP between 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number 800-735-2929, between 8:00 a.m. to 5:00 p.m. for help.

If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material,

please contact the MHP by calling (559) 673-3508 or (888) 275-9779.

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

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CONFIDENTIAL FAX (559) 661-2818

## FALLA EN PROPORCIONAR ACCESO A SERVICIOS DE MANERA OPORTUNA

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

<i>Date</i>	<i>Client ID#</i>	<i>Client DOB</i>
<i>Beneficiary's Name</i>	<i>Treating Provider's Name</i>	
<i>Address</i>	<i>Address</i>	
<i>City, State Zip</i>	<i>City, State Zip</i>	

**RE:** *Service requested*

*You or your provider [Name of requesting provider ha pedido al Plan de Salud Mental (MHP) obtener o aprobar Service requested. MHP no ha proporcionado servicios en los últimos number of días laborales. Nuestros archivos muestran que usted solicitó servicio(s), o que servicio se solicitó en su nombre el date requested.*

Nos disculpamos por la tardanza en proveerle servicios de forma oportuna. Estamos trabajando en su solicitud y le proporcionaremos con *Service requested* pronto.

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: "Sus Derechos"

*Enclose notice with each letter*



# ATTACHMENT V

Dispute of

Financial Liability



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
MENTAL HEALTH DIRECTOR  
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PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## DISPUTE OF FINANCIAL LIABILITY

### Notice of Adverse Benefit Determination About Your Treatment Request

Date

Client ID#

Client DOB

**Beneficiary's Name**

Address

City, State Zip

**Treating Provider's Name**

Address

City, State Zip

**RE:** Service requested

Plan has denied your dispute of financial liability regarding *insert a description of the disputed financial liability (e.g., cost-sharing, co-insurance, other liabilities)*. This is because *Using plain language, insert a clear and concise explanation of the reasons for the denial. If further information is needed, indicate what further information is needed and/or additional steps need be taken, if necessary.*

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call the Madera County Mental Health Plan (MHP) at (559) 673-3508 or (888) 275-9779.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP between 8:00 a.m. to 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number (800) 735-2929, between 8:00 a.m. to 5:00 p.m. for help.

If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material,

please contact the MHP by calling (559) 673-3508 or (888) 275-9779.

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

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CONFIDENTIAL FAX (559) 661-2818

## DISPUTA DE RESPONSABILIDAD FINANCIERA

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

*Date*

*Client ID#*

*Client DOB*

*Beneficiary's Name*  
*Address*  
*City, State Zip*

*Treating Provider's Name*  
*Address*  
*City, State Zip*

**RE:** *Service requested*

El Plan de Salud Mental (MHP) ha negado su disputa sobre su responsabilidad financiera. *insert a description of the disputed financial liability (e.g., cost-sharing, co-insurance, other liabilities).* Esto es debido a *Using plain language, insert a clear and concise explanation of the reasons for the denial. If further information is needed, indicate what further information is needed and/or additional steps need be taken, if necessary.*

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

Puede pedir copias gratuitas de toda la información utilizada para hacer esta decisión. Esto incluye una copia de la guía, protocolo, o criterio que usamos al tomar nuestra decisión. Para pedir esto, por favor llame a MHP al (559) 673-3508.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato

electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: NOABD "Sus Derechos"  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD "Your Rights"  
Language Assistance Taglines  
Beneficiary Non-Discrimination Notice

# ATTACHMENT W

Failure to Timely

Resolve

Grievances and

Appeals



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

209 E. 7<sup>th</sup> Street / Madera, CA 93638

DENNIS P. KOCH, MPA  
DIRECTOR OF BEHAVIORAL HEALTH SERVICES  
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PHONE (559) 673-3508 TTY (800) 735-2922  
CONFIDENTIAL FAX (559) 661-2818

## FAILURE TO TIMELY RESOLVE GRIEVANCE AND APPEALS

### Notice of Adverse Benefit Determination

Date Client ID# Client DOB

Beneficiary's Name  
Address  
City, State Zip

Treating Provider's Name  
Address  
City, State Zip

**RE:** [Service requested]

Our records show that you filed a *grievance or appeal* with the Madera County Mental Health Plan (MHP) on *date filed*. Unfortunately, the Madera County MHP did not finish reviewing the *grievance or appeal* within the required timeline.

We apologize for the delay in processing your *grievance or appeal*. We are working on it and will provide you with a decision as soon as possible.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The MHP can help you with any questions you have about this notice. For help, you may call the MHP between 8:00 a.m. – 5:00 p.m. at (559) 673-3508 or (888) 275-9779. If you have trouble speaking or hearing, please call TTY/TTD number (800) 735-2929, between 8:00 a.m. – 5:00 p.m. for help.

If you need this notice and/or other documents from the MHP in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the MHP by calling (559) 673-3508 or (888) 275-9779.

If the MHP does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

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*Signature Block*

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## FALLA DE RESOLUCIÓN OPORTUNA DE QUEJA & APELACIÓN

### Aviso de Determinación de Beneficios Adversa Sobre su Petición de Tratamiento

*Date*

*Client ID#*

*Client DOB*

*Beneficiary's Name*  
*Address*  
*City, State Zip*

*Treating Provider's Name*  
*Address*  
*City, State Zip*

**RE:** *[Service requested]*

Nuestros expedientes demuestran que usted presentó una *grievance or appeal* con MHP en *date filed*. Desafortunadamente, el Plan de Salud Mental (MHP) no termino de revisar su *grievance or appeal* dentro de los límites de tiempo requeridos.

Nos disculpamos por la tardanza en procesar su *grievance or appeal*. Estamos trabajando en ésta y le proporcionaremos una decisión lo más pronto posible.

Usted puede apelar esta decisión si piensa que es incorrecta. El aviso de información "Sus Derechos" adjunto le indica cómo. También le dice dónde puede obtener ayuda con su apelación. Esto también significa ayuda legal gratuita. Se le anima a mandar con su apelación cualquier información o documentos que pudieran ayudar su apelación. El aviso de información "Sus Derechos" adjunto le proporciona líneas de tiempo que debe seguir al solicitar una apelación.

El Plan le puede asistir con cualquier pregunta que pueda tener sobre este aviso. Para asistencia, puede llamar a MHP de lunes a viernes de 8am a 5pm al (559) 673-3508. Si tiene dificultad al hablar u oír, por favor llame al número TTY/TDD (800) 855-3000, entre las horas de 8am a 5pm para recibir ayuda.

Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte a MHP al llamar al (559) 673-3508.

Si el Plan no le ayuda a su satisfacción y/o necesita ayuda adicional, la oficina del Mediador 'Ombudsman' Estatal de Cuidado Administrado de Medi-Cal le puede ayudar con cualquier pregunta. Puede llamarle de lunes a viernes, 8am a 5pm PST, excluyendo días festivos, al 1-888-452-8609

Este aviso no afecta ninguno de sus otros servicios de Medi-Cal.

*Signature Block*

Adjunto: NOABD "Sus Derechos"  
Mensaje de Asistencia Lingüística  
Aviso para Beneficiario de No Discriminación

Enclosures: NOABD "Your Rights"  
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Beneficiary Non-Discrimination Notice

# ATTACHMENT X

## Credentialing

## Policies

CRD 1.00 -7.00

**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD 01:00

**SUBJECT:** CREDENTIALING PROCESS FOR NETWORK/GROUP PROVIDERS

**REFERENCE:**

- ❖ CFR, title 42, section 438.230(a)
- ❖ CMP 10:00, Excluded Individuals and Entities
- ❖ CRD 08.00, Credentialing Process for Hospitals

**POLICY:**

All providers entering into a contract with the Madera County Mental Health Plan (MHP) must be credentialed by Madera County Behavioral Health Services (BHS) and have a verified and approved credentialing packet on file.

**PURPOSE:**

To establish a credentialing process to assure the competency of mental health professionals who contract with the Madera County Mental Health Plan (MHP) to provide mental health services to Madera County Medi-Cal beneficiaries.

**PROCEDURE:**

- I. Application Process.
  - A. Each provider contracting to be a network/group provider for Madera County Behavioral Health Services (BHS) will be sent an application packet consisting of the following:
    1. Instructions for Completion of Application (CRD 01.A1)
    2. Application Check-List (CRD 01.A2)
    3. Application to Participate As Provider (CRD 01.A3)
    4. Confidential Certification (CRD 01.A4)
  - B. Providers will return completed forms to the BHS Credentialing Coordinator.
  - C. The application must contain the following:
    1. Completed questionnaire which includes copies of the following documents:
      - Valid, current and unrestricted licensure to practice in California.

Approved by BHS Director: <i>Signature on File</i>	Date: 7-16-15	Effective Date: 10-01-03	Revision Dates: 12-05-03, 12-28-04, 02-23-05, 10-04-06, 9-14-07, 8-28-12, 7-1-15
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- Current DEA Certificate (if appropriate)
  - Evidence of current professional liability coverage which, meet or exceeds MHP minimum limits.
  - Curriculum Vitae
2. Signed release granting MHP access to records for credentialing purposes of any medical society, medical board, college of medicine, hospital, malpractice insurance carrier or any other institution, organization, licensing agency or entity which does or may maintain records concerning the applicant's.
  3. Statement in writing by the applicant regarding:
    - a. Physical and mental health status.
    - b. Lack of impairment due to chemical dependency.
    - c. History of loss of license.
    - d. History of felony convictions.
    - e. History of limitation of privileges or disciplinary action.
    - f. Work history.
    - g. History of professional liability claims.
  4. Signed attestation by applicant to the correctness and completeness of the application.

**II. General Criteria and Standards**

Each provider applying for credentialing by Madera County Mental Health Plan (MHP) shall meet the following criteria as applicable:

- A. Valid, current, unrestricted California license.
- B. Hospital/Facility Privileges: (if appropriate)
  1. Physicians will have current unrestricted staff clinical privileges and admitting privileges granted by an MHP participating hospital within the service area.
- C. Valid, current Drug Enforcement Agency (DEA) registration. (if appropriate)
- D. Current professional liability coverage which meets or exceeds MHP limits.
- E. Absence of a history of involvement in malpractice suit, arbitration, or settlement within the past two years. In the case of a provider with such history, there must be evidence that the history does not demonstrate probable future sub-standard professional performance.
- F. Absence of a history of denial, suspension, restriction, or termination of hospital

privileges within the past two years; or in the case of a provider with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.

- G. Absence of a history of disciplinary actions within the past two years affecting provider's professional license, DEA or other required certifications; or for providers with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.
- H. Absence of a history of felony convictions within the past two years; or, for a provider with such history, evidence that the nature of the conviction does not affect provider's current ability to perform the professional duties for which provider is contracted or does not demonstrate probable future sub-standard care.
- I. Absence of a history of sanctions by regulatory agencies, including Medicare/Medicaid sanctions, within the last two years; or, for a provider with such a history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in federal or state sponsored programs or evidence that past sanctions do not demonstrate probable future sub-standard performance.
- J. Absence of a history of chemical dependency/substance abuse within the past two years for those providers who have such history, evidence that the provider is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect provider's ability to adequately perform the professional duties for which provider is contracted.
- K. Absence of a physical or mental health condition that would impair or would be likely to impair provider's ability to adequately perform the professional duties for which provider is contracted.

Meeting these Criteria and Standards does not automatically entitle an applicant to participate in the Plan.

III. Application Review by Credentialing Coordinator

- A. The Credentialing Coordinator will review the application for completeness and verify that the confidentiality/release form is signed and dated.
  - 1. If an application is incomplete, it will be returned to the applicant for completion.
  - 2. If application is complete, a file will be created for that applicant and all of the following will be verified by the National Data Bank (NDB):
    - Licenses

- Insurance
  - Education including graduation from an accredited professional school, or highest training program applicable to the academic degree, discipline, and licensure of the mental health professional applicant.
3. A copy of query from the NDB will be kept with application in the applicant's file.
  4. Applicants will also be screened for the following in accordance with CMP: 10:00, Excluded Individuals and Entities:
    - Federal: Health and Human Services, Office of the Inspector General, List of Excluded Individual/Entities (LEIE) at <http://oig.hhs.gov>
    - State: California Department of Health Care Services Medi-Cal Ineligible Provider List (MIPL) at <http://files.medi-cal.ca.gov>
  5. Applicant will be notified if a need for more documentation is indicated.
  6. Credentialing Coordinator will send the Reference Questionnaire (CRD: 01:05) to individuals/agencies listed on the Application Check List.
  7. The completed folder will be presented to the Credentialing Committee for review and approval at the next regular meeting or a special meeting will be called.

IV. Application Review by Credentialing Committee

- A. The Credentialing Committee will review the folders prepared by the Credentialing Coordinator, asking questions about information that is unclear.
- B. The Committee will decide whether or not each application for credentialing is approved and will sign off on the Desk Review form (CRD 01.A6).
  1. If application is approved, the mental health professional applicant will be notified by the Credentialing Coordinator that credentialing has been approved.
    - a. A Provider Manual and County Contract will be sent to the provider or group for signature.
    - b. The MHP will contact the provider once the signed contract is returned in order to provide orientation and training.
  2. If the application is not approved, a notice will be sent to the provider describing why the application was not approved and explaining the appeal process procedures.
    - a. Providers shall not be excluded solely because of the provider's type of license or certification.

- b. Providers who serve high-risk populations or specialize in mental health conditions that require costly treatment will not be discriminated against.

V. Initiation of Contract

- A. The Credentialing Coordinator will prepare a "Notice of New Provider" form (CRD 01.A7), completing Section 1 based on information in the Applicant folder.
- B. Form will be sent to Quality Management (QM) Supervisor (or designee) who will complete Section 2.
- C. QM Supervisor will send the form to Contract Analyst who will initiate a contract and send two copies to the applicant/ for signature.
- D. Contracts will not be initiated for applicants when BHS is accepting the credentialing process of a contracted hospital.
- E. Contract Analyst will send completed form to Anasazi Support Staff for set up of provider numbers.
- F. Anasazi Support Staff will return the form to Credentialing Coordinator to update Provider List.

VI. Appeal Process

- A. An applicant may request a review and reconsideration of an adverse Credentialing Committee decision by contacting the Behavioral Health Services Director.
- B. The Behavioral Health Services Director shall appoint an ad hoc committee consisting of three (3) members of the BHS Quality Management Committee.
- C. The ad hoc committee will meet with the applicant to review the application folder and the Credentialing Committee's findings.
- D. The ad hoc committee will make a decision regarding the appropriateness of the application for credentialing and notify the Behavioral Health Services Director
- E. The Behavioral Health Services Director will consider the findings and make a final decision regarding applicant's credentialing.
- F. Applicant will be notified by mail of the final decision.

VII. Subcontractor Relationships and Delegation

- a. BHS is accountable and will oversee any functions and responsibilities that it delegates to any subcontractor.
- b. Before any delegation, BHS will evaluate the prospective contractor's ability to perform the activities to be delegated. BHS will have a written agreement with the subcontractor specifying the activities and report responsibilities delegated to the



subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

- c. BHS will monitor the subcontractor's performance on an ongoing basis and subject it to a formal review in accordance to a periodic schedule established by the State, consistent with industry standards or State Managed Care Organization (MCO) laws and regulations.
- d. If BHS identifies deficiencies or areas for improvement, BHS and the subcontractor will take corrective action.

**INSTRUCTIONS FOR COMPLETION OF APPLICATION  
TO PARTICIPATE AS PRACTITIONER IN MENTAL HEALTH PLAN OF MADERA COUNTY**

**General Instructions**

- \* Application (CRD: 01:A3) must be typed or printed legibly.
- \* All questions must be completed; incomplete applications will be returned.
- \* If there is insufficient room for any questions, additional sheets may be attached. Reference the attachment in the question being answered.

**Identifying Information**

- \* Checks will be made out to the practitioner or organization identified on the form.

**Licensure**

- \* List California license first.
- \* If licensure in a state (other than California) is no longer active, place the date it became inactive in the "expiration date" column.
- \* If you do not have one of the identified numbers, leave the section blank.
- \* Attach a copy of California license.

**Malpractice Liability Insurance**

- \* If the answer to any of the questions is "yes," provide full details on an attached sheet.
- \* Attach a copy of malpractice insurance.

**Attestation Questions**

- \* If the answer to any of the questions is "yes," provide full details on an attached sheet.

Return the following to the Credentialing Coordinator at the address below:

- \* The completed Application (CRD: 01.A3)
- \* The completed Application Check List (CRD: 01:A2)
- \* A signed Confidential Certification (CRD: 01:A4)\*
- \* A photocopy of the California professional license and DEA license (if applicable)
- \* Proof of professional liability (malpractice) insurance
- \* A current *curriculum vitae*
- \* Two letters of reference (unless references are listed on application)

Credentialing Coordinator  
Behavioral Health Services  
PO Box 288  
Madera, CA 93639-1288

If you have questions regarding this application, please contact Credentialing Coordinator:  
Phone: (559) 673-3508, ext. 1301      Fax: (559) 675-7758  
Email: [margaret.graham@co.madera.ca.gov](mailto:margaret.graham@co.madera.ca.gov)

**MADERA COUNTY BEHAVIORAL HEALTH SERVICES  
MANAGED CARE MENTAL HEALTH PLAN APPLICATION CHECK LIST  
FOR NETWORK, GROUP AND/OR ORGANIZATIONAL PROVIDERS  
(559) 673-3508      FAX (559) 675-7758**

NAME AND TITLE: \_\_\_\_\_

ORGANIZATION NAME and TYPE: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**Please ensure that the application is completed in its entirety.**

\_\_\_\_\_ APPLICATION: Including

\_\_\_\_\_ NAME & SOCIAL SECURITY NUMBER

\_\_\_\_\_ GENDER, DATE OF BIRTH & HOME ADDRESS

\_\_\_\_\_ NAME & ADDRESS THAT CHECKS WILL BE SENT TO

\_\_\_\_\_ PRACTICE SPECIFICS

\_\_\_\_\_ STATE LICENSURE INFORMATION (**\*\*ATTACH COPY OF LICENSE\*\***)

\_\_\_\_\_ MEDICAID/MEDI-CAL PROVIDER NUMBER (If applicable)

**Expiration Date** \_\_\_\_\_

\_\_\_\_\_ MEDICARE UPIN (If Applicable) **Expiration Date** \_\_\_\_\_

\_\_\_\_\_ NATIONAL PROVIDER IDENTIFIERS (NPI)

\_\_\_\_\_ DEA LICENSE (MDs ONLY) (**\*\*ATTACH COPY OF LICENSE\*\***)

\_\_\_\_\_ TAXONOMY NUMBER & CLASSIFICATION

\_\_\_\_\_ PROFESSIONAL LIABILITY (MALPRACTICE) (**\*\*ATTACH COPY\*\***)

\_\_\_\_\_ COMPLETED ATTESTATION QUESTIONS (Provide details on a separate page for all "YES" answers)

\_\_\_\_\_ CURRICULUM VITAE (CV) (**\*\*ATTACH COPY\*\***)

\_\_\_\_\_ REFERENCES (List on Application or ATTACH Reference Letters)

RETURN APPLICATION PACKET TO:      Madera County Behavioral Health Services  
Credentiaing Coordinator  
P.O. Box 1288  
Madera, CA 93639-1288

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**APPLICATION TO PARTICIPATE AS PROVIDER  
MADERA COUNTY MENTAL HEALTH PLAN**

**IDENTIFYING INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ SSN or Tax ID # \_\_\_\_\_  
 Gender: \_\_\_\_\_ Birth Date: \_\_\_\_\_ License: MD  Psychologist  LCSW  LMFT   
 Home Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
**Checks to be made out as follows:**  
 Name \_\_\_\_\_ City/ State/Zip \_\_\_\_\_  
 Population Served: Children under 5: Children 6-15: Children 6-15: Adults 18-59: Older Adults 60+:  
 Service Area(s) offered: Individual: Family: Group: Medications: Psych Testing:  
 Inpatient: Other: (Specify) \_\_\_\_\_  
 Days Available: Mon  Tues  Wed  Thu  Fri  Sat  Sun   
 Hours Available: \_\_\_\_\_  
 List languages spoken in addition to English: \_\_\_\_\_  
 Ethnic, Racial & Culture Specific Specialties: \_\_\_\_\_  
 Are you accepting new clients? Yes  No

LICENSURE			
State	License Number	Type of License	Expiration Date

*Please complete as applicable*

Medi-Cal Provider #:	Medicare UPIN:	NPI#:
DEA Number:	DEA Expiration Date:	
Taxonomy #:	Taxonomy Classification:	

PROFESSIONAL LIABILITY				
Insurance Carrier	Policy #	Per claim amt	Aggregate amt	Expiration Date
		\$	\$	

Yes  No Have any judgments been made against you, or settlements been agreed to, in professional liability cases, or are there any filed and served professional liability lawsuits pending against you.  
 Yes  No Has your professional liability insurance ever been terminated, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?  
 Madera County requires contractor to carry malpractice liability insurance of at least one million dollars (\$1,000,000.00) per person per occurrence, and three million dollars (\$3,000,000.00) in aggregate, insuring against professional errors and omissions (malpractice) in providing mental health services and for the protection of the interests and property of contractor, his/her officers and employees, County, its officers and employees, and Medi-Cal members.

**ATTESTATION QUESTIONS**

Yes  No Has your clinical license or narcotic registration ever been revoked, suspended or limited, or have you received a letter of reprimand, or is there action pending?  
 Yes  No Have you been the recipient of adverse actions or surrendered clinical privileges while under investigation for possible actions, such as revocation, suspension, limitation, disciplinary review action, denial, canceling, or is any such action pending?

<input type="checkbox"/> by Medicare, Medicaid or any public program? <input type="checkbox"/> a hospital medical staff, clinical group, independent practice association, health plan, HMO, PPO, private payer, professional association, professional school faculty or other health delivery entity or system? <input type="checkbox"/> by a specialty board? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any physical or mental conditions which impair your ability to practice?
---

**INCLUDE TWO (2) REFERENCES:** Attach reference letters or list references below with current addresses and phone numbers:

Reference #1:

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Reference #2:

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**MADERA COUNTY MENTAL HEALTH PLAN**

**CONFIDENTIAL CERTIFICATION**

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate, complete and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize you and your authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures from third parties that may be material to the questions in the Application. I also specifically authorize any third parties to release information to you and/or your authorized representatives upon request. I hereby release you and/or your authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by you and/or your authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.

I warrant that I have the authorization to sign this Application, on my own behalf, or on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Application is accepted by the Madera County Mental Health Plan, I will be bound by the terms of the Mental Health Plan, of which this Application is a part.

**ANY INFORMATION ENTERED INTO THIS APPLICATION WHICH SUBSEQUENTLY IS FOUND TO BE FALSE COULD RESULT IN REFUSAL OF APPROVED CREDENTIALING STATUS WITH MADERA COUNTY BEHAVIORAL HEALTH SERVICES.**

**YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION. STAMPED SIGNATURES ARE NOT ACCEPTABLE.**

Signature: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Please return this information to:

Madera County Mental Health Plan  
Attn: Credentialing Coordinator  
P. O. Box 1288  
Madera, CA 93639-1288  
(559) 673-3508  
FAX (559) 675-7758



**MADERA COUNTY**  
**BEHAVIORAL HEALTH SERVICES**  
**Administration**

**DENNIS P. KOCH, MPA**  
**DIRECTOR OF BEHAVIORAL HEALTH SERVICES**  
• MENTAL HEALTH DIRECTOR  
• ALCOHOL/DRUG PROGRAM ADMINISTRATOR

**P.O. BOX 1288**  
**MADERA, CA 93639-1288**  
**PHONE (559) 673-3508 TTY (800) 735-2922**  
**FAX (559) 675-4999**  
**CONFIDENTIAL FAX (559) 661-2818**

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**RE:** \_\_\_\_\_ (Mental Health Professional)

The above-referenced mental health care professional has applied for membership to the Madera County Mental Health Plan as a provider of outpatient services and has listed you as a reference. Your answers on the attached questionnaire, as presented by our Credentials Health Care Provider Committee, will be greatly appreciated.

A signed copy of the Consent and Release from Liability Statement executed by the provider in connection with this application is on file. Please return a signed hard copy of the attached document at your earliest convenience.

Or, you may submit a letter of reference, pertaining to the items listed below.

Thank you for your attention to this matter.

Sincerely,

(Name)  
Credentialing Coordinator

# REFERENCE QUESTIONNAIRE

Candidate's Name: \_\_\_\_\_

1. How long have you known the candidate? \_\_\_\_\_

2. I know the candidate

\_\_\_\_\_ As a friend

\_\_\_\_\_ Socially

\_\_\_\_\_ Professionally

\_\_\_\_\_ Other (describe) \_\_\_\_\_

3. My knowledge of the candidate's professional competence is based on:

\_\_\_\_\_ Personal observation from close working relationship

\_\_\_\_\_ As a teacher/student (please circle one)

\_\_\_\_\_ Long-time observations "from a distance"

\_\_\_\_\_ Short-time observations "from a distance"

\_\_\_\_\_ Hearing much feedback from respected colleagues who know his/her work more closely than I.

\_\_\_\_\_ By vague reputation

\_\_\_\_\_ Other (describe) \_\_\_\_\_

4. Please describe your knowledge of the candidate's professional competence:

	<u>Superb</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Unknown</u>
a. Understanding his/her field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Common sense in his/her field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dedication and industry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Humaneness & compassion in to patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Availability to patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Excellence & diligence in maintaining medical records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Please describe your perception of his/her integrity, commitment and honesty.

a. In the field of medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. In family and social areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. In the general community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: If the response to any of the above questions is fair or poor please supply a written explanation, giving full details.

6. Please describe any areas that could be future problems (or have been problems in the past). If no problems are identified, please so state.

a. Emotional stability

Professional \_\_\_\_\_

Private \_\_\_\_\_

b. Habit problems

Alcohol \_\_\_\_\_

Drugs \_\_\_\_\_

Other (please describe) \_\_\_\_\_

c. Physical health problems \_\_\_\_\_

7. Your recommendation to the Credentialing Committee:

Unqualified, enthusiastic endorsement

Enthusiasm for him/her is lukewarm or negative

Other comments or choices not listed above \_\_\_\_\_

8. Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Print Name, Title, Date



**MADERA COUNTY BEHAVIORAL HEALTH SERVICES  
DESK REVIEW  
CREDENTIALING COMMITTEE**

Please review the following applicant: \_\_\_\_\_

Approved: \_\_\_\_\_ Pending: \_\_\_\_\_ Disapproved: \_\_\_\_\_

Comments/Questions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Reviewer: \_\_\_\_\_

Debbie DiNoto

Date

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Please review the following applicant: \_\_\_\_\_

Approved: \_\_\_\_\_ Pending: \_\_\_\_\_ Disapproved: \_\_\_\_\_

Comments/Questions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Reviewer: \_\_\_\_\_

Sonja Bentley

Date

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Pleaser review the following applicant: \_\_\_\_\_

Approved: \_\_\_\_\_ Pending: \_\_\_\_\_ Disapproved: \_\_\_\_\_

Comments/Questions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Reviewer: \_\_\_\_\_

Debby Estes

Date



**Notice of New Provider  
(PLEASE ROUTE AS INDICATED)**

**1. CREDENTIALING COORDINATOR**

\_\_\_\_\_  
(Applicant Name and License)

\_\_\_\_\_  
(SS# / Tax ID #)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City/State/Zip)

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Other Languages Spoken)

\_\_\_\_\_  
Effective date DEA License # expiration date

\_\_\_\_\_  
Group Provider Name

\_\_\_\_\_  
Effective date Professional License expiration date

\_\_\_\_\_  
NPI# & Medi Care UPIN or PTAN#

\_\_\_\_\_  
Taxonomy Number & Description

\_\_\_\_\_  
(Credentialing Coordinator Signature/Date)

\_\_\_\_\_  
(Date Credentialing Completed)

License & Insurance Certificate Attached?

Yes

No

Accepting new clients?

Yes

No

**Population served:**

Children 5 & under

Children 6 to 12

Adolescents

Adults

Older Adults

**Service area(s) offered:**

Individual

Family

Group

Meds

Psych Testing

Inpatient only

Other (specify \_\_\_\_\_)

**2. CONTRACT SPECIFICATIONS (Mental Health Plan Coordinator)**

Preauthorization Required?

Yes

No

\_\_\_\_\_  
(QM Supervisor/Designee Signature/Date)

**3. DIRECTOR OR DESIGNEE**

\_\_\_\_\_  
(Director or Designee Signature/Date)

\_\_\_\_\_  
(\$ Amount of Contract)

\_\_\_\_\_  
(Date Contract Signed and Completed)

\_\_\_\_\_  
(Provider Services Start/End of Contract Dates)

**4. FISCAL STAFF FOR SETUP (KEEP COPY IN BINDER)**

\_\_\_\_\_  
(Provider ID)

\_\_\_\_\_  
(Provider Prefix)

\_\_\_\_\_  
(Fiscal Staff Signature)

\_\_\_\_\_  
(Date)

**5. RETURN TO CREDENTIALING COORDINATOR TO UPDATE PROVIDER LIST/FILE**

**CONFIDENTIAL**

**REVIEW/APPROVAL OF NETWORK PROVIDER  
APPLICATION PROCESS**

Policy Number: CRD: 02:00

**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD: 02:00

**SUBJECT:** REVIEW/APPROVAL OF NETWORK PROVIDER APPLICATION  
PROCESS

**POLICY:**

All applications to become a Network Provider will be reviewed by the Credentialing Committee.

**PURPOSE:**

To delineate procedure to review applications to become a network provider for Madera County Mental Health Plan.

**PROCEDURE:**

- I. The credentialing Committee consists of:
  - A. The Behavioral Health Services Assistant Director
  - B. The Credentialing Coordinator
  - C. The Division Manager for Managed Care
  - D. The Compliance Officer
- II. The Credentialing Committee meets quarterly or as needed.
  - A. The Credentialing Coordinator maintains committee minutes.
- III. Each application is reviewed and all documents are reviewed for completeness and accuracy. Applications are established and reviewed, following all internal as well as federal and state requirements.
- IV. If application is approved, the mental health professional applicant will be notified by mail that credentialing has been approved.
  - A. A Provider Manual and County Contract will be sent to the provider for signature.
  - B. The MHP will contact the provider once the signed contract is returned to schedule orientation and training.
- V. If the application is not approved, a notice will be sent to the provider describing why the application was not approved and explaining the appeal process procedures.
  - A. Practitioners shall not be excluded solely because of the practitioner's type of license or certification.
  - B. Providers who serve high-risk populations or specialize in the conditions that

Approved by BHS Director: <i>Signature on File</i>	Date: 7-16-15	Effective Date: 10-01-03	Revision Date: 06-16-04 / 11-05-04 / 10-04-06 / 7-1-15
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**REVIEW/APPROVAL OF NETWORK PROVIDER  
APPLICATION PROCESS**

Policy Number: CRD: 02:00

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require costly treatment will not be discriminated against.

Page: Page 2 of 2
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Initials:
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**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD: 03:00

**SUBJECT:** CREDENTIALING CRITERIA FOR NETWORK PROVIDERS

**REFERENCE:** CMP: 10:00 Excluded Individuals and Entities

**POLICY:**

Madera County Mental Health Plan (MHP) ensures that Medi-Cal beneficiaries receive services consistent with recognized community standards from qualified mental health practitioners.

**PURPOSE:**

To support the credentialing process of the MHP by establishing objective credentialing criteria for professional providers.

**PROCEDURE:**

An applicant for initial credentialing as a MHP provider shall meet the following standards:

STANDARDS	MEASURE
Completion of Provider Application.	On file; confirmed by Credentialing Coordinator.
Current professional license, evidence of any Board Certification, BNDD/DEA Certificate (if appropriate).	MHP confirmation with issuing authority.
Evidence of liability coverage as stipulated in contract.	Submission of evidence of coverage; review by Credentialing Committee; further review by legal and Risk Management staff as needed.
National Data Bank Inquiry	On file
Curriculum Vitae	On file
Office of Inspector General / Exclusion List	On file
Medi-Cal Ineligible Provider List	On file

Approved by BHS Director: <i>Signature on File</i>	Date: 7-16-15	Effective Date: 10-01-03	Revision Date: 06-21-04 / 11-05-04 / 10-04-06 / 7-1-15
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**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD: 04:00

**SUBJECT:** RECREREDENTIALING PROCESS FOR NETWORK/GROUP PROVIDERS

**REFERENCE:**

CRD 05:00 Recredentialing Criteria

CMP 10:00 Excluded Individuals and Entities

**POLICY:**

The following recredentialing process shall apply to all participating providers, as applicable, to be considered for recredentialing every two years.

**PURPOSE:**

To establish a recredentialing process to assure the competency of mental health professionals who contract with Madera County Mental Health Plan (MHP) to provide mental health services to Madera County Medi-Cal beneficiaries.

**PROCEDURE:**

- I. The Credentialing Coordinator will send the provider a Recredentialing Questionnaire (CRD: 04.A1) and Recredentialing Check List (CRD: 04.A2) every two years after initial credentialing is approved. A list of attained CEUs by hours and topics is requested but not mandated.
  - A. The provider will return the Recredentialing Questionnaire, Check List, copy of his/her license(s) and proof of professional liability (malpractice) insurance
  - B. Upon receiving the information, the Credentialing Coordinator will present the provider's file to the Credentialing Committee for review at the regularly scheduled meeting, where recredentialing approval or non-approval will be determined.
    1. Files will be placed in pending when incomplete or when there are concerns about whether or not recredentialing standards have been met.
    2. Reasons for not renewing a provider's contract are outlined in Section II. Credentials Documentation.
  - C. If a Network Provider has previously contracted with the MHP and was in good standing at resignation, he/she may reapply. A recredentialing package, a copy of current license, malpractice insurance verification and other verification is

Approved by BHS Director: <i>Signature on File</i>	Date: 7-16-15	Effective Date: 10-01-03	Revision Dates: 06-16-04 / 01-14-05 / 10-04-06 / 7-1-15
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required. If Network Provider was not in good standing at resignation, a full application must be made subject to the criteria outlined in CRD: 05:00.

II. Credentials Documentation

Before a participating provider will be reviewed for recredentiaing, the following prerequisites must be met:

- A. Completed questionnaire which includes copies of the following documents:
  - 1. Valid, current and unrestricted licensure to practice in California.
  - 2. Current DEA Certificate (if appropriate)
  - 3. Evidence of current professional liability coverage which, meet or exceeds MHP minimum limits.
- B. Statement in writing by the applicant regarding:
  - 1. Physical and mental health status.
  - 2. Lack of impairment due to chemical dependency.
  - 3. History of loss of license.
  - 4. History of felony convictions.
  - 5. History of limitation of privileges or disciplinary action.
  - 6. Work history.
  - 7. History of professional liability claims.
- C. Signed attestation by applicant to the correctness and completeness of the application.

III. Committee Requirements

All of the following requirements must be met in order for the Credentiaing Committee to consider continued participation of a provider.

- A. Acceptable compliance with Criteria and Standards for provider participation.
- B. The provider's recredentiaing documentation is complete and prerequisites have been met.
- C. Primary Source Verification of:
  - 1. Valid, current and unrestricted California license to practice verified directly with the California State Licensing Board.
  - 2. Valid current DEA certificate verified by viewing copy of DEA certificate. (if appropriate)
  - 3. Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting participating facility.

4. Professional liability claims history.
  5. Updates in board certification.
  6. Review of Office of Inspector General / Exclusion List
  7. Review of Medi-Cal Ineligible Provider List
- D. Review of performance data from:
1. Member complaints.
  2. Results of Quality Review.
  3. Utilization Management.
  4. Member Satisfaction Surveys.
  5. On-site visit.

The recredentiaLing process may include an on-site visit to provider offices that results in documentation of a structured review of the site and medical record keeping practices.



**MADERA COUNTY MENTAL HEALTH PLAN**  
**Bi-Annual Recredentialing Questionnaire for Network / Group Providers**

**INSTRUCTIONS:** Please complete all sections; enter "N/A" if not applicable. Please print or type information.

**A. IDENTIFYING INFORMATION**

Name: \_\_\_\_\_  
First MI Last

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Office Location(s): Please attach additional sheets if necessary.

**Office #1 (Primary)**

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

**Office # 2**

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Type of Practice (please provide legal name of practice):

Sole Proprietor

- Name: \_\_\_\_\_

Group - Group Name: \_\_\_\_\_ Address: \_\_\_\_\_

Please provide the names and disciplines of other providers in the group:

\_\_\_\_\_

Corporation - Corp Name: \_\_\_\_\_ Address: \_\_\_\_\_

**B. CONTINUING EDUCATION** (for past 2 years; for Psychologists, LCSWs and LMFTs only)

<u>Course Title</u>	<u>Date Completed</u>

**C. LICENSE INFORMATION** - Please attach a copy of all license(s)

<u>State</u>	<u>License Number</u>	<u>Type of License</u>	<u>Expiration Date</u>
Complete only if applicable	Medi-Cal Provider #:		
	Medicare UPIN:	NPI#:	
	DEA Number:	ECFMG# / Date	
	DEA Expiration Date:	Taxonomy:	

**D. BOARD CERTIFICATION**

<u>Name of Board</u>	<u>Certification Date</u>	<u>Expiration Date (if applicable)</u>

**E. HOSPITAL PRIVILEGES – Current and Previous**

<u>Hospital Name</u>	<u>Address, City and State</u>	<u>Appointment Date</u>	<u>Withdrawal Date (if applicable)</u>

**F. LICENSE INFORMATION – Please attach a copy of all license(s)**

Please answer all of the following questions #1-11. If you answer "Yes" to any question, please provide a detailed explanation on a separate page. Explanation should include dates, details of the incident, final outcome, current disposition, etc. In the past two years:

1. Yes  No  Have there been any disciplinary actions or investigations against you by any state licensing board?  
 Yes  No  Are there any actions or investigations in process?  
 Yes  No  Have you voluntarily surrendered your medical/clinical license?
2. Yes  No  Has your DEA registration ever been denied, suspended, revoked or limited in any other manner?  
 Yes  No  Are there any actions or investigations in process?  
 Yes  No  Have you voluntarily surrendered your DEA registration?
3. Yes  No  Has your professional liability insurance coverage ever been canceled, limited, denied or non-renewed?  
 Yes  No  Any malpractice claims filed against you?
4. Yes  No  Have you privileges at any hospital ever been denied, suspended, reduced, revoked or put on probation?  
 Yes  No  Are any investigations in process?  
 Yes  No  Have you resigned from any hospitals?
5. Yes  No  Have you ever been investigated, suspended, sanctioned or otherwise restricted from participating in a federal or State health insurance?
6. Yes  No  Have there been any criminal proceedings against you including, but not limited to, gross misconduct, a felony or a crime of moral turpitude?  
 Do you suffer from any illness, injury or health condition (physical or mental) which limits or impairs your ability to safely provide medical services? This includes medication that may affect either your clinical judgment or  
 7. Yes  No  motor skills.
8. Yes  No  Have you ever undergone treatment for alcohol or drug abuse dependency?
9. Have you ever had any of the following:  
 . Yes  No  Lawsuits dismissed, dropped or pending  
 Yes  No  Settlements including settled and dismissed with prejudice  
 Yes  No  Judgments  
 Yes  No  Reprimands or disciplinary action  
 Yes  No  Other
10. Yes  No  To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank?
11. Yes  No  Have you voluntarily quit or involuntarily been terminated from any Managed Care plan?

### G. AVAILABILITY / ACCESSIBILITY

Currently available for new clients? Yes  No

Ethnic, Racial & Culture Specific Specialties: \_\_\_\_\_

Days Available: Mon  Tues  Wed  Thu  Fri  Sat  Sun

Hours available: \_\_\_\_\_

List languages spoken in addition to English: \_\_\_\_\_

### H. POPULATION & SERVICE AREAS

Population served: Children 5 & under:  Children 6 to 12:  Adolescents:  Adults:  Older Adults:

Service area(s) offered: Individual:  Family:  Group:  Medications:  Psych Testing:

Inpatient:  Other (specify):

### I. Signature

Please read this statement before signing:

*Information provided on this questionnaire may be verified. My signature certifies that all the information on this questionnaire is true, correct and complete. I understand and agree that any misstatements or omissions of material facts herein may cause forfeiture on my part of my right to continued participation as a provider with the Madera County Mental Health Plan.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### J. PAYMENT INFORMATION

If I am recredentialed to continue being a provider with the Madera County Mental Health Plan, payments for services provided should be made to me as follows:

Make checks payable to: \_\_\_\_\_

Tax ID: \_\_\_\_\_

Send checks to the following:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

MADERA COUNTY IS AN EQUAL OPPORTUNITY, DISABILITIES, AFFIRMATIVE ACTION ORGANIZATION THAT DOES NOT DISCRIMINATE IN REGARDS TO AGE, GENDER, COLOR, RACE, RELIGION, NATIONAL ORIGIN, HANDICAP OR SEXUAL ORIENTATION.

**MADERA COUNTY BEHAVIORAL HEALTH SERVICES  
MANAGED CARE MENTAL HEALTH PLAN  
BI-ANNUAL RECREDENTIALING QUESTIONNAIRE CHECK LIST  
FOR NETWORK / GROUP PROVIDER  
(559) 673-3508      FAX (559) 675-7638**

NAME AND TITLE: \_\_\_\_\_

ORGANIZATION NAME and TYPE: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Please ensure that the Bi-Annual Recredentialing Questionnaire is completed in its entirety.**

- \_\_\_\_\_ QUESTIONNAIRE
- \_\_\_\_\_ NAME & SOCIAL SECURITY NUMBER
- \_\_\_\_\_ GENDER, DATE OF BIRTH & HOME ADDRESS
- \_\_\_\_\_ NAME & ADDRESS THAT CHECKS WILL BE SENT TO
- \_\_\_\_\_ PRACTICE SPECIFICS
- \_\_\_\_\_ STATE LICENSURE INFORMATION (**\*\*ATTACH COPY OF LICENSE\*\***)
- \_\_\_\_\_ MEDICAID/MEDI-CAL PROVIDER NUMBER (If applicable)  
**Expiration Date** \_\_\_\_\_
- \_\_\_\_\_ MEDICARE UPIN (If Applicable) **Expiration Date** \_\_\_\_\_
- \_\_\_\_\_ NATIONAL PROVIDER IDENTIFIERS (NPI)
- \_\_\_\_\_ DEA LICENSE (MDs ONLY) (**\*\*ATTACH COPY OF LICENSE\*\***)
- \_\_\_\_\_ TAXONOMY NUMBER & CLASSIFICATION
- \_\_\_\_\_ PROFESSIONAL LIABILITY (MALPRACTICE) (**\*\*ATTACH COPY\*\***)
- \_\_\_\_\_ COMPLETED ATTESTATION QUESTIONS (Provide details on a separate page for all "YES" answers)

RETURN APPLICATION PACKET TO: Madera County Behavioral Health Services  
Credentiaing Coordinator  
P.O. Box 1288  
Madera, CA 93639-1288

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**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD 05:00

**SUBJECT:** RECREREDENTIALING CRITERIA

**REFERENCE:**

CRD 04:00 Recredentialing Process for Network Providers

CMP 10:00 Excluded Individuals and Entities

**POLICY:**

Madera County Mental Health Plan (MHP) ensures that Medi-Cal beneficiaries receive services consistent with recognized community standards from qualified mental health practitioners. All providers must maintain an active license with the appropriate board and perform within MHP standards.

**PURPOSE:**

To provide criteria for monitoring providers to ensure standards set by the Mental Health Plan are being met.

**PROCEDURE:**

- I. A provider will be subject to recredentialing every two years and according to the following MHP standards:

<b><u>Standards</u></b>	<b><u>Measure</u></b>
Ability to work with beneficiary and family/support persons in a professional, collaborative and culturally competent manner.	Per client satisfaction survey per, presences/absences of documented complaints/grievances in provider file.
To support the credentialing process of the MHP by establishing objective rating by clients of at least 80% satisfaction with services.	Per client satisfaction survey
Ability to meet the Quality Management, authorization, clinical, documentation, and administrative requirements of the MHP, and to work cooperatively with the staff who authorize and re-authorize clinical services.	Per presence/absence of documented complaints in provider file.  Per chart review as indicated by Quality Management procedures.

Approved by: BHS Director  <i>Signature on File</i>	Date: 7-16-15	Effective Date: 10-01-03	Revision Date: 06-16-04, 9-17-07, 7-1-15
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II. General Criteria and Standards

Each provider responding to a re-credentialing questionnaire from the Mental Health Plan (MHP) shall meet the following criteria as applicable.

- A. Valid, current, unrestricted California license.
- B. Hospital/Facility Privileges: (if appropriate)
  - 1. Physicians will have current unrestricted staff clinical privileges and admitting privileges granted by an MHP participating hospital within the service area.
- C. Valid, current Drug Enforcement Agency (DEA) registration. (if appropriate)
- D. Current professional liability coverage which meets or exceeds MHP limits.
- E. Absence of a history of involvement in malpractice suit, arbitration, or settlement within the past two years; in the case of a provider with such history, evidence that the history does not demonstrate probable future sub-standard professional performance.
- F. Absence of a history of denial, suspension, restriction, or termination of hospital privileges within the past two years; or in the case of a provider with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.
- G. Absence of a history of disciplinary actions within the past two years affecting provider's professional license, DEA or other required certifications; or for providers with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.
- H. Absence of a history of felony convictions within the past two years; or, for a provider with such history, evidence that the nature of the conviction does not affect provider's current ability to perform the professional duties for which provider is contracted or does not demonstrate probable future sub-standard care.
- I. Absence of a history of sanctions by regulatory agencies, including Medicare/Medicaid sanctions, within the last two years; or, for a provider with such a history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in federal or state sponsored programs or evidence that past sanctions do not demonstrate probable future sub-standard performance.
- J. Absence of a history of chemical dependency/substance abuse within the past two years for those providers who have such history, evidence that the provider is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would Affect provider's ability to adequately perform the professional duties for which

provider is contracted.

- K. Absence of a physical or mental health condition that would impair or would be likely to impair provider's ability to adequately perform the professional duties for which provider is contracted.

Meeting these Criteria and Standards does not automatically entitle an applicant to participate in the Plan.

**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD 06:00

**SUBJECT:** BEHAVIORAL HEALTH SERVICES (BHS) AND ORGANIZATIONAL  
PROVIDER CREDENTIALING OF LICENSED PERSONNEL

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**POLICY:**

All providers must maintain an active license with the appropriate licensing board and perform within Mental Health Plan (MHP) standards.

**PURPOSE:**

To ensure staff/contractors are appropriately licensed or certified to perform assigned duties.

**PROCEDURE:**

- I. Behavioral Health Services (BHS) designated staff shall:
  - A. Maintain a list of all licensed staff and contractors.
  - B. Review, on a monthly basis, the list of all BHS staff/contractors and:
    - 1. Notify those whose license will expire within 60 days.
    - 2. Notify the BHS Director of any lapsed licenses or registrations.
  - C. Require all licensed BHS staff/contractors and registered interns to provide copies of their new/renewed licenses or registration.
  - D. Review appropriate databases (Office of Inspector General (OIG) and Medi-Cal Exclusion) on a monthly basis and provide a status report to the Compliance Officer.
  - E. Maintain licenses/registrations in a locked cabinet
- II. Organizational Provider Staff
  - A. MHP requires all organizational providers to credential their professional staff. Education and experience will be verified for all direct services staff.
  - B. Organizational Provider Administration will notify designated staff of their license expiration and will maintain a current list.
  - C. Have accounting/fiscal practices that meet the standards of the State Department of Health Care Services (DHCS).

Approved by BHS Director: <i>Signature on File</i>	Date: 11-19-07	Effective Date: 10-01-03	Revision Date: 06-16-04, 11-05-04, 12-02-04, 10-31-07, 7-1-15
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- D. Have a head of service meeting Title IX requirements.
- E. Licensed staff and registered interns will bring a copy of their new/renewed license or registration to the Administration of the Organizational Provider.
  - 1. The Organizational Provider Administration will provide BHS with a list of licensed/registered staff and the status of their license/registration on a monthly basis.
  - 2. MHP will review the list and notify the Organization Provider Administration of any lapsed licenses or registrations.
  - 3. The list of licensed organizational provider staff will be maintained in a locked cabinet in the MHP office.

**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD 07:00

**SUBJECT:** TERMINATION OF PRIVILEGES

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**POLICY:**

Madera County Behavioral Health Services (BHS) staff or anyone who contracts with BHS will maintain compliance with all criteria as a condition of continued participation.

**PURPOSE:**

To ensure that BHS mental health professionals and contractors provide continued competent health services to Madera County Medi-Cal beneficiaries.

**PROCEDURE:**

- I. Criteria for Termination of Full Privileges
  - A. The criteria for terminating privileges may include, but is not limited to, the following factors related to job performance, professional integrity or contractual provisions.
    - 1. Submission of inaccurate or misleading information on the application or failure to disclose relevant information.
    - 2. Violating the BHS Code of Ethical Conduct.
    - 3. Failure to meet compliance with the Board of Behavioral Sciences (BBS), General Services Administration (GSA) List of Parties Excluded from Federal Procurement and Nonprocurement Programs and the HHS/OIG Cumulative Sanction Report, the Medical Board of California and the Medi-Cal Suspended and Ineligible List-California Department of Health Care Services.
    - 4. Failure to obtain required training for licensure.
    - 5. MHP’s inability to complete a credentialing process due to the applicant’s failure to provide relevant information or necessary release.
    - 6. A provider not adhering to all contract terms, including, but not limited to, access and coverage requirements during the participation period.
    - 7. Current or past loss of significant restrictions to professional license.
    - 8. Current or past loss or significant restrictions to Drug Enforcement Administration (DEA), if appropriate.
    - 9. Current or past loss or significant restriction to hospital privileges.

Approved by BHS Director:	Date:	Effective Date: 01-01-05	Revision Date: 01-14-05, 6-4-07, 9-25-07, 9-4-12
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10. Criminal record affecting professional practice.
11. Current or past sanction by Medicare/Medicaid.
12. Current chemical dependency or substance abuse.
13. History of malpractice claims.
14. Quality problems as reported by licensing boards, Federation of State Medical Boards or prior work/training settings.
15. Quality problems identified during the participation period, as determined by the Quality Management Program.
16. Failure to follow MHP's policies, procedures and documentation requirements.
17. Current physical or mental health problem(s) which significantly impair provider's ability to perform professional contracted duties.
18. Member service issues or complaints identified and documented during the participation period.
19. Utilization issues identified and documented during the participation period.
20. MHP, at its sole discretion, has the right to deny full privileges based on plan and/or membership needs.

## II. Recommendation for Termination of Privileges

The Behavioral Health Services Director shall be notified of any instances involving a provider who meets one or more of the criteria for termination of full privileges (see section I.A.1-20 of this policy for criteria for termination).

### A. Process

1. The Behavioral Health Services Director will review the information presented, and if appropriate, convene with the Credentialing Committee to conduct a formal investigation/evaluation of the facts.
2. Following an investigation, the Credentialing Committee will make a recommendation to the Behavioral Health Services Director.
3. The Behavioral Health Services Director will review the Committee's findings and make a decision.
  - a. A recommendation for termination of privileges will be closed if the Director decides to continue credentialing and allow full privileges.
4. If the Behavioral Health Services Director decides to terminate privileges for cause, the Director will provide a written notice to the provider within twenty-one (21) days from the date recommendations were received by the Committee.

**III. Appealing a Decision for Termination of Privileges**

The information used to terminate privileges shall be made available to the provider and s/he shall receive the opportunity to provide additional information that may affect MHP's decision.

**A. Process**

1. The provider must submit a written request to appeal a decision to terminate privileges to the Behavioral Health Services Director within thirty (30) days following posting of the written decision.
2. A hearing will be scheduled with the Credentialing Committee within fifteen (15) days of receipt of an appeal, which will allow the provider an opportunity to discuss with the Credentialing Committee the reasons for termination of privileges and present any statements, documents or other materials the provider feels should be considered by the Committee.
3. After a formal meeting, the Credentialing Committee will provide a recommendation to the Behavioral Health Services Director within fifteen (15) days from the date of the hearing.
4. The Behavioral Health Services Director will give written notice to the provider on the final decision within twenty-one (21) days from the date Committee recommendations were received
5. If the Director decides to terminate privilege for cause, contract procedures for termination of privileges will be initiated.

B. The contract procedures to terminate will be initiated if the provider does not appeal the decision within thirty (30) days after the written decision is posted.

C. To protect the quality of care provided to Medi-Cal beneficiaries, a termination of privileges may be made effective immediately by MHP and/or the Credentialing Committee.

**MADERA COUNTY  
BEHAVIORAL HEALTH SERVICES**

**POLICY NO.:** CRD 08.00

**SUBJECT:** CREDENTIALING PROCESS FOR HOSPITALS

**REFERENCE:**

- ❖ CFR, title 42, section 438.230(a)
- ❖ CMP: 10:00, Excluded Individuals and Entities

**POLICY:**

At the discretion of the Madera County Behavioral Health Services Credentialing Committee; the Committee can accept the credentialing process of a contracted hospital or conduct a partial or complete internal credentialing review. The hospital must submit a letter verifying the credentialed status of the physician(s) used by that particular hospital.

**PURPOSE:**

To confirm the credentialed status of physicians when Madera County Behavioral Health Services (BHS) clients are placed in an inpatient facility.

**PROCEDURE:**

- I. Accepting the credentialing process of a hospital.
  - A. The hospital must submit a letter to the BHS Credentialing Coordinator, verifying the credentialed status of the physician(s) used by that particular hospital/agency.
  - B. For those hospitals contracted with BHS, in accordance with Master Contract #007, Section 1.06, Contractor shall provide an updated provider list, including professional license number and NPI number, to County Mental Health Plan (MHP) as applicable, including adding new providers and/or removing terminated providers.
  - C. Contractor shall immediately report to County any State/Federal sanctions against current providers.
  
- II. General Criteria and Standards
 

Each credentialed physician the hospital submits to BHS shall meet the following criteria as applicable:

  - A. Valid, current, unrestricted California license.
  - B. Hospital/Facility Privileges: (if appropriate)
    1. Physicians will have current unrestricted staff clinical privileges and admitting

Approved by BHS Director:  <i>Signature on File</i>	Date: 7-16-15	Effective Date: 7-1-15	Revision Dates:
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privileges granted by the participating hospital within the service area.

- C. Valid, current Drug Enforcement Agency (DEA) registration. (if appropriate)
- D. Current professional liability coverage which meets or exceeds MHP limits.
- E. Absence of a history of involvement in malpractice suit, arbitration, or settlement within the past two years. In the case of a provider with such history, there must be evidence that the history does not demonstrate probable future sub-standard professional performance.
- F. Absence of a history of denial, suspension, restriction, or termination of hospital privileges within the past two years; or in the case of a provider with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.
- G. Absence of a history of disciplinary actions within the past two years affecting provider's professional license, DEA or other required certifications; or for providers with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.
- H. Absence of a history of felony convictions within the past two years; or, for a provider with such history, evidence that the nature of the conviction does not affect provider's current ability to perform the professional duties for which provider is contracted or does not demonstrate probable future sub-standard care.
- I. Absence of a history of sanctions by regulatory agencies, including Medicare/Medicaid sanctions, within the last two years; or, for a provider with such a history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in federal or state sponsored programs or evidence that past sanctions do not demonstrate probable future sub-standard performance.
- J. Absence of a history of chemical dependency/substance abuse within the past two years for those providers who have such history, evidence that the provider is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect provider's ability to adequately perform the professional duties for which provider is contracted.
- K. Absence of a physical or mental health condition that would impair or would be likely to impair provider's ability to adequately perform the professional a duty for which provider is contracted.

Meeting these Criteria and Standards does not automatically entitle an applicant to participate in the Plan.

Page: Page 2 of 2
Initials:

# ATTACHMENT Y

Advance

Medical

Directive

MHP 37.00



Subject: <b>ADVANCE MEDICAL DIRECTIVE</b>	Policy No.: <b>MHP 37.00</b>	Original Issue Date: <b>06-01-04</b>	Revision Dates: 10-04-06, 9-18-07, 11-16-07, <b>09-25-15</b>
Approved by BHS Director: <b>Signature on File</b>	Supersedes:	Review Dates: 10-04-06, 9-18-07, 11-16-07, <b>09-25-15</b>	

**POLICY:**

All adult Medi-Cal beneficiaries will receive information concerning their rights under California State law regarding Advance Medical Directives.

**PURPOSE:**

To ensure adult Medi-Cal beneficiaries served by Madera County Mental Health Plan (MHP) are provided with information concerning their rights under California state law regarding Advance Directives (Title 42, Code of Federal regulations, section 422.128, 438.6(i)(1), (3) and (4) and 417.436(d)).

**PROCEDURES:**

- A. MHP staff and contracted providers shall provide written information regarding Advance Medical Directives when they have their first face-to-face service contact with the beneficiary and, thereafter, upon a request from a beneficiary.
- B. Informing material regarding Advance Medical Directives shall be maintained in compliance with existing California state law and be updated to reflect changes in state law within 90 days of the implementation of a change.
- C. In the event a Medi-Cal beneficiary presents a completed, appropriately witnessed, signed and executed Advance Medical Directive to Madera County MHP staff or contracted providers of the MHP, the Advance Medical Directive shall be placed in the beneficiary's mental health medical record and the presence of the Advance Medical Directive shall be noted prominently in the chart.
- D. Madera County MHP staff or contracted providers of the MHP will respect the implementation of the beneficiary's rights to make decisions concerning health care\*, including the right to accept or refuse treatment and the right to formulate, at the individual's option, advance directive.
  - \* Note: Section 4615 California Probate Code: "Health Care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition.
- E. Madera County MHP staff or contracted providers of the MHP will ensure that beneficiaries are not discriminated against based on whether or not they execute an advance directive.



- F. Madera County MHP will provide for the education of staff concerning its policies and procedures on advance directive.
- G. Madera County MHP Staff are not to assist in filling out advance directives for beneficiaries.
- H. Madera County MHP will inform beneficiaries that complaints concerning non-compliance with the advance directive may be filed with California Department of Health Services (DHS) Licensing and Certification Agency at 1-800-236-9747 or by mail at PO Box 997413, Sacramento, CA 95899-1413.
- I. Low or no cost help with completing the documentation for an advanced directive can also be obtained from California Rural Legal Assistance, Inc.; 126 North B Street, Madera, CA 93638 or by telephone at 559-674-5671 (toll free).
- J. Anytime there is a concern regarding how to proceed with a client's advanced directive, consultation with one's immediate supervisor should be sought before a decision is made.

**Legal Reference:**

1. California Probate Code Section 4600 - 4643
2. California Probate Code Section 4677
3. California Probate Code Section 4678
4. California Probate Code Section 4686
5. California Probate Code Section 4689
6. California Probate Code Section 4695
7. California Probate Code Section 4730 - 4732
8. California Probate Code Section 4740
9. California Probate Code Section 4742

Attachments:

[MHP 37.A1 Advance Medical Directive Form](#)

[MHP 37.A2 Advance Directive](#)

[MHP 37.A3 Advance Directive Spanish](#)

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

**ADVANCE DIRECTIVES**  
**DOCUMENTATION OF CHANGE**

COPY OF “YOUR RIGHT TO MAKE DECISIONS  
ABOUT MEDICAL TREATMENT” GIVEN TO CLIENT:

\_\_\_\_\_ DATE

ORIGINAL ADVANCE DIRECTIVES COMPLETED: \_\_\_\_\_

\_\_\_\_\_ DATE

Any changes to client’s advance directives must be documented on a progress note. Please document on this form the date of the progress note that contains the documented change.

DATE OF PROGRESS NOTE	COMMENTS	SIGNATURE

# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

## Your Right To Make Decisions About Medical Treatment

This brochure explains your right to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future. A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

### Who decides about my treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment that you don't want - even if the treatment might keep you alive longer.

### How do I know what I want?

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects". Your doctor must offer you information about problems that medical treatment is likely to cause you. Often, more than one treatment might help you-and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

### Can other people help with my decisions?

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

### Can I choose a relative or friend to make healthcare decisions for me?

Yes. You may tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare "surrogate" in your medical record. The surrogate's control over your medical decisions is effective only during treatment for your current illness or injury or, if you are in a medical facility, until you leave the facility.

### What if I become too sick to make my own healthcare decisions?

If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn't agree about

what to do. That's why it is helpful if you can say in advance what you want to happen if you cannot speak for yourself.

### Do I have to wait until I am sick to express my wishes about health care?

No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatments you want. These documents are called 'advance' because you prepare one before healthcare decisions need to be made. They are called 'directives' because they state who will speak on your behalf and what should be done. In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a Power of Attorney For Health Care. The part where you can express what you want done is called an Individual Health Care Instruction.

### Who can make an advance directive?

You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

### Who can I name as my agent?

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

### When does my agent begin making my medical decisions?

Usually, a healthcare agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the Power of Attorney for Health Care that you want the agent to begin making decisions immediately.

### How does my agent know what I would want?

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

### **What if I don't want to name an agent?**

You can still write out your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment. Even if you have not filled out a written Individual Health Care Instruction, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will probably be easier to follow your wishes if you write them down.

### **What if I change my mind?**

You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

### **What happens when someone else makes decisions about my treatment?**

The same rules apply to anyone who makes healthcare decisions on your behalf - a healthcare agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your Health Care Instructions or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest. The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

### **Will I still be treated if I don't make an advance directive?**

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that: A Power of Attorney For Health Care lets you name an agent to make decisions for you. Your agent can make most medical decisions - not just those about life sustaining treatment - when you can't speak for

yourself. You can also let your agent make decisions earlier, if you wish. You can create an Individual Healthcare Instruction by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an Instruction provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf. These two types of Advance Healthcare Directives may be used together or separately.

### **How can I get more information about making an advance directive?**

Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

Complaints regarding non-compliance with Advance Directive requirements may be filed with California Department of Health Services Licensing and Certification by calling 1-800-236-9747 or by mail at P.O. Box 997413, Sacramento, CA 95899-1413.

# SERVICIOS MÉDICOS DEL COMPORTAMIENTO del CONDADO de MADERA

## Su Derecho de Hacer Las Decisiones Sobre el Tratamiento Médico

Este folleto explica su derecho de tomar decisiones de su cuidado de salud y cómo usted puede ahora planear para su asistencia médica si usted no puede hablar por sí mismo en el futuro. Una ley federal nos requiere darle esta información. Esperamos que esta información ayude a aumentar su control sobre su tratamiento médico.

### ¿Quién decide sobre mi tratamiento?

Sus doctores le darán la información y el consejo sobre el tratamiento. Usted tiene el derecho de elegir. Usted puede decir "sí" a los tratamientos que usted desee. Usted puede decir "no" a cualquier tratamiento que usted no desee - incluso si el tratamiento pudo guardarlo vivo más largo.

### ¿Cómo sé lo que deseo?

Su doctor debe decirle sobre su condición médica y sobre qué diversos tratamientos y alternativas de la gerencia del dolor pueden hacer para usted. Muchos tratamientos tienen "efectos secundarios". Su doctor debe ofrecerle la información sobre problemas que el tratamiento médico puede causarle. A menudo, más de un tratamiento puede ayudarle - y gente tiene diversas ideas sobre las cuales es la mejor. Su doctor puede decirle qué tratamientos están disponibles para usted, solamente si su doctor no puede elegir para usted. Esa opción es la suya para hacer y depende de cuál es importante para usted.

### ¿Puede otra gente ayudar con mis decisiones?

Sí. Los pacientes dan vuelta a sus parientes y a menudo a amigos cercanos para la ayuda en tomar decisiones médicas. Esta gente puede ayudarle a pensar de las opciones que usted enfrenta. Usted puede pedir que los doctores y las enfermeras hablen con sus parientes y amigos. Pueden preguntar a los doctores y enfermeras las preguntas para usted.

### ¿Puedo elegir a un pariente o a un amigo para tomar las decisiones del cuidado médico para mí?

Sí. Usted puede decir a su doctor que usted quisiera que otro tome las decisiones del cuidado médico para usted. Pida que el doctor enumere a esa persona como su "sustituto" de cuidado médico en su expediente médico. El control del sustituto sobre sus decisiones médicas es eficaz solamente durante el tratamiento para su enfermedad o lesión actual o, si usted está en una facilidad médica, hasta que usted deje la facilidad.

### ¿Qué si llego a estar demasiado enfermo para tomar mis propias decisiones del cuidado médico?

Si usted no ha nombrado un sustituto, su doctor preguntará a su pariente disponible más cercano o el amigo por ayuda a decidir que es lo mejor para usted. La mayoría del tiempo eso trabaja. Pero a veces todos no están de acuerdo sobre que hacer. Ése es porqué es provechoso si usted puede decir por adelantado lo que usted desea que suceda si usted no puede hablar para sí.

### ¿Tengo que esperar hasta que este enfermo para expresar mis deseos sobre cuidado médico?

No. En hecho, es mejor elegir antes de que usted se ponga muy enfermo o tenga que entrar al hospital, la clínica de reposo, o a otra facilidad de cuidado médico. Usted puede utilizar un Directorio Anticipado del Cuidado Médico para decir quién usted desea que hable por usted y qué clase de tratamientos usted desea. Estos documentos se llaman 'anticipados' porque usted prepara uno antes de que las decisiones de cuidado médico necesiten ser tomadas. Se llaman los 'directorios' porque indican quién hablarán en su favor y qué debe ser hecho. En California, la parte de un directorio anticipado que usted puede utilizar para designar a un agente para tomar decisiones de cuidado de salud se llama un Poder de Abogado Para el Cuidado Médico. La pieza donde usted puede expresar lo que usted desea hecho se llama una Instrucción Individual de Cuidado Médico.

### ¿Quién puede hacer un directorio anticipado?

Usted puede si usted tiene 18 años o más y es capaz de tomar sus propias decisiones médicas. Usted no necesita un abogado.

### ¿A quién puedo nombrar como mi agente?

Usted puede elegir a un adulto relativo o a cualquier otra persona que usted confíe para hablar para usted cuando las decisiones médicas deben ser tomadas.

### ¿Cuándo comienza mi agente a tomar mis decisiones médicas?

Generalmente, un agente de cuidado medico tomará decisiones solamente después que usted pierda la capacidad de hacerlas usted mismo. Pero, si usted desea, usted puede indicar en el Poder de Abogado para el Cuidado Médico que usted quisiera que el agente comience a tomar decisiones inmediatamente.

### **¿Cómo sabe mi agente lo que desearía?**

Después de que usted elija su agente, hable con esa persona sobre lo que usted desea. Las decisiones del tratamiento son a veces duras de hacer, y en verdad ayuda si su agente sabe lo que usted desea. Usted puede también escribir sus deseos en su Directorio Anticipado.

### **¿Qué si no deseo nombrar un agente?**

Usted puede poner sus deseos en escrito en su directorio anticipado, sin el nombramiento de un agente. Usted puede decir que usted desea hacer su vida que continúe tan largo como sea posible. O usted puede decir que usted no quisiera que el tratamiento continuara su vida. También, usted puede expresar sus deseos sobre el uso de la relevación del dolor o de cualquier otro tipo de tratamiento médico. Incluso si usted no ha completado una Instrucción Individual escrita de Cuidado Médico, usted puede discutir sus deseos con su doctor, y pida que su doctor enumere esos deseos en su expediente médico. O usted puede discutir sus deseos con sus miembros o amigos de la familia. Pero será probablemente más fácil seguir sus deseos si usted los escribe.

### **¿Qué si cambio mi mente?**

Usted puede cambiar o cancelar su directorio anticipado en cualquier momento mientras usted puede comunicar sus deseos. Para cambiar a la persona que usted desea tomar sus decisiones de cuidado medico, usted debe firmar una declaración o decirle al doctor a cargo de su cuidado.

### **¿Qué sucede cuando algún otro toma decisiones sobre mi tratamiento?**

Las mismas reglas se aplican a cualquier persona que tome decisiones de su cuidado medico en su favor - un agente del cuidado medico, un sustituto que nombre usted dio a su doctor, o a una persona designada por una corte para tomar las decisiones para usted. Todos son requeridos a seguir sus instrucciones del cuidado médico o, si ninguno, su deseo general sobre el tratamiento, incluyendo parar el tratamiento. Si sus deseos del tratamiento no se

saben, el sustituto debe intentar de determinar cuál es de su mejor interés. La gente que proporciona su cuidado médico debe seguir las decisiones de su agente o sustituir a menos que un tratamiento solicitado fuera mal práctica médica o ineficaz en ayudarlo. Si esto causa el desacuerdo que no puede ser resuelto, el proveedor debe hacer un esfuerzo razonable de encontrar otro proveedor de cuidado medico para asumir el control de su tratamiento.

### **¿Me tratarán sin embargo si no hago un directorio anticipado?**

Absolutamente. Usted todavía conseguirá el tratamiento médico. Apenas quisiéramos que usted supiera que si usted llega a ser demasiado enfermo para tomar decisiones, alguien tendrá que hacerlas para usted. Recuerde eso: Un Poder de Abogado Para el Cuidado Médico le deja nombrar a un agente para tomar las decisiones para usted. Su agente puede tomar la mayoría de las decisiones médicas - no solamente éstas sobre el tratamiento que sostiene de la vida - cuando usted no puede hablar por si mismo. Usted puede también dejar que su agente tome decisiones anteriores, si usted desea. Usted puede crear una Instrucción Individual de Cuidado Medico anotando sus deseos sobre cuidado médico o hablando con su doctor y pidiendo que el doctor registre sus deseos en su archivo médico. Si usted sabe cuándo usted o no desearía ciertos tipos de tratamiento, una Instrucción proporciona una buena manera de hacer sus deseos claros a su doctor y a cualquier otra persona quién puede estar implicada en decidir sobre el tratamiento en su favor. Estos dos tipos de Directorios Anticipados de cuidado medico se pueden utilizar juntos o por separado.

### **¿Cómo puedo conseguir más información sobre la fabricación de un directorio anticipado?**

Pida que su doctor, enfermera, trabajador social, o proveedor de cuidado medico consigan más información para usted. Usted puede hacer que un abogado escriba un Directorio Anticipado para usted, o usted puede terminar un Directorio anticipado completando los espacios en blanco en una forma.

Las quejas con respecto a incumplimiento con los requisitos Directivos Anticipados se pueden archivar con el Departamento de California de los Servicios Médicos de Licencias y Certificación llamando 1-800-236-9747 o por correo al P.O. Box 997413, Sacramento, CA 95899-1413.

# ATTACHMENT Z

Medication

Evaluation



Subject: <b>MENTAL HEALTH SERVICES: AUTHORIZATION TO USE, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION</b>	Policy No.: <b>PRV 07:00</b>	Original Issue Date: <b>10/11/03</b>	Revision Dates: 11/06, 9/07, 2/08, 10/08, 11/5/15, 12/15, <b>4/1/16</b>
Approved by BHS Director: <i>Signature on File</i>	Supersedes: PRV 14:00	Review Dates: 11/06, 9/07, 2/08, 10/08, 11/15, 12/15, 3/16	

**IMPORTANT:** This policy applies to Behavioral Health Services (BHS) clients receiving any type of service other than substance use disorder services. BHS staff working with clients who are receiving drug and/or alcohol services alone, or in combination with mental health services (such as participating in a dual diagnosis group) should follow PRV: 09:00 Substance Use Disorder Services: Authorization To Use, Disclose and Exchange Protected Health Information.

**PURPOSE:**

This policy reflects BHS commitment to protect the privacy of client health information by complying with professional ethics and all applicable laws or regulations permitting disclosures pursuant to authorization.

- 45 C.F.R. Parts 160 & 164 / HIPAA
- Welfare and Institutions Code 5328, et seq

**DEFINITIONS:**

**PHI** is health information in any form that identifies or *can be used* to identify the individual. *Health information* is broadly defined to include any information (oral, written and electronic) relating to the past, present or future physical or mental health or condition of an individual, the health care provided to an individual, or the past, present, or future payment for health care provided to an individual.

**Use** of PHI takes place within the BHS Department and applies to members of the BHS workforce and its business associate’s workforce.

**Disclosure and exchange** takes place external to BHS and refers to sharing of PHI with individuals or entities outside the Department.

**POLICY:**

Client mental health information is confidential and protected by state and federal laws. BHS requires a valid, written authorization for the use, disclosure and exchange of protected health information (PHI) for all purposes, except those listed in PRV: 08:00



## Mental Health Services: Allowable Uses and Disclosures of PHI Without Authorization.

An authorization provides the client's (or their personal representative's) permission for BHS to use, disclose and exchange their PHI for a specified purpose. When PHI is used or disclosed by BHS using an authorization, the use or disclosure must be consistent with the purposes allowed by the authorization. Information may be exchanged orally and in writing, unless otherwise restricted by the client and limited to the minimum necessary.

When BHS initiates the request to use, disclose or exchange PHI, clients are always provided sufficient information to make a knowing and informed decision.

BHS strives to accommodate all reasonable third party requests for PHI. Authorizations received from third parties are checked for validity and the identity of the requestor is verified.

All client and third party authorizations are subjected to a review by the client's treating licensed or waived mental health clinician. BHS is permitted—but not required—to act on authorizations. Therefore, the treating clinician may decide to approve the authorization as written or limit or deny the authorized use, disclosure or exchange of PHI based on what is in the best interest of the client.

Uses and disclosures of PHI requiring an authorization are described in the BHS Notice of Privacy Practices provided to all clients.

Workforce members who do not obtain the appropriate written authorization are in violation of client rights, privacy law, and BHS policy. In such instances, BHS will take corrective action as deemed appropriate including contract cancellation or discipline up to and including termination of employment as well as possible civil and criminal penalties.

### **PROCEDURE:**

- I. Authorization Purpose
  - A. To provide and document the client's (or their personal representative's) permission to use, disclose or exchange specified PHI and state who may use, disclose, receive or exchange PHI.
  - B. To state the purpose and describe and limit the specific information to be used, disclosed or exchanged.
- II. Sources of Authorization Requests
  - A. The client
    1. The client or their personal representative initiates the authorization because he/she wants BHS to disclose his/her PHI to a third party external to BHS.
    2. Reminder: an authorization is not required from the client when he/she is seeking access to their own PHI. See PRV: 01:00 Client's Right to Access His/Her Own PHI.
  - B. BHS
    1. Staff may ask a client to authorize the use, disclosure or exchange

of PHI for purposes other than treatment, payment or health care operations.

2. Examples of communications with third parties requiring a written authorization include but are not limited to:
  - ❑ Multidisciplinary Teams
  - ❑ Client's spouse or significant other
  - ❑ Client's family members or advocates
  - ❑ DSS worker (except if client is a minor under age 12 and a dependent of the court)
  - ❑ Probation officer or legal counsel (no court order)
  - ❑ Police except under limited conditions specified by law (contact Privacy Officer if police request PHI)
  - ❑ Current or potential landlord or employer
  - ❑ Community agencies as shelters, food banks, job training, etc.
  - ❑ Coroners
  - ❑ Hope House personnel
  - ❑ For BHS marketing, fundraising, and research.

C. A third party

1. A third-party may have a client complete an authorization and then forward the authorization to BHS.
2. Only legally valid authorizations are considered for response.

III. BHS Authorizations Forms

A. *General–Authorization To Exchange Protected Health Information and Records. (Attachments [PRV 07:A1, General Authorization English](#) and [PRV 07.A2, General Authorization Spanish](#))*

1. Primary authorization form used by all mental health programs for use, disclosure and exchange of PHI.
2. Exceptions: Foster Care Youth Program and BHS Multidisciplinary Teams.

B. *Foster Youth Services–Authorization To Use, Disclose and Exchange PHI (Attachments [PRV 07.A3, Foster Youth Authorization English](#) and [PRV 07.A4, Foster Youth Authorization Spanish](#))*

1. Used ONLY by the Foster Youth Services Program.

C. *BHS Multidisciplinary Team (MDT)-Authorization To Exchange Information & Records*

1. Used ONLY by formally designated MDTs operating under the direct control of BHS.
2. MDT Authorization forms are custom designed by the Privacy

Officer.

NOTE: All authorization forms are federal/ HIPAA and state law compliant.

- D. Correcting Minor Errors On an Authorization Prior to Signature
  - 1. The client should review the completed form for accuracy.
  - 2. Staff correct any identified errors by putting a single line through the incorrect information, writing in the correct information and initialing.
  - 3. Never use white out to make corrections.
  - 4. IF an error is discovered after the client has signed the authorization, destroy the form and complete a new one.
- E. Updating/Changing Authorization Information
  - 1. To modify or change an authorization, the old authorization must be revoked and a new authorization form completed and signed.
  - 2. Never change information on an existing authorization.
- IV. Minimum Necessary
  - A. All disclosures must be limited to the minimum necessary information to accomplish the specific purpose for the disclosure unless the patient has requested the entire chart be sent to a named third party.
  - B. Minimum necessary does **not** apply when the client has sought access to their own chart or for disclosures for treatment purposes.
- V. Signatures
  - A. Adults (persons 18+) can sign for themselves.
  - B. Minors
    - 1. Consenting Minors Age 12+:
      - a. Minors who do, or could consent for their own outpatient mental health services control the chart in terms of access and authorization to release to third parties. Therefore, they, not their parents, must sign any authorization to release PHI.
      - b. Minors who do, or could, consent for their own outpatient mental health services must be advised under Family Code 6924(d) their parents must be involved in their treatment and notified about it unless it would be inappropriate.
        - 1) Prior to making any disclosure to the parents, the minor is given the option of discontinuing services if involving the family is appropriate, but the teen disagrees.
        - 2) If the teen agrees, he/she signs an authorization form so issues of communication with the parent/legal guardian can be resolved and recorded prior to any disclosures.

3. Non-consenting minors
  - a. Minors whose treatment requires parental consent should be involved in the decision to disclose to other third parties *whenever appropriate*.
  - b. Although children under age 12 don't have legal authority to decide on disclosures, if a child is mature enough to give input into the decision, the clinician should take into account the impact on them before deciding to disclose the information.
4. Minors Removed From the Home
  - a. Parents/guardians of minors removed from the physical custody of his/her parent in a dependency proceeding are prohibited from inspecting, releasing or copying the minor's records based solely on an authorization signed by the parent or guardian.
  - b. The juvenile court must issue an order authorizing such release based on the parent's signed authorization—otherwise, it's prohibited.
  - c. The above provision does not impact the parent/guardian's right to *consent* to mental health treatment.
  - d. If the minor has consented to his/her own treatment, this provision does not impact the minor's right to authorize the release or inspection of his/her own mental health records.

**IMPORTANT REMINDER:** Just because the law gives permission to disclose doesn't mean it is required. Clinicians should use their professional judgment to decide what is in the client's best interest.

## VII. BHS Initiated Authorization For Use, Disclosure or Exchange of PHI

### A. BHS Authorization Form

1. The correct BHS authorization form must be used (See III. A, B and C above).
2. Medical Records or clinical staff assist the client complete the form.

### B. Informed Consent

1. The client must be given sufficient information to make a knowing and informed choice about authorizing the sharing of PHI.
2. Explain the following in the client's primary language:
  - a. Legal right to refuse to sign or limit the scope of the authorization.

- b. The impact, if any, of refusing to sign or limiting the authorization's on the client's eligibility for services.
  - c. The specific information to be used, disclosed or exchanged.
  - d. Expiration date.
  - e. Right and procedures for revoking permission.
- C. Fill Out Authorization Form
  - D. Client Copy
    - 1. Always offer the client a copy of the authorization.
    - 2. The client must be given (not just offered) a copy of the authorization when it is initiated by BHS for marketing, research or fundraising.
  - E. Final Processing By Medical Records
    - 1. The original signed authorization is scanned into the client's EHR.
    - 2. The original is mailed or faxed to the person/entity from whom PHI is being requested.

## VIII. Revocation

- A. Client Right:
  - 1. May revoke an authorization at any time for any reason with no questions asked.
  - 2. A revocation nullifies an entire authorization-cannot cancel or part of an authorization.
  - 3. Never edit or modify an authorization after signature—initiate a new form.
- B. Procedure
  - 1. Must be in writing.
    - a. Option 1: Complete the Revocation section on the bottom of the BHS authorization form to be revoked.
    - b. Option 2: Client provides a written note with all the required information which is filed in the chart with the authorization to be revoked.
  - 2. The revocation is effective as soon as BHS receives the written revocation.
  - 3. **EXCEPTION:** To comply with the "spirit" of the law, if a client verbally (in person or by telephone) requests the revocation of an authorization, this should be noted on the authorization form in question, initialed and dated. The client should then be required to follow up in writing.
- C. BHS Responsibilities

1. BHS must stop processing the information for use, disclosure or exchange to the greatest extent practicable.
2. The revocation does not apply to the use or disclosure of information already released in reliance on the authorization. BHS is not required to retrieve information disclosed under the authorization prior to its revocation.
3. BHS does not need to inform those to whom they have disclosed information that the authorization has been revoked.

IX. Expiration and Renewal

A. Expiration Period

1. All BHS authorizations automatically expire after 2 years from the date the form is signed. OR
2. The client may request a specific date or event for the authorization to expire.

B. Annual Review

1. At the time of the client's annual financial review, the client is also given the opportunity to review his/her active authorization(s) and to make changes if needed.
2. This is not required by law but an extra measure taken by BHS to protect privacy.



Behavioral Health Services

GENERAL: AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Part I: Client Name: \_\_\_\_\_ DOB \_\_\_\_\_ MR# \_\_\_\_\_

I hereby authorize Madera County Behavioral Health Services to use or disclose this information to:

\_\_\_\_\_  
Name Of Person(s) / Organization Address - Street, City, State and Zip Code

Part II: Check (X) Type of Information. Table with columns: Mental Health, Substance Use Disorder, HIV Test Results (ONLY). Rows include DSS Report, Probation Report, Assessment / Diagnosis, Treatment Plan, Discharge Summary, MD (orders, medical, psyc eval, Med Rec), Billing / Payment / Insurance, Progress Notes, Clinical MD Nursing, and Other: (specify).

TIME PERIOD: [ ] Last Admission [ ] Date From: \_\_\_\_\_ Date To: \_\_\_\_\_  
Mo Da Yr Mo Da Yr

Part III: Client Rights/Advisements: I understand and agree to allow Madera County Behavioral Health Services (MCBHS) to use or disclose my protected health information as stated above. I also understand signing this form is voluntary and my refusal to sign this form will not generally affect my ability to receive services from MCBHS, unless I am in a court ordered program, in which case, my refusal to sign a release could affect my participation in that program. I understand I have a right to a copy of this form. Fees may apply to certain requests. A photocopy of this form is as valid as the original. I understand I may revoke this authorization in writing (or by completing the bottom of this form) at any time by contacting Medical Records (559) 673-3508. My revocation takes effect upon receipt of written notification by MCBHS, except to the extent others have acted in reliance upon it.

Part IV: If not revoked earlier, this authorization terminates 2 (two) years from the date of this release \_\_\_\_\_  
Mo Da Yr

Part V: \_\_\_\_\_  
Client or Legal Representative Signature Mo Da Yr

If not signed by the client, indicate relationship: \_\_\_\_\_ Staff: \_\_\_\_\_

Part VI: To Recipient: This information is protected by state and federal laws and are not to be further redisclosed to someone not included as an authorized recipient on this form without a new authorization from the client unless otherwise legally allowed. If you have received substance abuse disorder (drug/alcohol) information the following admonition applies: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Part VII: REVOCATION  
As of (date) \_\_\_\_\_, I hereby revoke this authorization \_\_\_\_\_  
Mo Da Yr Client or Legal Representative Signature

Client Name: \_\_\_\_\_ [ ] Verbal Request To (staff): \_\_\_\_\_



Servicios de Salud de Comportamiento (MCBHS)

AUTORIZACIÓN GENERAL: PARA EL USO, ACCESO O INTERCAMBIO DE INFORMACIÓN PROTEGIDA DE SALUD

Parte I: Nombre de Cliente: \_\_\_\_\_ Fec. Nac.: \_\_\_\_\_ MR# \_\_\_\_\_

Yo autorizo al Dpto. de Servicios de Salud de Comportamiento del Condado de Madera a usar o divulgar esta información:

Persona(s)/Organización) \_\_\_\_\_

Domicilio – Calle, Ciudad, Estado y Código Postal \_\_\_\_\_

Parte II: **MARQUE (X) Tipo de Información**

<input type="checkbox"/> <b>Tratamiento de salud mental</b> Reporte de DSS Reporte de <i>Probation</i> Asesoramiento/Diagnosis Plan de Tratamiento Resumen de Alta MED (órdenes, médico, eval. psiquiátrica, reg. med) Factura/Pago/Seguro Notas: <input type="checkbox"/> Clínicas <input type="checkbox"/> MED <input type="checkbox"/> Enfermería Otro: (especifique) _____	<input type="checkbox"/> <b>Desorden de Uso de Sustancia</b> Reporte de DSS Reporte de <i>Probation</i> Asistencia/Reporte de Estatus Detección/Referido Asesoramiento Plan de Tratamiento Resumen de Alta Notas de Progreso Factura/Pago/Seguro	<input type="checkbox"/> <b>VIH (SOLO) Resultados</b> Incluir No Incluir _____ Testigo
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PERÍODO DE:  Última Admisión  Fecha: de \_\_\_\_\_ hasta: \_\_\_\_\_  
Mes/Día/Año Mes/Día/Año

**Parte III: Derechos del Cliente/Aviso:** Entiendo y estoy de acuerdo en permitir que MCBHS use y divulgue mi información médica como indicado arriba. Entiendo que el firmar esta forma es voluntario y el reusarme a firmar este formulario no afectará por lo general mi habilidad de recibir servicios de MCBHS a menos que esté en un programa ordenado por la Corte, en cual caso el negarme a firmar una autorización podría afectar mi participación en ese programa. Entiendo que tengo derecho a recibir una copia de esta autorización. Cargos pueden aplicar a ciertos tipos de solicitudes. Una copia de esta forma es tan válida como la original. Entiendo que puedo revocar esta autorización por escrito (o al completar la parte de debajo de esta forma) cuando así lo decida al contactar a registros médicos (559) 673-3508. Mi revocación entrará en vigencia al ser recibida por escrito por MCBHS, excepto cuando otros ya hayan actuado sobre tal. Si no es revocada antes, esta autorización concluye a los (2) años de la fecha de esta autorización.

**Parte IV:** Si no es revocada antes, esta autorización concluye a los (2) años de la fecha de esta autorización: \_\_\_\_\_  
Mes/Día/Año

**Parte V:** \_\_\_\_\_  
Firma de Cliente o Representante Legal Mes/Día/Año

Si no firmada por el cliente, indique parentesco: \_\_\_\_\_ Personal: \_\_\_\_\_

**Parte VI: A Recipiente:** Esta información es protegida bajo las leyes estatales y federales y no deberá ser compartida con aquellos no incluidos como recipientes autorizados en esta forma sin una autorización nueva del cliente a menos que lo contrario sea proporcionado por la ley. Si ha recibido información del programa de desorden de abuso de sustancia (droga/alcohol) lo siguiente aplica: Esta información ha sido divulgada a usted de registros protegidos por reglas de confidencialidad Federales (42 CFR, Parte 2). Regulaciones federales le prohíben divulgar esta información a menos que la persona a la que pertenece haya expresado tal consentimiento por escrito o como sea permitido por 42 CFR Parte 2. Una autorización general para divulgar información médica u otra clase de información NO es suficiente para este propósito. Las leyes Federales restringen cualquier uso de la información para uso en investigación criminal o para enjuiciar a pacientes de alcohol o abuso de droga.

**Parte VII: REVOCACIÓN**

Efectivo (fecha) \_\_\_\_\_, Yo revoco esta autorización \_\_\_\_\_  
Mes/Día/Año Firma del Cliente o Representante Legal  
Nombre de Cliente: \_\_\_\_\_  Solicitud Verbal a (Personal): \_\_\_\_\_



# ADDITIONAL ATTACHMENTS

Mandatory Forms  
to Accompany  
Letters and  
Brochures

## YOUR RIGHTS UNDER MEDI-CAL

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If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the Madera County Mental Health Plan (MHP) by calling (559) 673-3508 or (888) 275-9779.

**IF YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH YOUR PLAN.**

### HOW TO FILE AN APPEAL

You have **60 days** from the date of this “Notice of Adverse Benefit Determination” letter to file an appeal. **If you are currently getting treatment and you want to keep getting treatment, you must ask for an appeal within 10 days** from the date on this letter OR before the date your Plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

You can file an appeal by phone or in writing. If you file an appeal by phone, you must follow up with a written signed appeal. The Plan will provide you with free assistance if you need help.

- To appeal by phone: Contact the Madera County MHP between 8:00 a.m. – 5:00 p.m. by calling (559) 673-3508 or (888) 275-9779. Or, if you have trouble hearing or speaking, please call (800) 735-2929.
- To appeal in writing: Fill out an appeal form or write a letter to your plan and send it to:

*Madera County Mental Health Plan  
P.O. Box 1288  
Madera, CA 93639*

Your provider will have appeal forms available. The Madera County MHP can also send a form to you.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, provider, or attorney file the appeal for you. This person is called an “authorized representative.” You can send in any type of information you want your MHP to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

Your MHP has 30 days to give you an answer. At that time, you will get a “Notice of Appeal Resolution” letter. This letter will tell you what the Plan has decided. **If you do not get a letter with the Plan’s decision within 30 days, you can ask for a “State Hearing” and a judge will review your case.** Please read the section below for instructions on how to ask for a State Hearing.

## **EXPEDITED APPEALS**

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an **“expedited appeal.”**

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## **STATE HEARING**

If you filed an appeal and received a “Notice of Appeal Resolution” letter telling you that your MHP will still not provide the services, or **you never received a letter telling you of the decision and it has been past 30 days**, you can ask for a “State Hearing” and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within **120 days** from the date of the “Notice of Appeal Resolution” letter. You can ask for a State Hearing by phone, electronically, or in writing:

- **By phone:** Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- **Electronically:** You may request a State Hearing online. Please visit the California Department of Social Services’ website to complete the electronic form: <https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx>
- **In writing:** Fill out a State Hearing form or send a letter to:

**California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, CA 94244-2430**

Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. You may want to ask your provider or Plan to write a letter for you, or you can write one yourself. The letter must explain in detail

how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an “**expedited hearing**” and provide the letter with your request for a hearing.

### **Authorized Representative**

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, provider, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an “authorized representative.”

### **LEGAL HELP**

You may be able to get free legal help. You may also call the local Legal Aid program in your county at 1-888-804-3536.

**SUS DERECHOS BAJO MEDI-CAL**

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Si necesita este aviso y/u otros documentos del Plan en un formato de comunicación alternativo como letra grande, Braille, o formato electrónico, o, si desearía ayuda en leer el material, por favor contacte al *Plan de Salud Mental (MHP)* al llamar al *(559) 673-3508*.

**SI NO ESTÁ DE ACUERDO CON LA DECISIÓN TOMADA EN RESPECTO A SU TRATAMIENTO DE SALUD MENTAL O TRASTORNO DE USO DE SUSTANCIA, USTED PUEDE PRESENTAR UNA APELACIÓN. ESTA APELACIÓN SE PRESENTA CON SU PLAN.**

**CÓMO PRESENTAR UNA APELACIÓN**

Tiene **60 días** a partir de la fecha de esta carta de "Aviso de Determinación de Beneficios Adversa" para presentar una apelación. **Si está recibiendo tratamiento actualmente y desea seguir recibiendo tratamiento, debe pedir una apelación a más tardar 10 días** de la fecha de esta carta O antes de la fecha que su Plan indica que cesarán sus servicios. Usted debe decir que desea seguir recibiendo tratamiento al presentar la apelación.

Puede presentar una apelación por teléfono o por escrito. Si presenta una apelación por teléfono, esta debe ser seguida por una apelación escrita y firmada. El Plan le proporcionara con asistencia gratuita si requiere ayuda.

- **Para apelar por teléfono:** Contacte al *Plan de Salud Mental (MHP)* de lunes a viernes de *8am y 5pm* al llamar al *(559) 673-3508*. O, si tiene dificultad al oír o hablar, por favor llame al número TTY/TDD *(800) 855-3000*.
- **Para apelar por escrito:** Complete un formulario de apelación o escriba una carta a su plan y mándela a:

*Madera County Behavioral Health  
Managed Care  
PO Box 1288  
Madera, Ca 93639*

Su proveedor tendrá formularios de apelación disponibles. *MHP* también le puede mandar una.

Usted puede presentar una apelación personalmente O, puede asignar a alguien como un familiar, amigo, representante, proveedor, o abogado para que presente la apelación por usted. Esta persona se conoce como un "representante autorizado." Puede mandar cualquier información que quiera que su Plan revise. Su apelación será revisada por un proveedor diferente al que tomó la primera decisión.

Su Plan tiene 30 días para darle una respuesta. En ese momento, recibirá una carta de “Aviso de Resolución de Apelación.” Esta carta le indicará la decisión del Plan. **Si no recibe una carta con la decisión del Plan dentro de 30 días, usted puede pedir una “Audiencia Estatal” y un juez revisará su caso.** Por favor lea la siguiente sección para instrucciones en como pedir una Audiencia Estatal.

### **APELACION ACELERADA**

Si piensa que el esperar 30 días podría dañar su salud, podría recibir una respuesta dentro de 72 horas. Al presentar la apelación, indique cómo es que el esperar dañará su salud. Asegúrese de pedir una “**apelación apresurada.**”

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### **AUDIENCIA ESTATAL**

Si presentó una apelación y recibió una carta de “Aviso de Resolución de Apelación” informándole que su Plan aún no proporcionará los servicios, **o jamás recibió una carta informándole sobre la decisión y ya han pasado más de 30 días**, usted puede pedir una “Audiencia Estatal” y un juez revisará su caso. Usted no tendrá que pagar por una Audiencia Estatal.

Debe pedir una Audiencia Estatal dentro de **120 días** de la fecha de la carta de “Aviso de Resolución de Apelación.” Puede solicitar una Audiencia Estatal por teléfono, electrónicamente, o por escrito:

- Por teléfono: Llame al **1-800-952-5253**. Si no puede hablar u oír bien, por favor llame al **TTY/TDD 1-800-952-8349**.
- Electrónicamente: Puede solicitar una Audiencia Estatal en línea. Por favor visite el sitio del Departamento de Servicios Sociales de California para completar el formulario electrónico:  
<https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx>
- Por escrito: Complete un formulario de Audiencia Estatal o mande una carta a:

**California Departamento of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, CA 94244-2430**

Asegúrese de incluir su nombre, domicilio, número telefónico, fecha de nacimiento, y la razón por la que quiere una Audiencia Estatal. Si alguien le está ayudando a solicitar una Audiencia Estatal, añada su nombre, domicilio y número telefónico al formulario o carta. Si necesita un intérprete, díganos que lenguaje habla. No tendrá que pagar por un intérprete. Nosotros le conseguiremos uno.

Después de que solicite una Audiencia Estatal, podría tomar hasta 90 días para decidir su caso y mandarle una respuesta. Si piensa que el esperar tanto tiempo podría dañar su salud, quizás podría recibir una respuesta dentro de 3 días laborales. Tal vez desee pedirle a su proveedor o Plan que escriba una carta por usted, o usted podría escribir una. La carta debe explicar en detalle por qué el esperar hasta 90 días para que se decida su caso podría seriamente dañar su vida, su salud, o su habilidad de lograr, mantener, o recuperar función máxima. Después, pida una “**audiencia apresurada**” y presente su solicitud para una audiencia.

### **Representante Autorizado**

Usted podrá hablar durante la Audiencia Estatal. O alguien, como un familiar, amigo, representante, proveedor o abogado puede hablar por usted. Si quiere que otra persona hable por usted, entonces es necesario que le diga a la oficina de Audiencia Estatal que le da permiso a la persona para que hable por usted. Esta persona se conoce como “representante autorizado.”

### **AYUDA LEGAL**

Es posible que pueda recibir ayuda legal gratuita. También puede llamar al programa de Ayuda Legal en su condado al 1-888-804-3536.

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**NONDISCRIMINATION NOTICE**

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Discrimination is against the law. The Madera County Mental Health Plan (MHP) follows Federal civil rights laws. The Madera County MHP does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

The Madera County MHP provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the MHP 24 hours a day, 7 days a week by calling (559) 673-3508 or (888) 275-9779. Or, if you cannot hear or speak well, please call (800) 735-2929.

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## **HOW TO FILE A GRIEVANCE**

If you believe that the MHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Madera County MHP. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact the MHP between 8:00 a.m. to 5:00 p.m. by calling (559) 673-3508 or (888) 275-9779. Or, if you cannot hear or speak well, please call (800) 735-2929.
- **In writing:** Fill out a grievance form, or write a letter and send it to:

*Madera County Mental Health Plan  
P.O. Box 1288  
Madera, CA 93639*

- **In person:** Visit your provider's office or the MHP and say you want to file a grievance.

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## **OFFICE OF CIVIL RIGHTS**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- **In writing:** Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

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**AVISO DE NO DISCRIMINACION**

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La discriminación es contra la ley. *El Plan de Salud Mental (MHP)* sigue leyes Federales de derechos civiles. *MHP* no discrimina, excluye a personas, o los amenaza debido a su raza, color, origen nacional, edad, discapacidad, o género.

*MHP* provee:

- Formatos auxiliares y servicios gratuitos para personas con discapacidades para ayudarles a comunicarse mejor, como:
  - Interpretes calificados en lengua de señas
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, y otros formatos)
- Servicios de lenguaje gratuitos a personas para quienes su idioma primario no es Inglés, como:
  - Interpretes Calificados
  - Información escrita en otros lenguajes

Si usted necesita estos servicios, contacte a *MHP* 24 horas al día, 7 días a la semana al llamar al (559) 673-3508. O, si no puede oír o hablar bien, por favor llame al número TTY/TDD al (800) 855-3000.

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## **CÓMO PRESENTAR UNA QUEJA**

Si piensa que *MHP* ha fallado en proveer estos servicios o discriminado de otra forma a base de raza, color, origen nacional, edad, discapacidad, o género, usted puede presentar una queja con *MHP*. Usted puede presentar una queja por teléfono, por escrito, en persona, o electrónicamente:

- **Por Teléfono:** Contacte al *MHP* de *lunes a viernes de 8:00am and 5:00pm* al llamar al *(559) 673-3508*. O, si no puede oír o hablar bien, por favor llame al número TTY/TDD al *(800) 855-3000*.
- **Por escrito:** Complete un formulario de queja, o escribe una carta y mándela a:

*Madera Mental Health Plan  
P.O. Box 1288, Madera Ca, 93639*

- **En persona:** Visite la oficina de su proveedor o de *MHP* y diga que desea presentar una queja.

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## **OFICINA DE DERECHOS CIVILES**

También puede presentar una queja de derechos civiles con el Departamento de Salud y Servicios Humanos de E.U., Oficina de Derechos Humanos por teléfono, por escrito, o electrónicamente:

- **Por Teléfono:** Llame al **1-800-368-1019**. Si no puede hablar u oír bien, por favor llame al **TTY/TDD 1-800-537-7697**.
- **Por Escrito:** Complete un formulario de queja o mande una carta a:

**U.S. Departamento of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201**

Formularios de queja están disponibles en:  
<http://www.hhs.gov/ocr/office/file/index.html>.

- **Electrónicamente:** Visite el Portal web de quejas de la Oficina de Derechos Civiles en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

## LANGUAGE ASSISTANCE

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### **English**

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call \_\_\_\_\_ (TTY: \_\_\_\_\_).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call \_\_\_\_\_ (TTY: \_\_\_\_\_).

### **Español (Spanish)**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al \_\_\_\_\_ (TTY: \_\_\_\_\_).

### **Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số \_\_\_\_\_ (TTY: \_\_\_\_\_).

### **Tagalog (Tagalog – Filipino)**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa \_\_\_\_\_ (TTY: \_\_\_\_\_).

### **한국어 (Korean)**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. \_\_\_\_\_ (TTY: \_\_\_\_\_)번으로 전화해 주십시오.

### **繁體中文(Chinese)**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 \_\_\_\_\_ (TTY: \_\_\_\_\_)。

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### **Հայերեն (Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք (TTY (հեռատիպ)՝ ):

### **Русский (Russian)**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (телетайп: ).

### **فارسی (Farsi)**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: ) تماس بگیرید.

### **日本語 (Japanese)**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。  
(TTY: ) まで、お電話にてご連絡ください。

### **Hmoob (Hmong)**

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (TTY: ).

### **ਪੰਜਾਬੀ (Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।  
(TTY: ) 'ਤੇ ਕਾਲ ਕਰੋ।

### **العربية (Arabic)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: ).

### **हिंदी (Hindi)**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।  
(TTY: ) पर कॉल करें।

### **ภาษาไทย (Thai)**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (TTY: ).

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**ខ្មែរ (Cambodian)**

ប្រយ័ត្ន: រ សី ិនជាអ្នកនិយាយ ភាសាខ្មែរ , រសវាជំនួយមននកភាសា រោយមិនគិតថ្លៃ  
គឺអាចមានសំរា ំរ អុើ នក។ ចូ ទូ ស័ព្ទ (TTY: )។

**ພາສາລາວ (Lao)**

ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,  
ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (TTY: ).

## LANGUAGE ASSISTANCE

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Send with all notices

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### **ਪੰਜਾਬੀ (Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।  
(TTY: ) 'ਤੇ ਕਾਲ ਕਰੋ।

### **العربية (Arabic)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: ).

### **हिंदी (Hindi)**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।  
(TTY: ) पर कॉल करें।

### **ภาษาไทย (Thai)**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (TTY: ).



Send with all notices

**ខ្មែរ (Cambodian)**

ប្រយ័ត្ន៖ រសើនជាអ្នកនិយាយភាសាខ្មែរ, រសវាជំនួយមននកភាសា រោយមិនគិតថ្លៃ  
គឺអាចមានសំរាប់អូរ អុរើនក។ ចូរ ទូរស័ព្ទ (TTY: )។

**ພາສາລາວ (Lao)**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,  
ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (TTY: ).