**Psychosocial Rehabilitation Services**

*Protection and Advocacy Information*

(*Medicaid Provider Agreement E-9)*

In accordance with the method of informing participants of their rights described in the Medicaid Provider Agreement, the agency provides participants and their families information pertaining to protection and advocacy services.

**REGIONAL MENTAL HEALTH OFFICES**

Children’s Mental Health (Per Dept’s Website) Adult Mental Health

Region 5 Region 5

601 Pole Line 823 Harrison

Twin Falls, ID 83301 Twin Falls, ID 83301

Phone (208) 734-4000 Phone (208) 736-2177

Fax (208) 736-2120

**DISABILITY RIGHTS OFFICES**

**DISABILITY RIGHTS OF IDAHO**

Boise Office Pocatello Office

4477 Emerald Street, Suite B-100 845 West Center Street, C107

Boise, ID 83706-2066 Pocatello, ID 83204-4237

(208) 336-5353 (TDD/Voice) (208) 232-0922 (TDD/Voice)

(208) 336-5396 Fax (208) 232-0938 Fax

Email: [info@disabilityrightsidaho.org](mailto:info@disabilityrightsidaho.org) Email: [info@disabilityrightsidaho.org](mailto:info@disabilityrightsidaho.org)

Moscow Office

107 East 4th Street

Moscow, ID 83843-2907

(208) 882-0962 (TDD/Voice)

(208) 883-4241 Fax

Email: [info@disabilityrightsidaho.org](mailto:info@disabilityrightsidaho.org)

<http://www.disabilityrightsidaho.org/>

Child Protection Services

601 Pole Line Road, Suite 1 Twin Falls, ID 83301

24-hour emergency: 208-734-4000

Adult Protection Services

998 N. Washington

Twin Falls, ID 83303

(208) 736-2122

(800) 574-8656

**Psychosocial Rehabilitation Services**

*Choice of Providers*

*(16.03.10.116.04, 16.03.10.136.07)*

Participant Name: Date of Birth:

**Provider Name City**

A+ SOLUTIONS CENTER LLC BURLEY

HEALTHY PROGRESSION LLC - REG 5 PSR BURLEY

IDAHO DEPARTMENT OF HEALTH AND WELFARE BURLEY

PATHWAYS BURLEY

POSITIVE CONNECTIONS LLC BURLEY BURLEY

PRO ACTIVE ADVANTAGE LLC REG 5 PSR BURLEY

PRO ACTIVE ADVANTAGE LLC GOODING

PROGRESSIVE BEHAVIOR SYSTEMS PA REG 5 RUPERT

A+ SOLUTIONS CENTER TWIN FALLS

ALA MAGIC VALLEY 4 KIDS TWIN FALLS

DME HEALTH MANAGEMENTS GROUP TWIN FALLS

DME/LIBERTY CARE SERVICES TWIN FALLS

HARMONY PSR SERVICES INC TWIN FALLS

IDAHO DEPARTMENT OF HEALTH AND WELFARE TWIN FALLS

JOLLIFF COUNSELING AND BEHAV HLTH REG 5 TWIN FALLS

MAGIC VALLEY REHABILITATION SERVICES INC TWIN FALLS

POSITIVE CONNECTIONS LLC REG 5 TWIN FALLS

PREFERRED CHILD AND FAMILY SERVICES TWIN FALLS

PRO ACTIVE ADVANTAGE LLC TWIN FALLS

PSYCHIATRIC SERVICES TWIN FALLS

SYRINGA SUPPORT SERVICES REG 5 PSR TWIN FALLS

VALLEY COMMUNITY COUNSELING LLC TWIN FALLS

I verify that I desire to receive services.

I verify that I have been informed of my rights to choose providers.

I verify that I have selected Progressive Behavior Systems as the provider to assist me in accomplishing the objectives stated in my individualized treatment plan.

I verify that I have been informed of my rights to refuse services.

Participant/Guardian Date

*\*Provider choice list developed in accordance with provider list dated 12/6/10 as per the Idaho Department of Health and Welfare’s website*

**Information on Benefits**

*Medicaid Provider Agreement E-2*

**The USPRA has published the following information regarding the benefits of psychosocial rehabilitation services:**

**Psychosocial rehabilitation services** promote recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs functioning. Psychosocial rehabilitation services are collaborative, person directed, and individualized, and an essential element of the human services spectrum, and are evidence-based. They focus on helping individuals re-discover skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice.

It is the principle behind numerous evidenced-based practices.  Psychiatric rehabilitation services directly address the high risks that many persons with serious and persistent mental illness experience of repeated hospitalizations, high utilization of emergency room services, low levels of functioning in the community, homelessness, and unemployment

1. Recovery is the ultimate goal
2. Services may help people re-establish normal roles in the community and their reintegration into community life.
3. Services facilitate the development of personal support networks.
4. Services facilitate an enhanced quality of life for each person receiving services.
5. People receiving services have the right to direct their own affairs, including those that are related to their disability.
6. Culture and/or ethnicity play an important role in recovery.
7. Services build on the strengths of each person.
8. Services are to be coordinated, accessible, and available as long as needed.
9. All services are to be designed to address the unique needs of each individual, consistent with the individual’s cultural values and norms.
10. Services actively encourage and support the involvement of persons in normal community activities, such as school and work, throughout the rehabilitation process.
11. The involvement and partnership of persons receiving services and family members is an essential ingredient of the process of rehabilitation and recovery.

As you can see, there are many potential benefits to receiving services. We look forward to assisting you in accomplishing your goals!

**16.03.10.129.03, 16.03.10.130.10. Crisis Service Availability**. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services.

For crisis response services, please contact our Administrator, Heather Harper, at 208-300-0413.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each and understand the information provided regarding services. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Participant/Guardian Date

**Information on Services to be Received**

*Medicaid Provider Agreement E-2*

In 1985, the International Association of Psychosocial Rehabilitation Services (IAPRS) published the following definition of psychosocial rehabilitation as

‘The process of facilitating an individual's restoration to an optimal level of independent functioning in the community .... While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. In many settings, participants are called members. The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational, residential, social/recreational, educational and personal adjustment services.' (Cnaan et al, Psychosocial Rehabilitation Journal, Vol. 11, No. 4: April 1988, p.61)

Psychosocial rehabilitation is based on a number of assumptions, including two essential ones

1. People are motivated by a need for mastery and competence in areas, which allow them to feel more independent and self-confident.
2. New behavior can be learned and people are capable of adapting their behavior to meet their basic needs.

**Psychosocial Rehabilitation Principles**

* + Utilization of full human capacity.
  + Equipping people with skills (social, vocational, educational, interpersonal and others).
  + People have the right and responsibility for self-determination
  + Services should be provided in as normalized environment as possible.
  + Differential needs and care.
  + Commitment from staff members.
  + Care is provided in an intimate environment without professional, authoritative shield and barriers.
  + Early intervention.
  + Changing the environment.
  + No limits on participation.
  + There is an emphasis on a social rather than a medical model of care.
  + Emphasis is on the client's strengths rather than on pathologies.
  + Emphasis is on the here and now rather than on problems from the past.
  + Flexibility of structure and service models.
  + Non-obligatory attendance.
  + Support for mobility and choice of service options.
  + Active participant involvement in services.
  + Support for participant decision-making.
  + Concentration on quality of relationships and interactions between participants and staff.
  + Encouragement of peer support.
  + Responsiveness to participants' needs.
  + Provision of most 'normal' environment.
  + Utilization of a broad range of skills.
  + Active community education.
  + Active advocacy.
  + Cost-effectiveness: both operational and preventative.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each and understand the information provided regarding services. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Participant/Guardian Date

**Psychosocial Rehabilitation Services**

*Information on Legal Assistance*

(*Medicaid Provider Agreement E-9)*

**Idaho Volunteer Lawyers**

PO Box 895

Boise ID 83701-0895

1-800-221-3295

www.state.id.us/asb/pub\_info/ivlp.htm

Services available:

Statewide network of volunteer attorneys that provide free legal assistance in family law cases to persons living in poverty. Services may include advice and consultation, brief legal services, and representation. Eligible case types include custody and visitation, guardianship for adults or children, wills in non-property matters, or limited debt defense, enforcement or modifications of court orders, and divorce. Domestic violence cases are given priority.

**Disability Rights of Idaho**

Pocatello Office

845 West Center C-107

Pocatello ID 83204

(208) 232-0922 (TDD/voice) or 1-866-262-3462

(208) 232-0938 (fax)

www.**disabilityrightsidaho**.org

Services available:

Disability Rights of Idahois a private, nonprofit legal services organization which manages several federally funded programs designed to protect the rights of people with disabilities and is the designated Protection and Advocacy system for Idaho.

Disability Rights of Idahoprovides advocacy for people with physical disabilities, developmental disabilities, mental illness, or traumatic brain injury who have experienced abuse or neglect, have been denied service or benefits, have had their rights violated or experienced discrimination because of a disability; or have experienced problems with voting accessibility. Disability Rights of Idahoalso assists persons in getting assistive technology or services; people seeking information about applying for, or receiving services from rehabilitation programs; and SSI and/or SSDI beneficiaries with return to work concerns. Disability Rights of Idahoalso administers the WIPA Program, which provides work incentive planning, assistance and outreach services to SAA beneficiaries receiving SSI/SSDI, and who are seeking employment.

Disability Rights of Idahoprovides information and referral; direct advocacy; assistance with negotiation and mediation; short term and technical assistance; and legal advice and/or representation to persons with disabilities on issues related to their disability.

The following programs are offered:

• **PADD – Protection and Advocacy for Persons with Developmental Disabilities**. Services to address disability related rights violations for individuals who have a severe and chronic developmental or physical disability.

• **PAIMI – Protection and Advocacy for Individuals with Mental Illness**. Priority representation is provided to individuals with mental illness alleging abuse, neglect or violations of rights occurring in treatment facilities. Services may also be provided to address rights violations in the community.

• **PAIR – Protection and Advocacy for Individual Rights**. Services addressing disability related rights violations for all other individuals with physical and/or mental disabilities who are not eligible for services under the PADD, PAIMI, or CAP Programs..

• **CAP – Client Assistance Program**. Services to provide information and advocacy to individuals who are involved with federally funded rehabilitation programs.

• **PAAT – Protection and Advocacy for Assistive Technology**. Services to individuals with disabilities who need information or assistance enforcing legal rights to obtain assistive technology devices and services.

• **PABSS – Protection and Advocacy for Beneficiaries of Social Security**. Services to provide information and advocacy to beneficiaries of Social Security seeking to secure, retain, or regain gainful employment..

• **PATBI – Protection and Advocacy for Individuals with Traumatic Brain Injuries.** Services to individuals with traumatic brain injury and their families to improve access to health and other services.

• **PAVA – Protection and Advocacy for Voting Accessibility.** Services to ensure the full participation of individuals with disabilities in the electoral process.

• **WIPA – Work Incentives Planning and Assistance.** Provides work incentive planning, assistance and outreach services to SSA beneficiaries receiving SSI/SSDI seeking employment

Contact Disability Rights of Idaho for individual program eligibility criteria.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Participant/Guardian Date

**Authorization for Exchange of**

**Confidential Information**

Client’s Name: Date of Birth:

Parent/Guardian Name:

Adult Participant’s or Parent/Guardian Address:

**A. The names of parties exchanging information:**

I authorize:

Progressive Behavior Systems

Name/Title

ID

Address City State

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

Zip Code Phone Number Fax Number

*(Check either or both as needed.)*

[X] to release information to: [X] to obtain information from:

Name/Title

Address City State

( ) ( )

Zip Code Phone Number Fax Number

**B. The information to be released:**

[ ] Psychological test results [ ] Speech therapy reports [ ] Psychiatric test results

[ ] Social histories [ ] IEP/504 plans [ ] Vocational Assessments

[ ] Developmental assessments [ ] Medical history/physical [ ] Vocational Plans

[ ] Treatment plans of care [ ] Counseling records [ ] Vocational History

[ ] Occupational therapy reports [ ] Academic records

[ ] Other

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of my child, unless otherwise specified. I release the parties involved from all liability arising from such exchange of information. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of this information.

I understand that this release of information is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), and the Code of Federal Regulations (42, Part 2).

**C. Effective date of authorization:**

This authorization takes effect the day that you sign it and terminates on: or one year from the date it is signed.

You may revoke this authorization at any time except to the extent that the program instructed to make the disclosure has already taken action in reliance on it. Please notify us in writing or verbally at the above number.

Adult Participant’s or Parent/Guardian Signature Date

**Psychosocial Rehabilitation Services**

*Alternate Forms of Services Available*

*(Medicaid Provider Agreement E-2)*

Psychosocial rehabilitation is an intensive treatment program designed to reduce the risk of future hospitalization and other impending crises. Our goal, as a rehab treatment provider is to facilitate enough progress among our clients that we are no longer needed. We do this by incorporating a wide range of services and supports.

**Alternate Services and Supports Available:**

* Psychotherapy
* Group and Individual PSR
* Crisis services
* Case management
* Service coordination
* Developmental services
* Vocational services
* Residential services
* Personal care services
* OT, PT, Speech, Audiology
* Friends
* Family
* Churches
* Civic groups
* Community organizations

We encourage, and will help you cultivate all of the supports you need to be successful and accomplish your goals. We will actively pursue unpaid service options to promote optimum independence.

By signing this form I verify that I have read, understood, received an explanation of the information listed above, provided copies of each and understand the alternate forms of services and supports available to me. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Participant/Guardian Date

**Psychosocial Rehabilitation Services**

*Complaint, Grievance, and Appeal Rights*

COMPLAINTS, GRIEVANCES AND APPEALS

In accordance with the Participant Rights Statement, participants and their families as well as, Medicaid, advocates are offered the opportunity report complaint and/or grievances. The complaint, grievance and appeal policy and procedure must be posted in every room of the office in all relevant languages so as to be easily understood. Complaints and/or grievances may be filed as a result of problems with training, service delivery, supervision, funding, planning, service barriers, staff, etc. The agency has a rigorous, internal process for assuring quality services and resolving problems in a prompt fashion. Please refer to the Problem Resolution policy and procedure for additional information. All grievances will be solved verbally as quickly as possible when appropriate. If a formal written grievance is filed, the right to file a grievance is outlined below:

A grievance is made by calling the Administrator, Jerrod Catmull (208-312-1911), or by filling out a grievance report.

* The Administrator or designee of will investigate the grievance in a timely fashion (within 1 week).
* The Administrator or designee will consult with other Administrative team members regarding the appropriate actions required.
* The Administrator or designee will implement any required changes (Within 1 week).
* The Administrator will report findings of the investigation to the participant/guardian and advocate within 1 week.

* Any grievances made by a participant and their family, must be documented and placed in their file.
* At any time, the participant and his/her family may appeal the findings of the review and request a second, independent review of the complaint and/or grievance.
* A local mediator will be procured if necessary to resolve the complaint and/or grievance. The mediator will be agreed upon by all parties to the grievance in writing.

Complaint/Grievance reports are to be handled with the utmost confidentiality. The report is to remain amongst the Administrative team and the people directly involved in any corrective actions. The content or context of the report may be used as training material as decided by the Administrative team.

If appropriate, the Administrator or designee is responsible for notifying the participant and or person filing the grievance report of the corrective action.

EXPLANATION/RECEIPT OF COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

Upon initiation of services, participants and/or guardian, where applicable, shall be provided with a packet of information, which outlines rights, responsibilities, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services and legal assistance. This packet will be reviewed with the participant or guardian and written in easily understood terms. Participants will be encouraged to reflect their understanding of the grievance by the agency’s staff to encourage optimum independence. The agency will assure one copy of the packet is filed in the company’s administrative records to be used for employee training and quality assurance with respect to assuring the exercise of participant’s right to file a grievance. Participants and their families will be encouraged to have a team consisting of paid and non-paid advocates. All applicable advocates will also receive information regarding participants’ rights with the agency.

SERVICE DELIVERY PROBLEM RESOLUTION

**Policy I:**

Services provided produce measurable outcomes, are high quality, and are consistent with individual choices, interests, needs, and current standards of practice.

**Procedure I:**

1. The administrator or designee will review the contents and findings of service delivery investigations into problems within one week, so as to implement corrective actions and provide feedback.
2. As needed the administrator or designee will instruct the participant, guardians, Medicaid, advocates or staff to use the grievance procedure to report service delivery problems

Quality Assurance Probes will be conducted covering Administrative issues such as utilization trends, finances, Rights, services delivered, and others which may arise, on an on-going basis. These will be conducted by designated administrative staff.

Participant satisfaction surveys will be conducted to ensure individuals are satisfied with the services received at all levels of the organization.

Any quality assurance probes, which document problems of significance, will be turned over immediately to administrative personnel so immediate corrective action can be taken. These include but are not limited to negligence, inadequate supervision of the participant, problems with the environment, lack of dignity in regard to interactions with the participant, insubordination, etc.

In the case of significant problems, the following may result: If warranted, Administrative staff will immediately contact adult/child protection with any issues of abuse/neglect. Reviewing employee schedules and assignments, transferring employees to other work assignments on both a temporary and/or permanent basis may occur.

Issues and concerns will be outlined in writing approved by the QA committee.

*Note: Newly discovered problems need to be added to the initial and ongoing training done with staff.*

Further training will generally be assumed as the first course of action. This will include time lines for correction. During the next follow up QA, corrective action time lines must be met as specified. If not, the administrator will determine what disciplinary action to take related to the seriousness of the concern.

A QA committee will meet to review all QA's and determine the need for further training, adjustment of programmatic procedures, and to recognize employees for doing a good job.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Participant/Guardian Date

**HIPAA PRIVACY STATEMENT**

*Medicaid Provider Agreement 1.1-1.6*

**HIPAA Privacy Statement**

**Notice Of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

1. The agency respects you and your privacy. We are committed to keeping all information received or created confidential.
2. We want you to have a clear understanding of how we use and safeguard information about you. This Notice of Privacy Practices describes how we may use and disclose your protected health information in order to carry out services, voucher for payment and for other purposes permitted or required by law. It also describes your rights to access and control your information.
3. We are required by law to maintain the privacy of your protected health information and to provide you with notice of the legal duties and privacy practices with respect to your protected health information.
4. Health information means any information, whether oral or recorded in any form, that is created or received by the agency, relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

**How Your Protected Health Information May Be Used or Disclosed**

1. The agency uses protected health information about you for services, payment and regular health care operation purposes. We do not require authorization to use your protected health information for these purposes.
   * **Services**

Providing you with care and services related to your health, such as working with other agencies involved with the delivery of services.

* **Payment**

Information needed for billing, insurance, or compensation for services, if necessary. We may provide necessary portions of your protected health information to our billing department and to your health plan to get paid/reimbursed for the services we provide to you.

* **Regular Health Care Operations**

Activities that may include quality assessment, program evaluation and auditing.

* **Emergency Care**

To help you obtain treatment in a medical emergency. An authorization is required as soon as reasonably possible after the emergency and the provider should document the reasons as to why the authorization could not be received.

* **When Legally Necessary**
  1. If required by federal, state or local law. We may make disclosures when a law requires that we report information to government agencies or law enforcement personnel about victims of abuse, neglect, domestic violence or to avoid serious threat to health or safety of a person or the public.
  2. We may provide protected health information to a family member, friend or other person that you indicate is involved in your services or the payment for your services unless you object, in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
  3. ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.

IN ADDITION, ANY ALCOHOL OR SUBSTANCE ABUSE RECORDS ARE PROTECTED UNDER FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY. (42CFR Part II)

ANY HIV RECORDS ARE PROTECTED UNDER PUBLIC HEALTH LAW GOVERNING CONFIDENTIALITY. (Article 27-F)

**When the agency May Not Use or Disclose Your Health Information**

1. Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**Your Health Information Rights**

1. You have the right to inspect and obtain a copy of your health information.
2. You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the requested restriction.
3. You have a right to request that we amend your health information. An amendment can only be granted if the information requested to be amended is created by the agency.
4. You have a right to receive an accounting of disclosures of your health information.
5. You have a right to receive confidential communications of protected health information and the manner in which it is sent to you. Within reason, you have the right to ask that we send information to you at an alternate address (such as requesting that we send information to your work address rather than your home address) or by alternate means (such as by regular mail versus e-mail, if such methods are reasonably available).
6. You have a right to a paper copy of this Notice of Privacy Practices. You will be asked to sign an Acknowledgement of Receipt of this Notice.
7. You have a right to complain if you believe your privacy rights have been violated or if you are dissatisfied with the services you are receiving. You will not be punished in any way for filing a complaint. (Please refer to our Complaint Form for information regarding internal and/or external complaints.) The agency will provide you with any or all of the form(s) upon your request.

**Changes to This Notice of Privacy Practices**

1. We are bound by the terms of this notice currently in effect and reserve the right to amend this Notice of Privacy Practices at any time in the future. If such amendment is made, all individuals currently active in our programs will be provided a revised Notice of Privacy Practices by mail or at their next scheduled meeting.
2. If you have any questions regarding this notice or need further information please contact the Compliance Officer Heather Harper, at 208-300-0413.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Participant/Guardian Date

**Psychosocial Rehabilitation Services**

*Risks Associated with Services*

*(Medicaid Provider Agreement E-2)*

Psychosocial rehabilitation is an intensive treatment program designed to reduce the risk of future hospitalization and other impending crises. Our goal, as a rehab treatment provider is to facilitate enough progress among our clients that we are no longer needed. To reiterate, the point of rehab treatment is to eliminate the need for it. This is especially important as the State, who provides funding for this program, views rehab as both intensive and SHORT TERM.

**Risks**

Risks associate with PSR services include, but are not limited to the following items. Remember, all services provided must be clinically appropriate in content, service location and duration.

* There are inherent risks associated with receiving services in the home or community.
* There is a risk associated with transportation.
* Working with various therapists could be a source of frustration and pose some behavioral risk
* Therapy might be difficult, but worth it.
* You may need to occasionally reset your expectations of activities and therapy.
* You might get worse before you get better.
* Our agency is here to support you, but hold you accountable to the goals you’ve helped develop.
* There is some risk associated with interacting with others in the community.
* The ultimate goal is for you to not need services, which can be intimidating to realize.

We believe that assuming some of these risks will enable you to make the most progress in the shortest amount of time. We are committed to supporting to minimize the risk to you as you received services. Please actively participate with us in managing the risks. Remember, you are part of a team and we’re all striving for the same goal!

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each and understand some of the risks associated with the services. I also agree that the risks associated with services are not limited to those identified in this document or in conversation with representatives of the agency.

Participant/Guardian Date

**Psychosocial Rehabilitation Services**

*Participant Rights Information*

(*Medicaid Provider Agreement E-9)*

* 1. **Policy:** The purpose of this section is to inform of participant rights in receiving services from The agency. Upon initiation of services, participants and/or guardian, where applicable, shall be provided with a packet of information, which outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet will be written in easily understood terms.
  2. **Procedure:** The agency will provide the following rights for participants:
  3. Humane care and treatment
  4. Not be put in isolation
  5. Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others
  6. Be free of mental and physical abuse
  7. Voice grievances and recommend changes in policies or services being offered
  8. Practice his own religion
  9. Wear his own clothing and to retain and use personal possessions
  10. Be informed of his medical and habilitative condition, of services available at the agency and the charges for the services
  11. Reasonable access to all records concerning himself
  12. **Refuse services**
  13. Exercise all civil rights, unless limited by prior court order.
  14. **Additional Participant Rights**. The agency will also ensure the following rights for each participant:

1. Privacy and confidentiality
2. Be treated in a courteous manner
3. Receive a response from the agency to any request made within a reasonable time frame
4. Receive services that enhance the participant's social image and personal competencies and, whenever possible, promote The agency in the community
5. Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law
6. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction
7. All other rights established by law
8. Be protected from harm.
   1. **Policy II:** The agency will ensure and document that each person receiving services is informed of his rights in the following manner:
   2. **Procedure II:**
9. Upon initiation of services, the agency will provide each participant and his parent or guardian, where applicable, with a packet of information which outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet will be written in easily understood terms, i.e. in the participants’ native language.
10. When providing facility-based services, the agency will prominently post a list of the rights contained in the regulations.
11. The agency will provide each participant and his parent or guardian, where applicable, with a verbal explanation of their rights in a manner that will best promote individual understanding of these rights.
12. Upon initiation of services, or within one week after the ITP is developed, each individual will be informed of their rights and responsibilities, grievance procedure, and the names, addresses, and telephone numbers of protection and advocacy agencies.
13. Each individual will be given a copy of the rights statement for their own use, and verification of the receipt of rights will be placed in their file.

* The agency, its employees and subcontractors interact with participants in a respectful manner.
* Provider interventions promote participant empowerment and choice. Participants are recognized as primary decision-makers in accessing any and all services, unless an appropriate guardianship has been established by a court or the participant is a minor.
* Services are provided at a time and location that is convenient, acceptable and suitable for the participant and the participant’s Provider, and are coordinated, consistent and not a duplication of any other service the participant is receiving.
* The agency’s decision to accept or continue services for a participant is based on its ability to meet the needs of the participant.
* The agency schedules services to ensure that the treatment plan for each service is developed and implemented effectively.
* The agency conducts a quality assurance program consisting of: sufficient training sessions to ensure staff qualifications and competence to provide the services the Agency delivers; quarterly audits of services; participant satisfaction surveys; and annual professional credential and competency review*.* The agency shall implement a Quality Improvement plan for any deficiencies identified by the Department or its designee.
* The agency informs each participant (or legal guardian) of the services to be received, the expected benefits and attendant risks of receiving those services, of the right to refuse services, and alternative forms of services available.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

Participant/Guardian Date