

Eastern Montana Community Mental Health Center Financial Application

Please complete this form with information specific to the applicant seeking services.

Full Name of Applicant: _____			SSN/Client ID: _____		
Last	First	MI			
Other Names used in past: _____					
Mailing/Residence Address: _____				Education Level: _____	
City, State, Zip: _____			Current County of Residence: _____		
Home Phone #: _____		Work Phone #: _____		Message Phone #: _____	
Date of Birth: _____	Marital Status: _____	Gender: _____	Race: _____	Ethnicity: <i>Of Hispanic or Latino Origin</i> Yes No	Tribal Affiliation: _____
Has the applicant ever served on active duty in the Armed Forces? Yes No <i>(Not counted are those whose only service was in the Reserves, National Guard or Merchant Marines)</i>					
Who is legally responsible for the applicant? <i>(circle one to specify)</i> Self Guardian Limited Guardianship					
Other <i>(specify)</i> _____					

LIST EVERYONE WHO LIVES WITH APPLICANT. (Attach additional sheet if more than five people live with applicant.)					
Last Name, First, Middle Initial	How is this person related to applicant?	Sex	Birth Date	Education Level	Social Security Number
1.					
2.					
3.					
4.					
5.					

INCOME: SUBMIT VERIFICATION OF <u>ALL</u> INCOME FOR ALL HOUSEHOLD MEMBERS			
List all income and benefits you, your spouse, dependents, or other household members receive from any source (i.e., employment, Social Security, SSI, Pensions, VA, Child Support, BIA, etc.) 2 months of paystubs			
Name	Source	Gross Amount of Income	How Often Received
If Zero income, what is your source of support? _____			
Do you anticipate this income to change in the next two months? Yes No			
If yes, what is the expected change: _____			
Number of Family Members Dependent on Family Income? _____			

PLEASE LIST THE MENTAL HEALTH CARE PROVIDER(S) AUTHORIZED TO RECEIVE COPIES OF MHSP CORRESPONDENCE

Name: _____ Agency: _____

Address: _____ Phone #: _____

City, State, Zip: _____

Name: _____ Agency: _____

Address: _____ Phone #: _____

City, State, Zip: _____

DO YOU HAVE HEALTH INSURANCE COVERAGE? Yes ☐ No ☐

(If yes, please complete the following for all insurance coverage including Medicare. **ATTACH COPY OF CARDS**)

Name of Insured: _____ Relationship to Applicant: _____

Insured's SSN: _____ Policy # _____ Group # _____

Insurance Carrier Name: _____ Start Date: _____

Insurance Carrier Address: _____ End Date: _____

ARE YOU RECEIVING MEDICARE: Yes ☐ No ☐

I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they shall form a part of the insurance contract for which I am applying. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, organization, institution or person that has any records or knowledge of my health to disclose to Eastern Montana Community Mental Health Center (EMCMHC) or its designee any such information. A photographic copy of this authorization shall be as valid as the original. I may revoke this authorization at any time except to the extent that the person or entity making the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year from the date that I sign.

I agree to notify EMCMHC of any changes of income, family size or other insurance coverage within 30 days of the change.

Signature of Applicant: _____ Date: _____

This application is considered complete only when income documentation has been attached.

**Please Mail to:
EMCMHC
PO Box 1530
Miles City, MT 59301**

October 2016

**EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
ADMISSION FORM**

Name:

(Last)

Social Security Number:

(First)

SOURCE OF REFERRAL

- ☐ 1. Self
- ☐ 2. Private MH Professional
- ☐ 3. Courts
- ☐ 4. Schools
- ☐ 5. Social/Community Agency
- ☐ 6. Other
- ☐ 7. Clergy
- ☐ 8. Non-psychiatric Physician
- ☐ 9. Montana State Hospital
- ☐ 10. Residential Facility
- ☐ 11. Other Mental Health Center
- ☐ 12. Law Enforcement
- ☐ 13. Crisis Center
- ☐ 14. Hospital Emergency Room
- ☐ 15. Native American Agency
- ☐ 16. Homeless Shelter
- ☐ 17. Alcohol/Drug Treatment Center
- ☐ 18. Agency of the Elderly
- ☐ 19. Agency for Children
- ☐ 20. Developmental Disabilities
- ☐ 21. Veteran=s Administration
- ☐ 22. FAP

RESIDENTIAL ARRANGEMENT

- ☐ 1. Homeless
- ☐ 2. Jail
- ☐ 3. Hospitalization
- ☐ 4. Nursing Home
- ☐ 5. Single Room Occupancy (Transient Hotel)
- ☐ 6. Shelter/Mission
- ☐ 7. Personal Care Home
- ☐ 8. Mental Health Group Home
- ☐ 9. Non-Mental Health Group Home
- ☐ 10. Foster Home
- ☐ 11. Living with others (in their care)
- ☐ 12. Supported Independent Living
- ☐ 13. Living Independently With Others
- ☐ 14. Living Independently
- ☐ 15. Other (Please Specify in File)
- ☐ 16. Therapeutic Foster Care
- ☐ 17. Residential Treatment Facility

RECENT MH SERVICES

- ☐ 1. MT State Hospital
- ☐ 2. Other Inpatient Care
- ☐ 3. Partial Hospitalization
- ☐ 4. Outpatient
- ☐ 5. No Prior Services
- ☐ 6. Unknown
- ☐ 7. This Facility
- ☐ 8. Psychiatric or Other Residential

EMPLOYMENT AT ADMISSION

- ☐ 1. No Interest in Work
- ☐ 2. Unemployed but desiring & able to Work
- ☐ 3. Involved in Day Treatment
- ☐ 4. Job Corps
- ☐ 5. Being Evaluated by Voc Rehab Services
- ☐ 6. Employed in Ongoing Volunteer Work
- ☐ 7. Employed in Sheltered Workshop
- ☐ 8. Transitional Employment Program
- ☐ 9. Supported Employment
- ☐ 10. Part-time Gainful Employment
- ☐ 11. Full-time Gainful Employment
- ☐ 12. Homemaker
- ☐ 13. Retired: Age 55 or Over
- ☐ 14. Other
- ☐ 15. Student/Preschool
- ☐ 16. Disabled

YEARS OF EDUCATION: _____ **Years**

EDUCATIONAL STATUS

- ☐ 1. No Formal Education Activity
- ☐ 2. Adult Education Classes/GED
- ☐ 3. Attends Vocational School
- ☐ 4. Attends College Part-time
- ☐ 5. Attends College Full-time
- ☐ 6. Other
- ☐ 7. Public School
- ☐ 8. Home School
- ☐ 9. Private School For General Population

DEVELOPMENTAL DISABILITY

- ☐ 1. Yes
- ☐ 2. No
- ☐ 3. Unknown

MOST SEVERE PRESENTING PROBLEM AT TIME OF ADMISSION

- ☐ 1. Marital/Family Problems
- ☐ 2. Social/Interpersonal (not family)
- ☐ 3. Problems Coping with Daily Activities
- ☐ 4. Medical/Somatic
- ☐ 5. Depression or Mood Disorder
- ☐ 6. Attempt, Threat, or Danger of Suicide
- ☐ 7. Alcohol
- ☐ 8. Drug
- ☐ 9. Involved w/Criminal Justice System
- ☐ 10. Eating Disorder
- ☐ 11. Thought Disorder
- ☐ 12. Abuse/Assault/Rape Victim
- ☐ 13. Runaway Behavior

HOMELESS IN THE LAST 6 MONTH

- ☐ 1. Yes
- ☐ 2. No
- ☐ 3. Unknown

ON PROBATION OR PAROLE DURING LAST

- ☐ 1. Yes
- ☐ 2. No

CHRONICAL MEDICAL PROBLEMS IN THE LAST YEAR

- ☐ 1. Yes
- ☐ 2. No

MEDICAL EXAM IN LAST 3 MONTHS

- ☐ 1. Yes
- ☐ 2. No

DENTAL EXAM IN LAST 3 MONTHS

- ☐ 1. Yes
- ☐ 2. No

VISION EXAM IN LAST 3 MONTHS

- ☐ 1. Yes
- ☐ 2. No

NEW GENERATION MEDS

- ☐ 1. Yes
- ☐ 2. No

NEW GENERATION MEDS ARE

Clozaril (clozapine)
Zyprexa (olanzapine)
Fumarate Seroquel (quetiapine)
Risperdal (risperidone)
Geodon (ziprasidone)

SMOKING STATUS

- ☐ 1. Current Every Day Smoker
- ☐ 2. Current Some Day Smoker
- ☐ 3. Former Smoker
- ☐ 4. Never Smoker

ELIGIBILITY DETERMINATION

- ☐ 1. SSI Due to Mental Illness
- ☐ 2. SSI Not Due to Mental Illness
- ☐ 3. SSDI Due to Mental Illness
- ☐ 4. SSDI Not Due to Mental Illness
- ☐ 5. Does Not Apply

SNAP BENEFITS

- ☐ 1. Yes
- ☐ 2. No

TANF BENEFITS

- ☐ 1. Yes
- ☐ 2. No

Eastern Montana Community Mental Health Center

CONTRACT FOR PAYMENT OF SERVICES

CLIENT NAME: _____

The Eastern Montana Community Mental Health Center is a private, non-profit corporation financed largely by the collection of client fees.

1. State Funded Coverage/Self Pay:

- _____ I am Medicaid eligible. I agree to notify EMCMHC regarding any changes in my eligibility.
- _____ I am Medicaid eligible. I agree to pay **\$150.00** for PFL Group.
- _____ I am eligible for the Chemical Dependency Service Plan. I agree to provide monthly income verification.
- _____ I qualify for a reduced monthly rate based on the Sliding Fee Scale.
- _____ I am applying for HELP Medicaid or HELP TPA thru HealthCare.gov.

☐ I am FULL FEE ☐ \$350/PFL ☐ \$150/MIP ☐ \$200/CD EVAL ☐ OTHER \$ _____

2. Insurance/Medicare Coverage:

- I understand that I am responsible for payment of all services received at the Center. After I complete and sign an insurance information form, the Center will submit a claim to my insurance company for services rendered. Payment from the insurance or Medicare will be sent directly to the Center. If I receive payment and do not remit the payment to the Center in a timely manner, I understand that I will be billed for the full amount of services.
- _____ I agree to pay the full difference between what my insurance/Medicare pays.

3. No Third Party Coverage Payment Plan:

- _____ I agree to pay full fee for all Center services according to my monthly payment plan:
- ☐ \$25 per mo. ☐ \$50 per mo. ☐ \$75 per mo. ☐ \$100 per mo. ☐ Payment in Full
- (The above monthly payment plan is based on poverty guideline)

4. Cancellations / Broken Appointments

- I agree to be responsible for notifying the Center at least 24 hours in advance if I am unable to keep my appointment. I understand that I will be charged \$100.00 (\$150.00 for nurse practitioners) for every broken appointment without the 24 hour notification. If I break two appointments without advance notice the Center may not schedule a third appointment.
- I understand that should my circumstances change, I am responsible to inform Eastern Montana Community Mental Health Center. I understand that I will be billed full fee until the updated financial information has been received by the Center. I also understand that should I fail to make the above agreed upon payments, Eastern Montana Community Mental Health Center can pursue legal action to collect the outstanding balance in my account, and I will be responsible for court costs and attorney fees.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS, AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE AND CORRECT, AND I AGREE TO THIS PAYMENT CONTRACT AND ITS TERMS.

Signature of client or responsible party: _____ Date: _____

Address of client or responsible party: _____

Signature of Staff: _____ Date: _____



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12



PICA

[illegible]

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary in process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 41 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1080; 5 USC 2101 et seq; and 38 USC 901 et seq; 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primarily to Federal programs, and as otherwise necessary to administer these programs. Federal law makes it mandatory to disclose information about the benefits you have to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil action; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3201-3212 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review this information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Paperwork Clearance Officer, Mail Stop C1-26-05, Baltimore, Maryland 21211-4260. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Eastern Montana Community Mental Health Center

ZERO INCOME VERIFICATION

Applicant's Name: _____

Present Living Arrangement:

- ☐ Homeless
- ☐ Alone
- ☐ With family
- ☐ With friends
- ☐ Other (please explain)_____

I hereby certify that I do not individually receive income from any of the following sources:

- Wages from employment (including commissions, tips, bonuses, fees, etc.),
- Income from operation of a business;
- Rental income from real or personal property;
- Interest or dividends from assets;
- Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;
- Unemployment or disability payments;
- Public assistance payments;
- Periodic allowances such as alimony, child support, or gifts received from persons living in my household;
- Sales from self-employed resources (Avon, Mary Kay, etc.);
- Any other source not named above.

Please explain how you are paying for your housing, food, and other necessities: _____

I hereby declare that all information provided by me on this form is complete and true to the best of my knowledge and belief. I agree to notify EMCMHC of any changes in the above information as soon as possible, but within 30 days of my knowledge of the change.

Applicant's Signature: _____

Date: _____

Applicant's Address: _____

Applicant's Social Security Number: _____

Employee/Witness Signature: _____

Date: _____



Eastern Montana Community Mental Health Center

Client Acknowledgement, Consent & Behavior

Please initial below to indicate you have received, read, and understood the following:

_____ Consent for Treatment

_____ Client Rights

_____ Grievance Procedure

_____ General Aggressive Behavior Policy

_____ Smoking and Weapons

_____ Notice of Privacy Practices

_____ For CSCT Clients Only – Coordination of Care Verification: "According to Administrative Rule (37.106.1956.4), Medicaid requires providers to inform youth and their parents about mandatory coordination expectations between CSCT, home support services, and outpatient therapy. I am aware that coordination is required among providers and collaboration is intended to improve outcomes for my child."

CLIENT SIGNATURE: _____

CLIENT PRINTED NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

PARENT/GUARDIAN PRINTED NAME: _____

STAFF SIGNATURE: _____

DATE: _____

Consent For Treatment

I consent to behavioral health treatment with EMCMHC for myself/minor child/designee.

I understand all clients of EMCMHC are eligible to receive a range of services addressing substance use disorders, mental health disorders, and medical issues (as applicable) on a limited basis.

The type and extent of services I/my child receive(s) will be determined through a collaborative treatment team effort and through discussion with me/my child in the development of an individualized treatment plan.

I understand a range of behavioral health professionals, some of whom are in training, provide EMCMHC services. Designated licensed staff provides oversight to all professionals in training.

I understand the various treatments offered provide significant benefits and may pose risks, which can be discussed with the treatment team. The process of behavioral health recovery may include relapse.

I understand some areas of EMCMHC campuses are under camera surveillance to address safety and security concerns.

I understand the success of treatment is dependent upon motivation to change with the therapeutic support of EMCMHC professional staff.

I understand if I am at least 16 years of age, I may consent to receive services from EMCMHC without parental consent.

Client Rights

1. You have the right to be treated in a non-discriminatory manner with dignity and respect while receiving behavioral health services at any EMCMHC facility.
2. You have the right to be treated without regard to physical or mental disability, unless such disability makes treatment afforded by the facility non-beneficial or hazardous. Treatment will reflect both your ability to benefit from services and others' treatment rights.
3. You have the right to practice your religion of choice, insofar as such practice does not infringe on the rights and treatment of others. You have the right to be excused from any religious practice.
4. You have the right to participate in the development of an individual treatment plan and any ongoing planning of your behavioral health services. You have the right to a reasonable explanation, in terms you can understand, of your general condition; treatment objectives; the nature and significant possible adverse effects of recommended treatment; reasons this treatment is considered appropriate; and what, if any, alternative treatment services and types of behavioral health providers are appropriate and available.
5. You have the right to be free from excessive or unnecessary medication. You have the right to give informed consent to take or not take antipsychotic or other medications if they are prescribed to you, unless the court has ordered differently or an emergency situation exists where your life or the lives of others are in danger.
6. You have the right to confidential records. Although you must give written approval to allow your records to be released in most cases, there are some exceptions to this rule under state and federal law.
7. You have the right to request access to your records and the right to request corrections or amendments to your records. These and other privacy rights are explained more fully in EMCMHC's Notice of Privacy Practices.
8. You have the right to the maximum amount of privacy consistent with the effective delivery of services to you.
9. You have the right to appropriate treatment and related services under conditions that are supportive of your personal liberty.

10. You have the right to not be subjected to experimental research or other experimentation without your informed, voluntary, and written consent.
11. You have a right to be free from abuse and neglect, or threats of abuse and neglect, while receiving services at EMCMHC.
12. You have the right to a humane psychological and physical environment while receiving services at EMCMHC.
13. You have the right to receive information about EMCMHC's client grievance procedure and how to file complaints. You must be allowed to exercise this right and other rights without reprisal, including reprisal in the form of denying you appropriate, available treatment. EMCMHC recognizes that some clients may need assistance and/or support in filing their grievance. If clients request assistance in this respect, EMCMHC will provide a referral to a local client support group, a family member's support group, or a state designated advocacy agency.
14. You have the right to communication with family in emergency situations.
15. You have the right to receive services which reflect the awareness of the special needs of gender.
16. You may have additional rights listed in Montana Statute, most of which apply to inpatient settings and jail diversion programs and rights during an involuntary commitment process. A member of your treatment team will explain these rights to you if you have concerns.

Grievance Procedure

EMCMHC has established a grievance procedure for clients who believe their rights have been violated by the Center. If you feel your rights have been violated, please see any staff member to request a Grievance Form.

General Aggressive Behavior Policy

All EMCMHC Programs are designed to provide a safe place for our clients and staff. Aggressive behavior does not fit into this philosophy, and will not be tolerated at EMCMHC facilities, against EMCMHC staff, or other clients. Aggressive behavior is defined as yelling, pushing, physical fighting, throwing objects, swearing, or acting in a manner perceived to be threatening. If aggressive behavior occurs, EMCMHC will follow the following established policies and procedures.

STEP ONE: You/your child will be asked to leave the program/office for the day and you/your child will be referred to a member of your treatment team to address the aggressive behavior.

STEP TWO: You/your child will be asked to leave the program/office for one week. Prior to returning, you/your child will be required to meet with a member of your treatment team to develop a plan for adherence to the policy.

STEP THREE: You/your child will be asked to leave the program/office for 30 days. Prior to returning, you will be required to attend a treatment team meeting to evaluate appropriateness for continued participation in the program.

The Executive Director and/or Program Manager may exercise discretion in following this procedure to protect the safety of clients, staff, and the program. At any time, if behavior is deemed as causing imminent danger to yourself or others, authorities may be called to intervene.

NOTE: Due to the unique nature of 24 hour crisis programs, residential programs, detention centers, and CSCT programs additional policies will apply.

Smoking & Weapons

EMCMHC is invested in the health and well-being of clients and staff. All EMCMHC facilities are non-smoking which include all types of tobacco and e-cigarettes. No firearms or weapons are allowed at any EMCMHC facility.

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER 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. PLEASE REVIEW IT CAREFULLY.

The confidentiality of mental health, alcohol and drug abuse patient records maintained by Eastern Montana Community Mental Health Center is protected by Federal law and regulations. Generally, Eastern Montana Community Mental Health Center may not say to a person outside Eastern Montana Community Mental Health Center that a patient attends Eastern Montana Community Mental Health Center, or disclose any information identifying a patient as a mental health, alcohol or drug abuser *unless*:

- (1) You authorize the disclosure in writing;
- (2) The disclosure is allowed by a court order; or
- (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

WHO WILL FOLLOW THIS NOTICE

This notice describes Eastern Montana Community Mental Health Center's practices and that of:

- Any health care professional authorized to enter information into your treatment records.
- All departments and units of Eastern Montana Community Mental Health Center.
- All employees, staff and other Eastern Montana Community Mental Health Center personnel.
- All Eastern Montana Community Mental Health Center entities, sites and locations will follow the terms of this notice and may share health information with each other for treatment or operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION

We are committed to protecting health information about you. We create a record of the care and services you receive at Eastern Montana Community Mental Health Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Eastern Montana Community Mental Health Center. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to 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.

For Treatment. We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, counselors, therapists, or other EMCMHC personnel who have a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment. For example, our counselors may share information about you with our psychiatrist if you have symptoms of depression or other mental disorder which may affect your recovery from chemical dependency. Likewise, our psychiatrist or medical doctor may share medical information about you with our staff in order to coordinate the different things you need, such as prescriptions or lab work.

For Health Care Operations. We may use and disclose health information about you for EMCMHC operations. These uses and disclosures are necessary to run EMCMHC and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many EMCMHC patients to evaluate trends in mental health and drug and alcohol use and to assess the effectiveness of our treatment services. We may also disclose information to doctors, nurses, technicians, therapists, and other EMCMHC personnel for review and learning purposes. We may also combine the health information we have with health information from other treatment centers to compare how we are doing and see where we can make improvements in the care and services we offer. We will remove the information that identifies you from this set of health information so others may use it to study treatment services without learning who the specific patients are.

Medical Emergencies. Medical information may be disclosed to medical personnel who have a need for information about you for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

Food and Drug Administration. Medical information may be disclosed to medical personnel of the Food and Drug Administration who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

Audit and Evaluation. Health information may be disclosed for the purpose of audit or evaluation by any federal, state, or local government agency which provides financial assistance to EMCMHC or is authorized by law to regulate our activities. Health information may also be disclosed for audit and evaluation purposes to a third party payer which covers our patients, to a peer review organization performing utilization or quality control review, or is determined by our program director to be qualified to conduct the audit or evaluation activities.

Child abuse or Neglect. We may report any information about suspected child abuse or neglect to appropriate state or local authorities.

Law Enforcement. We may disclose information about you to law enforcement officers concerning a crime committed on EMCMHC premises or against any person who works for EMCMHC or a threat to commit such a crime.

Vital Statistics. We may disclose information about you relating to cause of death under laws requiring the collection of death or vital statistics or permitting inquiry into the cause of death.

Subpoena and Court Order. If we receive a subpoena to disclose information about you, we will not do so unless a court of competent jurisdiction enters an authorizing order. A court order may authorize disclosure only if the court finds that the disclosure is necessary:

- (1) to protect against an existing threat to life or of serious bodily injury;
- (2) to investigate or prosecute an extremely serious crime; or
- (3) in connection with litigation or an administrative proceeding in which you offer testimony or other evidence relating to the information.

OTHER USES OF 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 authorization. If you provide us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical 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 authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

1. 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. Usually, this includes medical and billing records, but does not include counselor's own notes (hand generated by the clinician). To inspect a copy of health information that may be used to make decisions about you, you must submit your request in writing to **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. 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 health information, you may request that the denial be reviewed. Another licensed health care professional chosen by EMCMHC 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.

2. Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by EMCMHC. To request an amendment, your request must be made in writing and submitted to: **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. In addition, you must provide a reason that supports 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 no longer available to make the amendment;
- Is not part of the health information kept by Eastern Montana Community Mental Health Center;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

3. 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 disclosures to you or which you authorized. To request an Accounting of Disclosures, you must submit your request in writing to: **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. Your request must state a time period which may not be longer than seven years and may not include dates before April 14, 2003. The first Accounting of Disclosures you request within a 12 month period will be free. For additional requests, we may charge you for the costs of providing the Accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. 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 or health care operations. **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. To request restrictions, you must make your request in writing to **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

5. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail. To request confidential communications, you must make your request in writing to **EMCMHC, Administration, Box 1530, Miles City, Montana 59301**. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. Right to a Paper Copy of This 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. To obtain a paper copy of this notice, please contact **EMCMHC, Administration, Box 1530, Miles City, Montana 59301** or call **406-234-0234**.

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 at the Reception Desk at Eastern Montana Community Mental Health Center. The notice will contain on the first page, in the top left-hand corner, the effective date. In addition, each time you are admitted to Eastern Montana Community Mental Health Center for treatment or health care services as an outpatient, 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 with EMCMHC or with the Secretary of the Department of Health and Human Services. To file a complaint with EMCMHC, contact our Privacy Officer, **Eastern Montana Community Mental Health Center, PO Box 1530, Miles City, Montana 59301**, phone number: **406-234-0234**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** Violation of the federal laws and regulations by EMCMHC is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

FEDERAL STATUTES AND REGULATIONS

This notice is issued pursuant to the following federal statutes and regulations:

Statutes: 42 U.S.C. 290dd-2

42 U.S.C. 1320d-1329d-8

42 U.S.C. 1320d-2

Regulations: 42 C.F.R. Part 2, 45 C.F.R. Subtitle A, Subchapter C, Part 160, Sections 160.101 – 164.534

If you have any questions about this notice, please contact the **Eastern Montana Community Mental Health Center, Administration, PO Box 1530, Miles City, Montana 59301**. Our phone number is **406-234-0234**.

**AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

Patient Name: _____ **Date of Birth:** _____

I hereby request and authorize

Name of Individual/Organization	Address	Phone	Fax
<hr/>			
TO RELEASE TO: _____ Client Initials	OBTAIN FROM: _____ Client Initials	EXCHANGE WITH: _____ Client Initials	

Name of Individual/Organization	Address	Phone	Fax
<hr/>			

The type and amount of information to be used or disclosed is as follows: (provide a specific and meaningful description of the information, including dates where appropriate)

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychological/Mental Status Assess.	<input type="checkbox"/> Social History
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Medical Assessment	<input type="checkbox"/> Treatment Issues
<input type="checkbox"/> Master Treatment Plan	<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Referral For Med
<input type="checkbox"/> Educational Records	<input type="checkbox"/> Medication Update	<input type="checkbox"/> Hospital Records
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Biopsychosocial Evaluations	
<input type="checkbox"/> Medical Records/Reports	<input type="checkbox"/> Billing and Insurance processes	
<input type="checkbox"/> Other: _____		

PLEASE NOTE: the client (and parent/personal representative, if applicable) must initial here _____ to authorize disclosure of records of alcohol/drug evaluation and treatment.

I have the right to inspect and copy any information being disclosed.

I understand I may revoke this authorization in writing at any time except for the extent that action has already been taken on this authorization.

This authorization will expire on the following date or event: _____
Date Patient Initials

If I fail to specify a date or event, it will expire in six months.

I understand that I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may no longer be protected by federal confidentiality rules.

I have received a copy of this authorization.

Signature of Patient **Date**

Signature of Witness **Date**

Signature of Parent/Personal Representative **Date**

If the Patient is a minor (under age 18), both the Patient and Personal Representative must sign.

Nature of the Personal Representative's authority to act for the Patient: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: If 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 the 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 patient.



Eastern Montana Community Mental Health Center

Grievance Form

TO: Program Director

FROM: _____ (name of person filing grievance).

ADDRESS: _____

TELEPHONE NUMBER: _____

I would like resolution on a possible violation of my rights at the Mental Health Center.

DATE OF INCIDENT(S): _____

SPECIFIC RIGHTS VIOLATED: _____

DESCRIBE INCIDENT(S) AND HOW RIGHTS WERE VIOLATED: _____

I DO or DO NOT (circle one) wish to have the assistance of a representative in filing this grievance. My representative will be _____.

(Representative's Name)

Signature: _____ Date: _____



Eastern Montana Community Mental Health Center

Substance Use Screening

CAGE Ages 18 and over

1. Have you ever felt you should cut down or control your drug use or drinking?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have people annoyed you by criticizing your drug use or drinking?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you ever felt bad or guilty about your drug use or drinking?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?	<input type="checkbox"/> YES <input type="checkbox"/> NO

CRAFT Ages 11-17

1. Have you ever ridden in a car driven by someone, including yourself, who was high or had been using alcohol or drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Do you ever use drugs or alcohol to relax, feel better about yourself, or to fit in?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Do you ever use alcohol or drugs by yourself, alone?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Do you ever forget things you did while using alcohol or drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Does your family or friends ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO

PRE-ADOLESCENT Ages 10 and under

1. Do you have any friends who have used alcohol or drugs of any kind in the past year?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever had more than a few sips of alcohol or taken drugs of any kind in the past year? <ul style="list-style-type: none"> • If yes to alcohol, on how many days in the last year have you used alcohol? _____ • If yes to drugs, on how many days in the last year have you used drugs? _____ 	<input type="checkbox"/> YES <input type="checkbox"/> NO

EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER

MEDICATION/ALLERGY LIST[illegible][illegible]

Behaviors and Symptoms

Reason for Seeking Treatment: *Please describe the situation or problem that led you to this Center*

Life Stressors:

- ☐ Job Loss
- ☐ Relationship Breakup
- ☐ Military Deployment (combat or support)
- ☐ Sexual/Physical Assault Victim
- ☐ Court Ordered
- ☐ Substance Use Issues
- ☐ Other (Please explain)

Referred By:

Check all that apply to you AT THE PRESENT TIME

_____ Appetite Problem

_____ Sleep Problem

_____ Feel Stressed

_____ Depressed Mood

_____ Guilt Feelings

_____ Thinking About Harming Self Today _____

Within Last 2 Weeks _____

_____ Thinking About Harming Others Today _____

Within Last 2 Weeks _____

_____ Difficulty Maintaining Friendships

_____ Difficulty Making Decisions

_____ Experience Upsetting Thoughts That Will Not Go Away

_____ Sexual Problems

_____ Self-esteem Issues

_____ Difficulty Concentrating

_____ Frequent Temper Loss

_____ Bored Most of the Time

_____ Other