



Multiple Acknowledgment Receipt Form

Client's Name: _____ IBHIS# : _____ Date: _____

ADVANCED HEALTH CARE DIRECTIVE

Part One: For Agency Staff

Background

In accordance with California Probate Code 4600 et seq. and Federal requirements under Title 42, clients 18 years of age and older shall receive information about Advance Health Care Directive and be informed of his/her right to make decisions about his/her medical treatment.

► Instructions for completing this form

- Step One: At the client's first face to face contact or clinic visit, please provide the client/significant other/guardian with a copy of the Advance Health Care Directive Fact Sheet.
- Step Two: Please complete this form and provide the client/significant other/guardian with a copy.

Ask the client and complete the following questions:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you have an Advance Health Care Provider? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you receive the Advance Health Care Directive Fact Sheet from your mental health professional? | <input type="checkbox"/> | <input type="checkbox"/> |

If "NO" please explain: _____

(If the client/significant other/guardian would like to execute an Advance Health Care Directive, please refer the individual to the resources identified on the Fact Sheet. If the client/significant other/guardian already has an Advance Health Care Directive, insert a copy into the client's chart behind the Consent for Services Form. (Support staff is to adhere a label that indicates an Advance Health Care Directive is filed in the chart.)

Part Two: For Client/Significant Other/ Guardian

I have been given a copy of the Advance Health Care Directive Fact Sheet- DMH Policy No 200.3 and Acknowledgement Form?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If "No" please explain: _____

Cl't's Initial: _____ Guardian's Initials: _____

NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a copy of Didi Hirsch Mental Health Services' Notice of Privacy Practices which explains how my health information is protected and describes other rights that I have regarding my Protected Health Information.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Cl't's Initial: _____ Guardian's Initials: _____

GUIDE TO MEDI-CAL MENTAL HEALTH SERVICES & PROVIDER LIST(S)

Consistent with regulatory requirements stated in the Code of Federal Regulations §438.10 and the California Code of Regulations §1810.360(e) "The MHP of the beneficiary shall provide its beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service from the MHP or its contract providers."

I. I acknowledge that I have received a copy of the Guide to Medi-Cal Mental Health Services	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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II. Provider List: **Select one of the following:**

- Beneficiary was offered the Mental Health Plan Provider List upon first receiving services **Accepted** **Declined**
- Beneficiary received the Mental Health Plan Provider List **upon request**

The Provider List options include Service Area Network Providers, Directly-Operated and Contracted Providers

Cl't's Initial: _____ Guardian's Initials: _____



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NO SHOW CANCELLATION POLICY

In order to assure a consistent focus in the therapy process and to assure regular use of therapy time **I/We agree to the following Didi Hirsch Mental Health Services policies:**

1. I understand that if I/we have an appointment with a Didi Hirsch staff member, and an emergency arises where I/we cannot make the appointment, I/we will call to cancel the appointment as soon as possible, preferably at least 24 hours before the Scheduled appointment.
2. **Therapy Policy:** I understand that if I miss 2 consecutive therapy sessions without prior notification to my therapist or miss 3 therapy sessions within a 3-month period, with or without notifying my therapist, I may be terminated from mental health services in the program (although I may reapply for services at a later date).
3. **Medication policy:** I understand that if I/we reschedule, cancel or miss 2 consecutive or 3 doctor's appointment in a one-year period, I/we may or be terminated from medication services and/or be referred to a medication clinic (if available).

Cl't's Initial: _____

Guardian's Initials: _____

AUTHORIZATION TO LEAVE A MESSAGE

Didi Hirsch staff are authorized to leave a detailed message at the telephone number(s) listed below if I cannot be reached.

Name(s)	Relationship	Contact #

Cl't's Initials: _____

Guardian's Initials: _____

PERSONS IN HOUSEHOLD

This information is used to complete additional forms as needed.

Name(s)	Relationship	Birthdate

PERMISSION TO CONTACT FOR FOLLOW UP

I give permission for Didi Hirsch to contact me/us, or my/our Mental Health provider as a follow up to services at 3 months, 6 months, and one year after discharge to inquire about how well the program helped me meet my/our personal goals.

Yes **No**

FIELD BASED SERVICES

Please provide the following information to any client admitted while out in the field.

- Request for Change of Provider
 ADA- Disabilities Act
 Head of Service
 Beneficiary/Client Grievance or Appeal and Authorization Form +Booklet + brochure/2 envelopes

Client/Guardian Signature/Printed Name

Agency Staff Signature/Printed Name

Client/Guardian Contact #

Client/Guardian Email

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.	Name:	IBHIS#:
	Agency: Didi Hirsch M.H.S.	Provider#: