Section 2 Application for Services

QA.2.01 Application for Services

Application for Services

YOUTH INFORMATION

Full Legal Name: _____ SSN: _____ DOB: _____

Preferred Name: _____ Age: _____Gender: _____ Preferred Pronouns: _____
(she/her, he/him, they/them)

LEGAL CUSTODY/GUARDIANSHIP ***If other than biological parent, attach proof of guardianship****

Who does the youth currently live with? (name) _____

Who has legal custody of this youth ? _____

Does anyone else share custody? ☐ Y ☐ N If Yes, Who? _____

PAYMENT AGREEMENT (Parent, Legal Guardian, or Self)

Responsible Party: _____ Relationship to Client: _____

Payment source: ☐ Medicaid ☐ Private Insurance ☐ Self-Pay with Cash or Check (subject to sliding-fee scale)

Estimated Annual Household Income: _____

YOUTH'S MEDICAID/DENALI KID CARE INFORMATION ***Attach copy of current card****

☐ Medicaid Eligible Medicaid ID Number: _____ Expiration Date: _____

☐ Not Medicaid Eligible

YOUTH'S PRIVATE INSURANCE COVERAGE INFORMATION ***Attach enlarged copies of front and back of all insurance cards.****

☐ This youth is not eligible for benefits on any private insurance plans.

☐ This youth is eligible for benefits on one or more private insurance plans.

Subscriber Name: _____ Subscriber SSN: _____

Billing Address Associated: _____ Subscriber Relationship to Client: _____

By signing I authorize Youth Advocates of Sitka, Inc. to bill my insurance company, and to release such information as it is necessary to secure payment benefits. I authorize the use of this signature on my insurance submissions for the duration of treatment, unless otherwise noted. I agree to pay for all non-covered services. I understand that it is my responsibility to ensure current coverage by Medicaid and/or private insurance and to promptly notify my Case Manager of any changes.

_____

Responsible Party Signature Date

_____

Printed Name

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____

Street Address: _____ Home Phone: _____

Mailing Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

Email Address: _____

Name: _____ Relationship: _____

Street Address: _____ Home Phone: _____

Mailing Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

Email Address: _____

EMERGENCY CONTACT NUMBERS

Name	Relationship to Youth	Phone Number

YOUTH DEMOGRAPHIC INFORMATION

Races (check all that apply)

☐ Caucasian ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ American Indian

☐ Alaska Native (please specify): _____ ☐ Other: _____ ☐ Prefer not to answer

Ethnicity

☐ Not Spanish/Hispanic/Latino/Mexican ☐ Cuban ☐ Mexican American ☐ Puerto Rican ☐ Spanish/Hispanic Latino

☐ Chicano/Other Hispanic ☐ Hispanic—specific origin unknown ☐ Unknown ☐ Prefer not to answer

Special Needs

☐ None ☐ Developmentally Disabled ☐ Moderate to severe medical problems ☐ Severe hearing loss or deaf

☐ Traumatic Brain Injury ☐ Major difficulty in Ambulating or No ambulation ☐ Organically based problem

☐ Visual impairment or blindness ☐ Other

English Fluency

☐ Excellent ☐ Good ☐ Moderate ☐ Poor ☐ Not at All ☐ No Response

Does youth/family need an interpreter? ☐ Yes ☐ No

Languages Spoken

☐ Tlingit ☐ Haida ☐ Yupik ☐ Inupiaq ☐ Alutiiq ☐ Aleut ☐ Tsimshian ☐ Athabascan ☐ Eyak ☐ Tagalog ☐ Spanish ☐ French

☐ Russian ☐ Vietnamese ☐ Hmong ☐ Korean ☐ Other (please specify): _____

Household Composition

☐ Youth lives with parents or relatives ☐ Youth lives with non-relatives ☐ Youth lives alone

Living Arrangement

☐ Private residence ☐ Foster Care ☐ Therapeutic Foster Care ☐ Crisis Residence ☐ Shelter ☐ Homeless ☐ Other: _____

School Attendance

Number of days absent in the last 30 days: _____

INFORMED CONSENT

Client Name: _____

Please read and initial the following:

I,_____, authorize Youth Advocates of Sitka, Inc., to:

_____

_____ Provide a Mental Health Assessment.
Initial

_____ Provide Mental Health Treatment.
Initial

_____ Provide Psychological Testing.
Initial

_____ Transport my child in Youth Advocates of Sitka, Inc. vehicles.
Initial

_____ Allow my child to participate in supervised potentially hazardous activities (e.g. swimming, etc.)
Initial

_____ Give consent for emergency medical treatment and routine medical appointments.
Initial

_____ Allow YAS staff to supervise self-administration of prescription medication.
Initial

_____ Other (specify): _____
Initial

By signing below I agree that:

- Youth Advocates of Sitka, Inc. staff have informed us of all information that is material to the decision to give or withhold consent. This includes information about alternative treatments and their risks, side effects, and benefits. This also includes the risks of non-treatment, the procedure for withdrawing consent, and notification that a court may override any refusal of services.
- We understand that Youth Advocates of Sitka, Inc. is required to report statistical information and data about all clients to the Department of Health and Social Services. We understand that my child's records may be used in research and statistical analysis. *All identifying materials will be renamed or masked before being used*.
- It is our understanding that we will be kept fully informed of special concerns and needs in respect to the above. We agree to hold Youth Advocates of Sitka, Inc. staff and the Board of Directors harmless for any and all claims and demands for loss arising from my child's involvement with Youth Advocates of Sitka, Inc. supervised activities. This consent is true and binding until discharged from all Youth Advocates of Sitka, Inc. programs.

_____

Client Signature (14 and older) Date

_____

Printed Name

_____

Parent/Legal Guardian Signature Date

_____

Printed Name

APPROVAL OF ADMISSION TO SERVICES

Parent/Guardian and Recipient: I have received copies of the YAS Client Bill of Rights, Notice of Privacy Practices, Grievance Procedure, and Sliding Fee Scale and have read, understand, and agree to these documents.

By signing below, I acknowledge that I agree with all the statements contained in this document and approve of admission to services.

_____

Client Signature (14 and older) Date

_____

Printed Name

_____

Parent/Legal Guardian Signature Date

_____

Printed Name

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I VOLUNTARILY AUTHORIZE THE MUTUAL EXCHANGE OF INFORMATION BETWEEN YOUTH ADVOCATES OF SITKA, INC. AND THE ENTITY LISTED BELOW:

ONLY THE FOLLOWING INFORMATION MAY BE DISCLOSED:

(Only initial next to each type of information you would like to be shared between the above-listed agencies).

_____ *Initial*	**Treatment Plans and Reviews**	_____ *Initial*	**Discharge Summaries**	_____ *Initial*	**Behavioral Health Assessments**
_____ *Initial*	**Other: _____**	_____ *Initial*	**Progress Notes**	_____ *Initial*	**Psychological Assessments**
_____ *Initial*	**Other: _____**	_____ *Initial*	**Verbal/ written exchange of all relevant information to aid in assessment and/or treatment**		

This information is being released/requested for the following purpose (Initial next to one):

_____ *Initial*	**Coordination of Care**	_____ *Initial*	**Legal Request**	_____ *Initial*	**Insurance Claim**	_____ *Initial*	**Other: _____**

Disclosure of client information is permitted with the client's written consent; however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations: (42 CFR 2.32 and 2.33). In addition, health care information that has been disclosed to you under this agreement is protected by the Health Insurance Portability and Accountability Act (HIPAA). As such, any further disclosure of health care information provided is subject to HIPAA privacy and security regulations.

THE FOLLOWING PROHIBITION ON REDISCLOSURE APPLIES TO ALL INFORMATION DISCLOSED IN ACCORDANCE WITH THIS RELEASE: 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.

I understand that this authorization will expire one year from the date signed or upon written revocation, whichever comes first. I understand that I have the right to revoke this authorization, in writing, prior to the expiration, but not retroactively.

I acknowledge that the information to be released is protected by Federal law and may include information regarding drug/alcohol abuse, sexually transmitted diseases/HIV and/or Hepatitis B. My signature below authorizes the release of this information.

Photostatic and/or facsimile copies of this authorization will be considered as valid as the original.

_____ **Client Signature (Required if 14 or older)** _____ **Date** _____ **Legal Guardian Signature (for minors)** _____ **Date**

_____

Guardian Printed Name

CLIENT BILL OF RIGHTS

Youth Advocates of Sitka, Inc. supports and protects the fundamental human, civil, constitutional, and statutory rights of each client. Each client's personal dignity and autonomy are respected in the provision of all services. These client rights cannot be taken away by YAS unless the provision of such rights is deemed unsafe to the client or others. Such a determination must be documented in writing in the client's file.

As a person receiving Youth Advocates of Sitka Behavioral Health services, you have the right:

1. To be treated with dignity, respect and not be discriminated against based on race, culture, age, sex, spiritual beliefs, national origin, sexual orientation, disability, or psychological characteristics.
2. To ask questions and get answers about services.
3. To be in a safe and healthy environment that is free from verbal, physical, emotional, psychological, or financial abuse, or other harsh or unfair treatment including harassment, retaliation, physical punishment, neglect, and humiliating, threatening or exploiting actions.
4. To be protected from all forms of sexual abuse/harassment including gestures, verbal or physical, that reference sexual acts or sexuality, or that objectify any individual.
5. To confidentiality as outlined in the HIPPA regulations such as:
    i. Deciding who else can see your records, with several exceptions. Those who do not need to ask your permission are: YAS staff who are involved in your treatment or to whom you are referred for treatment, people providing emergency medical care, an attorney representing you at a commitment hearing, a court, people conducting program or utilization reviews, or third party payers (those who pay for your treatment). These people may only see as much information as they need for the specific purpose requested.
    ii. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals. Individuals shall not be required to disclose confidential or privileged information other than diagnosis, prognosis, type of treatment, time and length of treatment, and cost.
6. To receive treatment in the least restrictive setting - one that provides the most freedom appropriate to your treatment needs.
7. To privacy, and to the assurance that any intrusive procedures will be administered in a safe manner, with consideration given to the physical, developmental, and abuse history of the person served. These assurances and considerations include searches of rooms and/or belongings, pat downs for contraband, etc. YAS residential programs have more detailed policies for these types of activities.
8. To participate in regularly scheduled treatment review meetings in which you will be informed of your treatment progress and prognosis and to provide input into decisions about treatment, goals and services.
9. To receive quality case coordination such as:
    i. Timely completion of needed assessments and paperwork.
    ii. Scheduling of appointments.
    iii. Help access needed services.
    iv. Regular communication with parent(s) or guardian(s) and other family members, and others on the treatment team.
    v. Prompt communication among appropriate individuals regarding any incidents or emergencies which may occur.
10. To request specific forms of treatment.
11. To refuse treatment or service unless ordered by the Court to participate. Refusal of treatment services may result in discharge from the program.
12. To have rules, regulations, program expectations, and other information about your treatment explained in a manner that is understandable.
13. To receive a written summary of treatment including discharge and transitional plans.
14. To receive adequate medical care.
15. To have access to a full array of behavioral health clinical and rehabilitative services as prescribed by a mental health clinician and as available at YAS or in the local community.
16. To be informed about the rules that may result in discharge from YAS programs if violated.
17. To know the name of the medication(s) you are taking, why you are taking it, and what its possible side effects might be. You also have the right to refuse to take medication if you choose. (Note: Discontinuation may result in program discharge based on the advice of a medical provider or clinician).
18. To have your family involved in your treatment, if there are no safety issues related to family member involvement. You can also refuse family participation in your treatment of anyone other than your legal guardian, if you choose.
19. To make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result. You can also file a grievance according to the YAS client grievance policy if you are not satisfied with the response to a complaint.
20. To have access to educational and/or vocational opportunities as appropriate.
21. To access and participate in self-help groups, and work with a Guardian ad Litem, Tribal Advocate, advocacy services, and/or legal services when available and necessary.
22. To review your records, after making a request to your clinician in writing, [1] with two exceptions:
    i. Limited portions of your records can be withheld from you if your clinician has determined that seeing specific information would be harmful to your treatment, or
    ii. If specific information reveals the identity or breaks the trust of someone who has provided information in confidence.
23. To visit and communicate privately with family members, send and receive personal mail unopened, and have access to a telephone when appropriate and in compliance with applicable laws and court orders. These rights are subject to program-specific rules and guidelines and may be restricted based on concerns for emotional and/or physical safety deemed by your Clinician or Treatment Team.
24. To meet and participate with social, religious, and community groups of your choice.

---

[1] Federal law (United States Code, Title 42, §§290dd-2 [1992]) and the Federal regulations that implement it -- Title 42, Part 2, of the Code of Federal Regulations (42 C.F.R. Part 2), and Alaska Statute - AS 08.29.200. Confidentiality of Communications.

25. To receive and examine an explanation of billing, regardless of payment source.
26. To participate fully in decisions regarding your discharge from a program and receive advance notice regarding the proposed discharge, unless your behavior threatens the well-being of another person.
27. To coordinate planning for aftercare services including assistance in obtaining another place to live prior to discharge from a residential program.
28. To refuse to be involved in research projects, and to receive full disclosure if YAS programs are involved in research programs that involve specific clients or client information.

As a person receiving Youth Advocates of Sitka Behavioral Health services, you have the responsibility:

1. To actively participate in treatment.
2. To assist in always maintaining a safe and therapeutic environment and refrain from hurting yourself or others.
3. To inform your therapist and/or YAS staff member, working directly with you and your treatment team, of emotions, events, or commitments, which may affect treatment.
4. To maintain the confidentiality of other clients you may encounter at YAS facilities.
5. To be on time for appointments and/or give 24-hour notice if you cannot make an appointment.
6. To provide insurance information, Medicaid cards, or financial information to determine rates. Failure to provide this information may result in an obligation to pay for the full cost of treatment services.

Notice of Privacy Practices

For Your Protection
This notice describes the medical information that may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Health Care Information is Private

We understand that the information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.

2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees and Shares My Health Care Information?

Your health care givers, such as nurses, doctors, therapists, and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later. We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How is Payment Made?

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid for your health care services.

May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information. If you think some of your health care is wrong, you may ask in writing if we correct or add it to it. You may ask if the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information.

What if My Health Care Information Needs to Go Somewhere Else?

You may ask for your health care information sent to others. You will be asked to sign a separate form, called release of information (ROI), permitting your health care information to go to them.

The ROI tells us what, where, and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old and, by law, you can give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we must share health care information, even if you do not sign an authorization form. We always report:

1. contagious diseases, birth defects and cancer

2. firearm injuries and other trauma events

3. reactions to problems with medicines or defective medical equipment

4. to the police when required by law

5. when the court orders us to
6. to the government to review how our programs are working
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs
8. to Workers Compensation for work related injuries
9. birth, death and immunization information
10. to the federal government when they are investigating something of relevance.
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

May I Have a Copy of This Notice?

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan.

Questions or Complaints

If you have questions or feel your privacy rights have been violated, you can contact the Executive Director by calling (907) 747-3687 or by writing to Youth Advocates of Sitka, Inc., 805 Lincoln Street, Sitka, AK 99835.

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaints made to Youth Advocates of Sitka, Secretary of Health and Human Services or Office of Civil Rights.**

Client Grievance Policy and Procedure

Policy:

It is the policy of Youth Advocates of Sitka, Inc. to provide clients (and family members and/or guardians in the case of minors) the opportunity to file grievances, and YAS, Inc., will treat all grievances as genuine and pursue a resolution. The grievance process will be available to all clients without regard to services used or program and to all consumers denied access to services. YAS, Inc. staff will clearly explain the policy to all clients and families upon entry to services. Each family will also be given a simple language document (DBH approved) that outlines procedures, rights, and responsibilities under the policy. A signed form confirming that the client and family received this document and understands the policy will be part of the client's permanent file and copies given to the client and family. In addition, the policy, procedures, and resources will be prominently displayed at all facilities.

Agency Responsibilities:

1. YAS, Inc. will provide a Client Grievance Form with which any client and/or family may use to file a grievance. This form will include an optional waiver of confidentiality. YAS, Inc. will also accept grievances by phone or in person. A staff member will complete a Client Grievance Form if taken via phone or in person (indicating so on the form).

2. YAS, Inc. will maintain separate grievance files that contain all documents related to grievances and record all actions resulting from grievances.

3. All grievances will be reported to the Board of Directors.

4. Client confidentiality will be maintained throughout the process.

Procedures:

1. Once a grievance is received, the Executive Director will respond to the grievance, in writing, within 5 days. If the Executive Director is unable to respond within 5 days, the client will receive a written explanation from the Executive Director.

   Any grievance involving abuse or neglect or any description, or unnecessary seclusion or restraint will be investigated and reported immediately to the Board of Directors and the Department of Behavioral Health and/or Office of Children's Services.

2. The grievance process may also include the following:

   i. Meet with the staff member involved directly (with the staff supervisor present if the client wishes) and/or meet with the staff member's supervisor directly.

   ii. If the grievance is still unresolved after meeting with the staff member and/or the staff member's supervisor involved, then the grievance will go to the Executive Director.

   iii. If the grievance is still unresolved after meeting with the Executive Director, then the grievance will go to the Board of Directors.

Grievances unresolved to the client's satisfaction within 30 days shall be reported to the DBH Regional Coordinator pursuant to AS 47.30.660(b)(12).

Client Grievance Policy Questions and Answers

How do I file a complaint or concern?

You can make your complaint two ways:

1. Fill out the Youth Advocates of Sitka, Inc. Client Grievance Form.
2. Contact the Executive Director by phone or in person.

Youth Advocates of Sitka, Inc. believes that all clients have the right to file grievance without intimidation. We will not prevent any client from filing a grievance or retaliate in any way.

Can I have someone else present during the grievance process?

Yes, you can. You may have an advocate present during all steps of the grievance process. We can assign a staff member to help you during the grievance process and/or you can choose a staff member to help you. You can also seek outside help. A list of organizations that may be able to help you include:

1. Disability Law Center
2. Alaska Mental Health Consumer Web
3. NAMI Alaska

What if my grievance is still unresolved after going through the process?

If your grievance is still unresolved to your satisfaction within 30 days, your grievance will be reported to the Department of Behavioral Health Regional Coordinator pursuant to AS 47.30.660(b)(12).

What will happen if I submit a grievance?

We will maintain a file of each grievance we receive. The file will contain all documents related to the grievance and record all actions resulting from the grievance. All grievances will be reported to the Board of Directors. Throughout the process, we will maintain client confidentiality.

Client Grievance Form

Today's Date: ____ /____ /____

First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ Zip Code: _____ Telephone: _____

Grievance Information

Date of Incident: ____ / ____ / ____ Time of Incident: _____

Location: _____

Staff Member Name: _____

Client Name (if other than individual completing form): _____

What Happened? (Please Provide as much information as possible)

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Printed Name Signature Date

Form Received by: _____ Name of Supervisor: _____

Date Review Completed: _____ Date Response Given to Client: _____

Written Response to Grievance: _____

_____

_____

_____

Frequently Asked Questions About Payment Information

Our family (or child) has Medicaid (or Denali Care). Will we still be billed?

No. If your family is eligible and maintains coverage through Medicaid/Denali Care, you will not be billed. If your Medicaid lapses or you have not yet applied, you will be responsible for payment until Medicaid coverage is secured.

Our family does not qualify for Medicaid, but we have good health insurance coverage. Will it pay for services at your organization?

No. Private health insurance plans do not pay for non-clinical or residential services, including case management and in-school support services. Additionally, if the health insurance plan covers some clinical services, most plans require that the services be provided by a licensed clinician. Each plan is different, so it is beneficial for us to have your health insurance information before services begin to allow our Billing Manager time to determine which services are covered.

If we do not qualify for Medicaid and our private health insurance does not cover the full cost of services, how much will our family have to pay for services?

If you do not qualify for Medicaid, you will be responsible for paying the full cost of services (minus any amount that your private health insurance plan covers).

When is payment due?

We require that services be pre-paid each month. Services will not be provided if they have not been paid in advance.

What if we cannot afford to pay the full cost of services at Youth Advocates of Sitka?

If you do not qualify for Medicaid and cannot afford to pre-pay the full cost of services per month, we would be glad to make a referral for services to another mental health provider.

Why do Youth Advocates of Sitka bill clients for services that it provides?

We need to ensure that the costs of providing services are covered so that we can continue to provide services to youth and their families.

Don't grants cover the cost of services?

Unfortunately, no. Our grants only cover a very small portion of the overall cost of providing services and do not cover direct services.

List of Service Costs

Service Code	Admission Service	Cost
H0046	Client Status Review Screening Tool	$0
T1016 T1016/95	Case Management (per 15 minutes)	$33.73
T1023	Alaska Screening Tool	$149.40
T1007 V2 T1007 V2/95	Treatment Plan Development	$198.70
H0031* H0031/95*	Behavioral Health Assessment (BHA) (per assessment every 6 months) **	$537.79
H0031-HH*	Integrated Mental Health & Substance Use Intake Assessment *	$618.46
	Services that may be provided throughout treatment**	
90837 90837/95 90837/XE 90837/FQ 90837/XU	Psychotherapy, Individual (per hour)	$160.59
90832 90832/95 90832/XE 90832/FQ 90832/XU	Psychotherapy, Individual (16 – 37 minutes)	$80.29
90834 90834/95 90834/XE 90834/FQ 90834/XU	Psychotherapy, Individual (45 minutes)	$120.45
90846 90846/95	Psychotherapy, Family, w/o patient (per hour)	$168.93
90846/U7 90846//U7/95	Psychotherapy, Family, w/o patient (16 – 37 minutes)	$84.46
90847 90847/U7 90847/U7/95	Psychotherapy, Family, with patient (per hour)	$164.11
90847/U7 90847/U7/95	Psychotherapy, Family, with patient (per 30 minutes)	$81.95
90853/U7 90853/U7/95	Psychotherapy, Group (per hour)	$124.44
90853/U7 90853/U7/95	Psychotherapy, Group (per 30 minutes)	$64.24

H2020 V2	Therapeutic Treatment Homes (Daily)	$321.77
H2021 V2	Community and Recovery Support Services – Individual (hourly)	$108.80
H2021 HQV2	Community and Recovery Support Services – Group (hourly)	$39.04
T2033 V2	Children's MH Residential Treatment Level 1 (daily)	$579.90
T2033 TF V2	Children's MH Residential Treatment Level 2 (daily)	$656.97
H0031; H0031/95	Behavioral Health Assessment (per session, annually) **	$537.79
H0023	Intensive Case Management (per hour)	$122.60
T1007 V2	Treatment Plan Development/Review	$198.70
H2019 HQ	Group Therapeutic Behavioral Services (per hour)	$59.16
H2019	Individual Therapeutic Behavioral Services (per hour)	$126.04

*Either a Behavioral Health Assessment or an Integrated Mental Health and Substance Abuse Intake Assessment will be administered upon admission, not both.

**frequency and types of services provided will be based on individual client need and clinical recommendations

QA.2.02 Client Grievance Form

Client Grievance Form

Today's Date: ____ /____ /____

First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ Zip Code: _____ Telephone: _____

Grievance Information

Date of Incident: ____ / ____ / ____ Time of Incident: _____

Location: _____

Staff Member Name: _____

Client Name (if other than individual completing form): _____

What Happened? (Please Provide as much information as possible)

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Printed Name Signature Date

Form Received by: _____ Name of Supervisor: _____

Date Review Completed: _____ Date Response Given to Client: _____

Written Response to Grievance: _____

_____

_____

QA.2.03 Client Bill of Rights

CLIENT BILL OF RIGHTS

Youth Advocates of Sitka, Inc. supports and protects the fundamental human, civil, constitutional, and statutory rights of each client. Each client's personal dignity and autonomy are respected in the provision of all services. These client rights cannot be taken away by YAS unless the provision of such rights is deemed unsafe to the client or others. Such a determination must be documented in writing in the client's file.

As a person receiving Youth Advocates of Sitka Behavioral Health services, you have the right:

1. To be treated with dignity, respect, and not be discriminated against based on race, culture, age, sex, spiritual beliefs, national origin, sexual orientation, disability, or psychological characteristics.
2. To ask questions and get answers about services.
3. To be in a safe and healthy environment that is free from verbal, physical, emotional, psychological, or financial abuse, or other harsh or unfair treatment including harassment, retaliation, physical punishment, neglect, and humiliating, threatening or exploiting actions.
4. To be protected from all forms of sexual abuse/harassment including gestures, verbal or physical, that reference sexual acts or sexuality, or that objectify any individual.
5. To confidentiality as outlined in the HIPPA regulations such as:
    i. Deciding who else can see your records, with several exceptions. Those who do not need to ask your permission are: YAS staff who are involved in your treatment or to whom you are referred for treatment, people providing emergency medical care, an attorney representing you at a commitment hearing, a court, people conducting program or utilization reviews, or third party payers (those who pay for your treatment). These people may only see as much information as they need for the specific purpose requested.
    ii. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals. Individuals shall not be required to disclose confidential or privileged information other than diagnosis, prognosis, type of treatment, time and length of treatment, and cost.
6. To receive treatment in the least restrictive setting - one that provides the most freedom appropriate to your treatment needs.
7. To privacy, and to the assurance that any intrusive procedures will be administered in a safe manner, with consideration given to the physical, developmental, and abuse history of the person served. These assurances and considerations include searches of rooms and/or belongings, pat downs for contraband, etc. YAS residential programs have more detailed policies for these types of activities.
8. To participate in regularly scheduled treatment review meetings in which you will be informed of your treatment progress and prognosis and to provide input into decisions about treatment, goals and services.
9. To receive quality case coordination such as:
    i. Timely completion of needed assessments and paperwork.
    ii. Scheduling of appointments.
    iii. Help accessing needed services.
    iv. Regular communication with parent(s) or guardian(s) and other family members, and others on the treatment team.
    v. Prompt communication among appropriate individuals regarding any incidents or emergencies which may occur.
10. To request specific forms of treatment.
11. To refuse treatment or service unless ordered by the Court to participate. Refusal of treatment services may result in discharge from the program.
12. To have rules, regulations, program expectations, and other information about your treatment explained in a manner that is understandable.
13. To receive a written summary of treatment including discharge and transitional plans.
14. To receive adequate medical care.
15. To have access to a full array of behavioral health clinical and rehabilitative services as prescribed by a mental health clinician and as available at YAS or in the local community.
16. To be informed about the rules that may result in discharge from YAS programs if violated.
17. To know the name of the medication(s) you are taking, why you are taking it, and what its possible side effects might be. You also have the right to refuse to take medication if you choose. (Note: Discontinuation may result in program discharge based on the advice of a medical provider or clinician).
18. To have your family involved in your treatment, if there are no safety issues related to family member involvement. You can also refuse family participation in your treatment of anyone other than your legal guardian, if you choose.
19. To make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result. You can also file a grievance according to the YAS client grievance policy if you are not satisfied with the response to a complaint.
20. To have access to educational and/or vocational opportunities as appropriate.
21. To access and participate in self-help groups, and work with a Guardian ad Litem, Tribal Advocate, advocacy services, and/or legal services when available and necessary.
22. To review your records, after making a request to your clinician in writing,1 with two exceptions:
    i. Limited portions of your records can be withheld from you if your clinician has determined that seeing specific information would be harmful to your treatment, or
    ii. If specific information reveals the identity or breaks the trust of someone who has provided information in confidence.
23. To visit and communicate privately with family members, send and receive personal mail unopened, and have access to a telephone when appropriate and in compliance with applicable laws and court orders. These rights are subject to program-specific rules and guidelines and may be restricted based on concerns for emotional and/or physical safety deemed by your Clinician or Treatment Team.

24. To meet and participate with social, religious, and community groups of your choice.
25. To receive and examine an explanation of billing, regardless of payment source.
26. To participate fully in decisions regarding your discharge from a program and receive advance notice regarding the proposed discharge, unless your behavior threatens the well-being of another person.
27. To coordinate planning for aftercare services including assistance in obtaining another place to live prior to discharge from a residential program.
28. To refuse to be involved in research projects, and to receive full disclosure if YAS programs are involved in research programs that involve specific clients or client information.

As a person receiving Youth Advocates of Sitka Behavioral Health services, you have the responsibility:

1. To actively participate in treatment.
2. To assist in always maintaining a safe and therapeutic environment and refrain from hurting yourself or others.
3. To inform your therapist and/or YAS staff member, working directly with you and your treatment team, of emotions, events, or commitments, which may affect treatment.
4. To maintain the confidentiality of other clients you may encounter at YAS facilities.
5. To be on time for appointments and/or give 24-hour notice if you cannot make an appointment.
6. To provide insurance information, Medicaid cards, or financial information to determine rates. Failure to provide this information may result in an obligation to pay for the full cost of treatment services.

QA.2.04 Notice of Privacy Practices

Notice of Privacy Practices

For Your Protection
This notice describes the medical information that may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Health Care Information is Private

We understand that the information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

3. We must keep your health care information from others who do not need it.

4. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees and Shares My Health Care Information?

Your health care givers, such as nurses, doctors, therapists, and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later. We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How is Payment Made?

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid for your health care services.

May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information. If you think some of your health care is wrong, you may ask in writing if we correct or add it to it. You may ask if the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information.

What if My Health Care Information Needs to Go Somewhere Else?

You may ask for your health care information sent to others. You will be asked to sign a separate form, called release of information (ROI), permitting your health care information to go to them.

The ROI tells us what, where, and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old and, by law, you can give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we must share health care information, even if you do not sign an authorization form. We always report:

12. contagious diseases, birth defects and cancer

13. firearm injuries and other trauma events
14. reactions to problems with medicines or defective medical equipment
15. to the police when required by law
16. when the court orders us to
17. to the government to review how our programs are working
18. to a provider or insurance company who needs to know if you are enrolled in one of our programs
19. to Workers Compensation for work related injuries
20. birth, death and immunization information
21. to the federal government when they are investigating something of relevance.
22. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

May I Have a Copy of This Notice?

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan.

Questions or Complaints

If you have questions or feel your privacy rights have been violated, you can contact the Executive Director by calling (907) 747-3687 or by writing to Youth Advocates of Sitka, Inc., 310 Price Street, Sitka, AK 99835.

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaints made to Youth Advocates of Sitka, Secretary of Health and Human Services or Office of Civil Rights.**

Acknowledgement of Receipt of YAS Notice of Privacy Practices

Printed Name of Client/Patient	Client/Patient Date of Birth

Please indicate that you have received a copy of the YAS Notice of Privacy Practices by checking below and signing your name*:

☐ I have received a copy of the YAS Notice of Privacy Practices

X Signature of Client/Patient or Personal Representative (Or Witness if signature is by mark)	Date Acknowledgement Signed
Printed Name of Personal Representative or Witness	Description of Personal Representative's Authority

*Personal Representative signature required if client/patient is a minor or adult who is unable to sign this form.

YAS Staff Use Only: This portion to be completed by YAS staff ONLY if unable to obtain client/patient acknowledgement signature above OR if acknowledgement was translated for a client. Indicate that the acknowledgement was translated, or the reason acknowledgement was not obtained by checking the appropriate box, entering other information (if necessary) and print staff name and translator name (if necessary).

☐ Acknowledgement was translated for Client/Patient by:

_____ (Printed Name of Translator)

An attempt was made to obtain acknowledgement for receipt of the YAS Notice of Privacy Practices. Acknowledgement was not obtained because:

☐ Client/Patient declined to sign acknowledgement

☐ Other (explain): _____

X Printed Name of YAS Staff	Date