ADMISSION FORM

Case #

Referral date: **Admit Date:**

☐ Admission ☐ Update ☐ HCC ☐ OCC ☐ Uplift ☐ Linkage ☐ Health Now

☐ Emergency ☐ Reopen ☐ MCC ☐ LCC ☐ WPA ☐ WINGS ☐ School Based

Client Name Last First MI

Preferred Name

Street

Gender
☐ Male
☐ Female
☐ Other _____

Date of Birth

City **State** **Zip**

Client Social Security #

Parent/Guardian Name(Minor services)

Parent/Guardian Social Security Number

Home Phone **Mobile Phone**

Reminder call: ☐ Yes ☐ No

#TOTAL Persons in Household

 # persons under 18

Race
☐ White
☐ Black/African Am
☐ Native Alaskan
☐ Native Hawaiian
☐ Asian
☐ Other

Ethnicity
☐ Puerto Rico
☐ Mexican
☐ Cuban
☐ Other Hisp
☐ Not Latino

County / Residence
☐ - Butler ☐ - Warren
☐ - Preble ☐ - Clinton
☐ - Hamilton ☐ - Clermont

Marital Status
☐ Single ☐ Divorced
☐ Married ☐ Widowed

Employment
☐ Full Time
☐ Part Time
☐ Unemployed
☐ Homememaker
☐ Student
☐ Retired
☐ Disabled

Email Address

Emergency contact and number

Do you feel like harming yourself or someone else today? ☐ Yes ☐ No

Administrative staff only:

Was MPP Run? ☐ Yes ☐ No

Income Needed ☐ Yes ☐ No

Medicare Plan / Insurance Plan:

ID#

Needed:
☐ Photo ID
☐ Insurance Card

Income Source
☐ Wages/Salary
☐ SSI / SSDI
☐ Other: _____

Monthly Household Income

Co Insurance %

Copay $

Managed Medicaid / MITS

ID#

Clinical staff only:

Interpreter Needed? ☐ Yes ☐ No

Language Spoken

HN Eligible? ☐ Yes ☐ No

Emergency Contact Release signed ☐ Yes ☐ No

Client Specific Notes

Revised Date: March 2020

Butler Behavioral Health Checklist

Client Name: _____ **Date of Orientation** _____

Client #:_____

This information is in the packet received at the time of the assessment.

X	Hours of operation
X	Code of Ethics
X	Rules, regulations and expectations – copy received
X	Client rights and responsibilities of person served – copy received, reviewed with client
X	Client fee system explanation, financial arrangements, fees, obligations
X	Grievance and appeal procedures/complaint process – copy received
X	Full disclosure on all levels, types and duration of services and activities
X	Reports to referral sources for mandated persons served
X	Tobacco policy
X	Policy on seclusion and restraint
X	Hours of Operation HIV, Hepatitis B and C, Tuberculosis – copy received Policy re: informing primary provider of a communicable disease
X	Policy re: illicit/licit drugs/weapons brought on the premises

This information is explained by the intake therapist:

	Attendance and Timeliness policy
	Access to after-hours services
	Identification of counselor/service coordinator
	Ways in which client input is given re: quality of care, outcomes, and satisfaction
	Copy of program rules to client specifying and restrictions the program may place on a person, events, behaviors or attitudes that may lead to a loss of privileges and the means by which the lost rights/privileges can be regained by the client
	Developing feasible goals and achievement of outcomes
	Confidentiality policies 42 CFR Part 2 and Part B, paragraph 2.22 – copy received
	Site and safety organization (familiarization with premises, emergency exits and/or shelters, fire suppression equipment, first aid kits, etc.
	Purpose and process of assessment
	Description of how the individual plan is developed and client participation
	Information on discharge/transition criteria and procedures
	Aftercare and discharge/transition planning
	Person responsible for service coordination
	Education on advanced directives, as appropriate
	Policy re: Transportation (consent to transport)

_____ _____

Therapist Signature **Client Signature**

Butler Behavioral Health

Prevention. Healing. Wellbeing

INFORMED CONSENT STATEMENT

Any behavioral health service is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in behavioral health services, you have certain rights that are important for you to know about because these are your services, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As your provider, BBHS has corresponding responsibilities to you.

BBHS Responsibilities to You as Your Provider

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your behavioral health service. BBHS cannot and will not tell anyone else what you have said during services, or even that you are in behavioral health services without your prior written permission. Under the provisions of the Health Care Information Act of 1992, BBHS may legally speak to another health care provider or a member of your family about you without your prior consent, but BBHS will not do so unless the situation is an emergency. Your BBHS team will follow all policies and procedures for emergencies, including but not limited to medical emergencies. BBHS will always act to protect your privacy even if you do release BBHS in writing to share information about you. You may direct BBHS to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a behavioral health service session with appropriate releases.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever BBHS transmits information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

The following are legal exceptions to your right to confidentiality. BBHS would inform you of any time when BBHS will have to put these into effect.

1. Threat of harm to self
2. Threat of harm to others
3. Abuse or neglect of a child or vulnerable adult,
4. Court order to BBHS to release information

II. Record-keeping.

BBHS keeps records of each contact, which includes but not limited to dates and times of contact, interventions happened in session, your response to interventions, and the topics discussed.

III. Diagnosis

Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. According to your Comprehensive Diagnostic Assessment, a diagnosis will be noted as a presenting problem. Shall you have any questions or concerns regarding the diagnosis, please consult with your assigned clinician and we will be glad to review it to learn more about the criteria regarding the diagnosis.

IV. Other Rights

You have the right to ask questions about anything that happens while obtaining behavioral health services. We are always willing to discuss how and why your provider decided to implement that particular intervention, and to look at alternatives that might work better. You can feel free to ask your BBHS team to try something that you think will be helpful though the BBHS team has the right to refuse due to clinical discretion that may lead to further harm or out of the scope of the providing team. You can request a clinical team case collaboration if you feel that the interventions or your provider is not right for you. You are free to leave services at any time and your BBHS team will assist you with a discharge plan.

Your Responsibilities as a Client of BBHS

Attend and participate in all services identified in your Individualized Service Plan (ISP).

Provide all accurate, up-to-date financial information for your household and payor source to assist in behavioral health service reimbursement. **I understand that any refusal or neglect to provide current financial data for behavioral health services would prompt a discontinuation from ALL services at BBHS and a referral to another provider outside of BBHS to best meet your need would follow.**

By signing this Informed Consent you are also GIVING BBHS PERMISSION TO TREAT YOU and that you have understanding of the following:

- I understand that all services I receive at the Butler Behavioral Health Services Center will be provided by a qualified professional who is licensed in the State of Ohio or credentialed as a Qualified Mental Health Specialist (QMHS), and/or supervised by a qualified mental health professional.

- I understand that I will receive services which are consistent with a written, Individualized Service Plan which my licensed clinician and I will develop together with full consent. I understand that I will always have the right to decide if I will use services which are recommended.

- I understand that I will be ***advised of the possible benefits and risks of any services recommended***, if there are generally recognized risks. I will also be advised on any known risks or benefits of not receiving services.

- Further, I am aware that I may refuse or withdraw consent for part or all of my behavioral health services at any time. I have been advised that my licensed clinician will discuss with me any concerns about my services or my consent to continue behavioral health services. If I decide to discontinue services or withdraw consent for a particular service, my BBHS team will discuss with me the possible consequences and implications.

- I consent to be transported by authorized staff when appropriate according to my service plan.

As with all diagnoses, it is imperative that you follow all service recommendations identified from the Comprehensive Diagnostic Assessment for the most optimum benefit of reducing symptoms of your identified disorder. Based on those service recommendations and your input, an Individualized Service Plan has be developed indicating the interventions, services, frequency and duration of the appropriate level of care.

As stated above, you are aware that you may refuse or withdraw consent for part or all of your service recommendations at any time. **Due to the nature of your identified disorder and any other disorder, any refusal or withdraw from a service/treatment recommendation would prompt a referral to another provider outside of BBHS to best meet your need and termination from all services at BBHS would follow post referral.**

Client Consent to Behavioral Health Services

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process to my identified payor source. I understand my rights and responsibilities as a client, and BBHS's responsibilities to me. I agree to undertake behavioral health services with Butler Behavioral Health Services as indicated in my Individualized Service Plan. I know I can end services at any time I wish and that I can refuse any requests or suggestions made by BBHS which would lead to a referral with another provider.

_____ _____

Client Signature Date

_____ _____

Signature of Parent(s)/Guardian Signature of Witness

Rev. 08/2020

Mental Health Recovery Board
Serving Warren & Clinton Counties

MHRB RESIDENCY VERIFICATION FORM

Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB) uses public funds to pay for behavioral health services for local citizens based upon need. The benefits that MHRB provides are available to the residents of Warren and Clinton Counties through a network of contract providers. The purpose of this form is to verify benefit eligibility based upon residency. All individuals seeking coverage of services by MHRB (other than emergency or crisis) need to complete it and provide proof of county residency. In most cases, residency is determined by a person's physical address in the county and the intent to remain there.

Date Client Applied for Services: _____

Client's County of Residence: _____

Client's Name (last; first): _____

Client's Current Physical Address: _____

Client's Home Address if different than above: _____

Client is: ☐ Adult ☐ Minor
☐ College Student ☐ Jail ☐ Migrant Worker ☐ Homeless or Resides at Homeless Shelter (Document Attached) ☐ Resident of a MH or SUD residential facility, Group home, ACF, ICF, Recovery House
If Minor, legal custody status: ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): _____ Name of Parent/Legal Custodian: _____ County of Residence of Parent/Legal Custodian:_____ Address of Parent/Legal Custodian (if different than above):_____
If College Student, home address if different from above: _____
If in jail, home address at time of arrest:_____

An Individual's or Parent/Legal Custodian/Guardian's signature on this form along with the below documentation shall be sufficient for establishing residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.

SIGNATURES OF CLIENT OR PARENT/LEGAL CUSTODIAN/GUARDIAN (IF APPLICABLE)

Signature of Individual:	Date
If applicable, Printed Name and Signature of Parent/Legal Custodian/Guardian:	Date

FOR PROVIDER USE:

The following documentation is valid to verify an individual's county residency. Provider must copy any documentation the individual used to verify residency, that is consistent with the list below, and a copy must be part of the individual's record. In the case of a minor, documentation from parent/legal custodian shall be used.

☐ Current Ohio Driver's License with County Address same as Declared County Residence	☐ Current Utility Bill (gas, electric, water) with County Address same as Declared County Residence in clients' name*
☐ Current Ohio Personal Identification Card with County Address same as Declared County Residence	☐ Current Voter Registration Card that shows County Address same as Declared County Residence
☐ Current Ohio Medicaid Care that shows County Address same as Declared County Residence	☐ Current Mortgage Statement or Payment with County Address same as Declared County Residence in client's name*
☐ Current SSI/SSDI Benefit Eligibility Statement with County Address same as Declared County Residence	☐ Current Rent receipt with County Address same as Declared County in client's name*
☐ Current Pay Stub with Address same as Declared County in client's name*	* **DOCUMENTS MUST BE WITHIN THE LAST 60 DAYS.**

Provider must supply this form to GOSH Administrator (along with any requested documentation) when enrolling a client in which:

- The legal county of residence of the Individual as noted on the enrollment form (minor or adult, out-of-county) does not indicate Warren or Clinton Counties.
- The physical address of the Individual as noted on the enrollment form does not match the legal county of residence of the Individual (example: domestic violence shelter case, Individual temporarily living with relatives, child or adult, out-of-county).
- The minor's physical address as noted on the enrollment form does not match the legal custodian's address (minor only, in or out-of-county).

BUTLER BEHAVIORAL HEALTH SERVICES, INC.

FEE AGREEMENT

Date: _____ My Primary Therapist/ Case Managers: _____

1. This agency offers multiple Mental Health Services with different hourly charges. Fees are subject to change without notice. A current list of services and full cost charges are available upon request.

2. The Mental Health Levy and other State and Federal assistance may benefit me by reducing my fee, if I meet certain qualifications regarding household size and gross income.
   ☐ I have been a resident of _____ County for more than 90 days.
   ☐ I have moved to _____ County in the last 90 days. It is my intent to continue to reside here.

3. I understand that if I have provided the information (last year's tax return or current pay-stubs and a copy of my insurance or Medicaid card) requested when my initial appointment was scheduled, the percentage charged for each service will be determined. If I have not brought the requested information, I understand that my fee will not be reduced and I will be expected to pay full cost of service. If I bring the requested documentation at a later date, my fee can be reduced from that date.

4. This fee agreement is valid in most cases for one year, except in the case of 100% subsidy. I understand that I must provide documentation of my gross income and any other relevant information to the Business Office within thirty (30) days of the expiration of this agreement if I want to continue receiving services at a reduced rate. If my income or household size changes prior to _____, the scheduled date of my re-determination, I understand that I must notify the Business Office immediately.

5. Based on the information I have provided my fee is reduced to : (Check appropriate category)

   A) _____ % of actual cost **without insurance**. (See attached fee schedule.)
   B) _____ % of actual cost **with insurance**, after $_____ deductible has been met.
   C) Insurance co-pay in the amount of $_____per visit.
   D) _____ Medicaid
   E) _____ Board Subsidy
   F) Contracted Services _____

6. I understand that unless I have Medicaid or qualify for subsidy benefits, I am expected to pay my fee percentage or insurance co-pay at the time of service. If I am unable to pay at the time of service, I understand that I must pay within thirty (30) days or prior to the next scheduled appointment. The balance must be paid off each month.

7. I understand that any unpaid account balance will be turned over to an outside collection agency after sixty (60) days and reported to the credit bureau after written notification has been sent to my last known address. I also understand that I am responsible for any charges that the Agency may incur in recovering my unpaid balance.

8. I understand that if I qualify for Medicaid, I am required to provide a current copy of my Medicaid card. If I am ineligible for Medicaid, I must bring my Job & Family Services rejection notification in order to qualify for the subsidy program.

9. I release the Agency from any requirements that my insurance company may impose on me as an insured, such as obtaining pre-authorization, assuring that coverage is provided by my plan, etc. If I have failed to cooperate with the requirements of my insurance company or if the Agency is not accepted within my insurance provider list, I may be required to pay full cost of service. This will be determined by a standard set by the Agency with approval by a Program Manager or the Finance Director. If I choose not to have the Agency bill my insurance on my behalf, I am responsible for the full cost of service.

10. I understand that as residential parent; I am responsible for the charges determined by the Agency and not by a divorce decree. As a result, I will seek reimbursement from the non-custodial parent and/or insurance company. Non-custodial parents must sign a statement authorizing the Agency to bill their insurance if applicable. Should the non-custodial parent wish to request a reduced fee, documentation of income and household size must be provided.

11. I understand that I may request an itemized bill.

_____ _____ _____

Agency Representative Client Parent/Guardian

BUTLER BEHAVIORAL HEALTH SERVICES, INC.

Client Name _____ Insurance Carrier _____

CLIENT SIGNATURE ON FILE
FOR HEALTH INSURANCE BILLING

As a client of Butler Behavioral Health Services, Inc., I understand that my therapist must review my case with a licensed Psychologi n/a
request that payment of authorized Medicare benefits be made on my behalf to Butler Behavioral Health Services, Inc., for any service furnished to me by this therapist and supervised by the physician or psychologist listed below. I authorize release to the Health Care Finance Administration and its agents any medical information about me needed to determine the payments for related services.

X _____ _____

Client/Legal Guardian Signature Date

As an employee of Butler Behavioral Health Services, Inc., I understand that Medicare and/or other insurance companies generally will not reimburse clients for service provided by a Social Worker/Counselor unless the case has been reviewed with a Licensed Psychologist or Psychiatrist every 90 days.

Outpatient psychiatric services performed by a Social Worker/Counselor must meet the following criteria to be considered for coverage under Medicare:

- The services MUST be rendered under the direct supervision of a physician or a clinical psychologist as evidenced by a signature on the Personalized Service Plan.
- The Social Worker/Counselor MUST be an employee of Butler Behavioral Health Services, Inc.

An LISW is considered a principal agent and can direct bill in their own name under Medicare and some third party payers.

Agency policy, as well as insurance regulations, require that a physician or licensed psychologist sign documentation that that they have directly supervised the initial plan of treatment. This requires their signature indicating approval of the Personalized Service Plan and all subsequent Service Plan Reviews. The purpose of the signature requirement is to provide a minimum level of assurance that a physicians involvement in a clients care is substantial enough to qualify them them as an “attending physician” or that a specific service was provided by that physician.

I agree to abide by the above regulations of policies and procedures of Butler Behavioral Health Services, Inc., regarding supervisory review of Personalized Service Plans for this client in seeking reimbursement for services provided by me.

_____ _____

Therapist Signature & Title Date

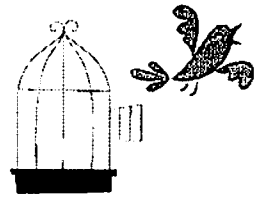
I agree to have my signature on file for the client listed above and authorize electronic billing for services rendered for this client by the therapist listed above. I authorize computerized billing of service provided to this client using electronic claims. I understand that my signature on a Personalized Service Plan will validate specific services performed by the therapist and that the absence of such authorization will preclude billing by Butler Behavioral Health Services, Inc., under this signatuatory agreement. This agreement will expire on the expiration date of the Personalized Service Plan or earlier upon my request.

_____ _____

Signature of Licensed Psychologist or Psychiatrist Date

Butler Behavioral Health Services, Inc.

WINGS Attendance Guidelines



1. Make a Commitment to Your Growth

Treatment is a partnership between your family and your WINGS clinical team, which may include a child psychiatrist if needed. To achieve good results, you must meet with your clinical team for a minimum of three times per week.

Your WINGS clinical team of *Butler Behavioral Health Services* will honor appointments that are scheduled. Unless there is an emergency, our clinical staff will reserve the time you have scheduled and will see you (or your son/daughter) on that scheduled time.

2. Cancellation

If an illness, weather or any other circumstance requires you to cancel an appointment with your WINGS clinical team member, including the psychiatrist, please contact your clinical team member immediately. The appointment cancelled must be rescheduled within the week or it will be considered a no show for the appointment time. If a member of your clinical team cancels or reschedules an appointment and rescheduling another time that week is not possible, you will **NOT** be charged with a no show appointment. A missed appointment for the psychiatrist is considered a no show appointment for the WINGS clinical team.

3. Termination of Treatment and/or Medication Services

Many people in the community are in need of the WINGS Program and the demand for services often exceeds availability. Therefore, *Butler Behavioral Health Services* policy requires therapists and psychiatrists to terminate services to families that have 3 no show cancellations. A reminder letter will be given to you after two missed no show appointments to indicate that if you have another no show appointment, services at BBHS will be terminated. Services that will be terminated at this time would include your WINGS clinical team, as well as the psychiatrist. Your WINGS clinical team will provide you with information at this time for other resources in the community that may meet your clinical needs.

Our child psychiatrist time is very valuable and a no show appointment to the psychiatrist may lead to the end of psychiatric services at BBHS, especially is this is a reoccurring problem.

Occasionally clients lose prescriptions or run out of medication before their next appointment with the doctor due to canceled or missed appointments. If this occurs a written prescription may be available at our office. **There is an administrative fee of $10.00 for the initial prescription plus $2.00 per additional prescriptions. Our physician will not call in orders to your pharmacy, except in emergency circumstances.**

- **I have read and understand the attendance guidelines and administrative fees of *Butler Behavioral Health Services.***
- **I am committed to making changes with the help of my WINGS clinical team. In order to do so, I agree to give priority to my IHBT family treatment by attending appointments regularly. I understand that treatment and/or medication services will be terminated by *Butler Behavioral Health Services* if I have three no shows for scheduled appointments with my WINGS clinical team and or/child psychiatrist.**
- **I have discussed these guidelines with my WINGS clinical team.**

Signature of Client or Parent/Guardian	Date	Signature of WINGS Team Member	Date

CLIENTS RIGHTS POLICY

AND

GRIEVANCE PROCEDURE

Butler Behavioral Health is a private non-profit community mental health center and a contract agency of the Butler County Mental Health (156) Board. The BBH provides comprehensive mental health services including outpatient psychotherapy and counseling, aftercare follow-up, crisis services, community support, consultation and education within the community and hotline and pre-hospital screening services. The Center provides individual, family and group therapy to all age groups.

The Butler Behavioral Health Service Client's Rights Officer (CRO) and alternate CRO are:

VICTORIA TAYLOR, CRO
MICHELLE RASP, ALTERNATE CRO
BUTLER BEHAVIORAL HEALTH SERVICES, INC.
1490 UNIVERSITY BOULEVARD
HAMILTON, OHIO 45011
(513) 896-7887 EXT. 3130

Available hours: 8:00 a.m. to 5:00 p.m., Weekdays

The CRO is available to any client or applicant who feels there has been a violation of his/her rights. The CRO will accept and oversee the process of any grievance filed by a client or other person or agency on behalf of a client, taking all necessary steps to assure compliance with the grievance procedure. The client's rights officer is also responsible for assuring that the BBH complies with state client's rights rules and policies and maintains records of client's rights activity. Should the CRO be the subject of a grievance or be unavailable, Michelle Rasp, shall serve as alternate CRO.

The BBH has adopted the following policies to guarantee that all clients of the BBH will have their rights protected and enhanced.

A written copy of the *Client's Rights Policy and Grievance Procedure* shall be distributed to each applicant or client at the intake or next subsequent appointment. Staff will explain any and all aspects of *Client's Rights Policy and Grievance Procedure* in a way meaningful to the client to assure clear understanding making adaptations for cognitive, physical, language or other communication needs. *Client's Rights* shall be shared annually with the client thereafter to termination of services.

In a crisis or emergency situation, the client or applicant shall be verbally advised of at least the immediate pertinent rights, such as the right to consent to or to refuse the treatment and the consequences of that agreement or refusal.

All staff of BBH will be fully apprised of the *Client's Rights Policy and Grievance Procedure* through an annual, all staff in service on the topic.

Internally, the Client's Rights Officer (CRO) will review and monitor these policies and procedures at least annually. The CRO will give the County Mental Health Board a summary of the number of grievances received, and the resolution status of grievances.

It is expected that the community Mental Health Board will at least annually review and monitor the *Client's Rights Policy and Grievance Procedure*.

A copy of the *Client's Rights Policy* and *Grievance Procedure* shall be posted for in conspicuous areas or locations of all buildings operated by the BBH for client review and clarification.

CLIENT RIGHTS

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy.

2. The right to services in a humane setting which is the least restrictive feasible as defined in the treatment plan.

3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of alternatives.

4. The right to consent or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal; a parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client.

5. The right to receive a copy of a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.

6. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan.

7. The right to freedom from unnecessary restraint or seclusion.

8. The right to freedom from unnecessary or excessive medication.

9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more services, treatments, or therapies, regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessary shall be explained to the client and written in the client's current service plan.

10. The right to be informed of and refuse any unusual or hazardous treatment procedures.

11. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, television, movies or photographs.

12. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.

13. The right to confidentiality of communications and of all personally identifying information within the limits and requirements for disclosure of various funding and/or certifying sources, state or federal statues, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client in accordance with rule 5122: 2-3-11 of the Administrative Code.

14. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's "treatment plan". Clear treatment reasons shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and others persons authorized by the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records.

15. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.

16. The right to receive an explanation of the reasons for denial of service.

17. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, life style, disability, or the inability to pay.

18. The right to know the cost of services.

19. The right to be fully informed of all rights.

20. The right to freedom from physical, sexual, psychological and financial abuse; harassment and physical punishment; humiliating, threatening or exploiting actions.

21. The right to exercise any and all rights without reprisal in any form including continued and un-compromised access to service.

22. The right to file a grievance.

23. The right to have oral and written instructions for filing a grievance.

24. All services are provided either by a licensed professional or under licensed professional supervision. Clients have the right to consult with the supervisor on request.

25. The right to be informed of available program services.

In addition to the rights listed above, no person shall be denied admission to a program due to their use of prescribed psychotropic medications. 2-1-05 (I)(4). This client rights and grievance policy will be given to each client at admission, with documentation kept in the client's record, 2-1-07(F)(2) and the policy will be posted at each program site in a place accessible to clients 2-1-07 (F)(1). All staff will receive and review a copy of the client rights and grievance policy and documentation of staff's agreement to abide by the policy and procedure will be kept in their personnel files 2-1-07(G).

BUTLER BEHAVIORAL HEALTH SERVICES, INC.
GRIEVANCE PROCEDURE

A client or their representative may initiate a grievance by contacting the CRO either verbally or in writing. The CRO will respond promptly, in writing within three days. The entire grievance process within the agency will not exceed twenty calendar days from the date the grievance was filed. Throughout the grievance procedure, the CRO will assist the griever by investigating the grievance and by serving as a representative and advocate for the griever should the griever so desire. Either the CRO or the griever may include other parties to assure an impartial unbiased hearing. Written notification and explanation of the resolution will be provided to the griever within twenty (20) calendar days.

At any point in the Grievance the griever may contact the Ohio Legal Rights Service, 8 East Long Street, 8th Floor, Columbus, Ohio 43266, (614) 466-7264 in writing or orally. He/she may also initiate a complaint with the Department of Health and Human Services or appropriate local/state/federal licensing or regulatory associations (see partial listing below). Upon request, the CRO will provide all relevant information about the grievance to any other organizations to which the griever has initiated a complaint.

Grievances may also be directed to:

Butler County Mental Health Board
5963 Boymel Drive
Fairfield, Ohio 45014-5541
(513) 860-9240

Attorney General's Office
101 E. Town Street, 5th Floor
Columbus, Ohio 43215
(614) 466-0722

Ohio Department of Mental Health
30 East Broad Street, Suite 1180
Columbus, Ohio 43215-3430
(614) 466-2333

Ohio Client Assistance Program
8 East Long Street
Columbus, Ohio 43215
(614) 466-7264

ADA – Ohio
700 Morse Road, Suite 101
Columbus, Ohio 43214
(800) 949-4232
(614) 844-5410

State of Ohio, Counselor & Social Worker Board
77 South High Street, 16th Floor
Columbus, Ohio 43215-0340
(614) 466-0912

State of Ohio, Board of Psychology
77 South High Street, 18th Floor
Columbus, Ohio 43215-0321
(614) 466-8808

Grievances may also be directed to:

State of Ohio, Medical Board

77 South High Street, 17th Floor
Columbus, Ohio 43215-0315
(614) 466-3934

Equal Employment Opportunity

Cleveland Office
Skylight Office Tower
1660 W. 2nd Street, Suite 850
Cleveland, Ohio 44113
(216) 522-2001

Ohio Board of Nursing
77 South High Street, 17th Floor
Columbus, Ohio 43215-0315
(614) 466-3947

Ohio Dept. of Alcohol &
Drug Addictions Services
2 Nationwide Plaza
280 N High Street 12th Floor
Columbus, Ohio 43215
(614) 466-3445

Office of Criminal Justice Services
400 East Town Street, Suite 300
Columbus, Ohio 43215
(614) 466-7782

Ohio Dept. of Job & Family Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215-3414
(800) 686-1595
(614) 466-6282

Ohio Department of Health
246 North High Street
Columbus, Ohio 43215
(614) 466-3543

(216) 522-2002

Ohio Civil Rights Commission
1111 East Broad St, 3rd Floor
Columbus, Ohio 43205
(614) 466-2785

Office of the Americans with
Disabilities Act
Civil Rights Division
U.S. Department of Justice
Box 66118
Washington, DC 20035
(800) 514-0383

U.S. Equal Employment
Opportunity Commission
1801 L. Street, NW
Room 9024
Washington, DC 20507
(202) 663-4900
(800) 669-4000