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 ID**:_____

	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	Tobacco policy
X	Policy on seclusion and restraint
X	Policy re: illicit/licit drugs/weapons brought on the premises
X	Attendance and Timeliness policy
X	Access to after-hours services

	This information is explained by the intake therapist:
	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
	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
	Tobacco policy
	Information on discharge/transition criteria and procedures
	Aftercare and discharge/transition planning
	Education on advanced directives, as appropriate

_____ _____

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

Mental Health
Recovery Board
Serving Warren & Clinton Counties

CLAIMS AND INFORMATION SYSTEM NOTICE OF ENROLLMENT

To be eligible to receive public funds to help pay for the cost of your mental health and/or addiction services, your personal information must be entered into the claims and information system used by Mental Health Recovery Board Serving Warren and Clinton Counties (MHRB). The billing system "GOSH" is administered on behalf of MHRB by the Clark, Greene, Madison Mental Health Recovery Board.

This information will be used by the Board to:

- Enroll you in the Board's Benefit Plans
- Determine your eligibility for publicly-funded services
- Pay the provider for those services
- Fulfill the Board's legal responsibilities

If applicable law requires you to consent to the disclosure of this information to the Board, your information will not be entered into the system without your written consent. Once in the system, your information will only be used or disclosed by the Board as authorized by you or as permitted by applicable law.

Other County Behavioral Health Boards that pay for your services may utilize the same billing management information system as the Board but will only access your personal information as authorized by you or as permitted by applicable law.

Name of Client: _____

Signature of Client: _____ Date _____

I have read and explained this information to the above-named individual.

_____ _____

Provider Agency Staff Date

Client has refused or is unable to sign this form but has been informed of its contents.
(Check if applicable) ☐

If Refusal, note reason: _____

* This form must be completed for every client seeking publicly funded services. This form must be kept with the client's record.

Butler Behavioral Health

Prevention. Healing. Wellbeing

Consent for Telepsych

Name: _____ Client ID No: _____

1. I understand that my health care provider wishes me to engage in a telepsych consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including Interruptions, unauthorized access and technical difficulties. I understand that my health consult/care provider or I can discontinue the telepsych consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate. the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence .in the consultation end thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask nonmedical personnel to leave the telepsych examination room: and or (3) terminate the consultation at. any time.

5. I have had the alternatives to a telepsych consultation explained to me, and in choosing to participate in a telepsych consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telepsych consulting specialists to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have had a direct conversation with my provider, during which l had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

That I have read or had t is form read and/or had this form explained to me
That l fully understand its contents including the risks and benefits of the procedure(s).
That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

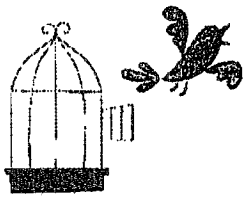
Patient’s / Parent / Guardian Signature Date

_____ _____

Witness Signature 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

Butler Behavioral Health

Prevention. Healing. Wellbeing

Dear patient,

Welcome to Butler Behavioral Health. We believe in a comprehensive approach to your mental and physical healthcare needs. We strongly support active case management and therapy services as the mainstay of your treatment for mental wellness. Prescription medications support the overall success of mental health treatment and are most helpful when used together with other forms of therapy. Examples of some common prescription medications prescribed here include antidepressants, mood stabilizers., antipsy9hotics, anti-anxiety stimulants, smoking cessation medications, and sleep aids. At present time1 we do not offer medication assisted therapy (MAT) for substance and opiate dependence disorders.

We would like to make you aware. of our practices regarding controlled medications and non-psychiatric medications. First, please be advised that our providers do not prescribe non-psychiatric medications. Non-psychiatric medication types include, but are not limited to, pain, asthma, diabetes, blood pressure, cholesterol, and antibiotics. We gladly make referrals to primary care providers when needed.

Benzodiazepines are a class of controlled medications commonly used for anxiety, panic and related disorders. This drug class includes lorazepam (Ativan), diazepam (Valium), alprazolam (Xanax), temazepam (Restoril), chlordiazepoxide (Librium), clonazepam (Kronospan) and others. These medications are best utilized only for short durations at the lowest effective dose. These medications have high potential for long term dependence, addiction, memory impairment and other unwanted side effects. Our providers will work with you to identify a long-term alternative solution.

Stimulants are a class of controlled medications commonly used for ADHP/ADD. This class includes methylphenidate (Concerta and Ritalin) dexmethylphenidate (Focalin), mixed amphetamine salts (Adderall), and dextroamphetamine (Dexedrine). Stimulants may be started or continued, on a case-by-case basis, at the discretion of the provider. Providers may require patients to undergo a formal evaluation in order to start or continue stimulant medications.

If a provider deems any medication potentially harmful to a patient's condition a drug discontinuation/titration schedule may be provided. In order to comply with national standards of care, a controlled substance agreement and urine drug screens may be utilized when prescribing any controlled substance. Thank you for allowing us to be part of your healthcare journey.

The Medication-Somatic Department at Butler Behavioral Health

Butler Behavioral Health

Orientation Handbook

WELCOME TO BUTLER BEHAVIORAL! You are the most important person on your treatment team and we want you to feel at ease participating in your care.

About our Agency

We are one of the oldest non-profit mental health organization in the state of Ohio! Our mission is to provide mental health care for Butler, Warren, and Clinton County residents that are both affordable and excellent.

We want to be known for being both, competent and compassionate. We have a staff of dedicated and seasoned professionals. All BBH therapists and Med-Som providers are licensed by the State of Ohio and are trained in medicine, counseling, social work or psychiatric nursing and abide by the code of Ethics of each of their disciplines.

About our Process

At the time of your first appointment, you will be given an explanation of your fees and financial responsibilities for services provided by the organization. You will also be provided a Clients Rights and Grievance Procedure handbook.

At BBH we promote an atmosphere of mutual respect. When you begin meeting with your therapist or other staff, depending on your program, they will talk with you about your current circumstances and history to identify your strengths, needs, and supports. Ask question about your staff person's training, experience, and treatment methods. Share your concerns so that you can feel comfortable and safe. After your assessment, you and your staff person will create a plan to outline your goals and identify your goals and identify evidence based practices to achieve them in the shortest period of time possible.

If you are scheduled to see a Med-Som provider, your provider is responsible for prescribing medications, adjusting medications, and monitoring your progress. Your relationships with all BBH providers are one of the most important ingredients to your success.

BBH provides a broad range of individual, family, and wellness centered services and programs to fit your needs. Please be sure to let your providers know what your expectation for services are so that they can meet you with the best services/program that BBH has to offer.

Your Personal Commitment

Treatment and Care are a partnership between you and your staff members. It may be tempting to "skip" appointments. However, there is evidence that your success happens more quickly and is more likely to last if you are consistent in attending scheduled sessions. Half of success is "just showing up." Stick with the process, it will pay off for you

What is Expected of You

To ensure effective quality services, we expect:

- **Regular attendance:** a pattern of poor attendance at scheduled appointment will result in closure of your case. Our psychiatric services are very valuable and 2 No-Show or late cancellations (less than 24 hours notice) in a year with our Med-Som providers may lead to the end of psychiatric services at BBH.
- **Parent/Guardian Involvement**: Caregivers are expected to participate and assist with the treatment process for children and adolescents.

To ensure a safe environment, we expect:

- **No Smoking**: Tobacco products are not allowed inside the facilities
- **No Drugs/Alcohol:** The abuse, distribution, sale or seeking of illegal or prescription drugs or alcohol is prohibited in our facilities. Abuse or sale of BBH prescription drugs may result in closure of your case, discontinuing medication services and police notification.
- **No Weapons**: Weapons of any kind are not permitted on our premises.
- **Zero Tolerance for Violence**: Treats of violence, verbal abuse or assault upon other clients, staff or visitors are prohibited. Agency policy and Ohio Law require staff to notify police and/or potential victims of threatened violence.

How to Reach Us

Our offices are opened M-Th from 8 am to 5 pm (with alternate late evening appointments per site) and Fridays from 8 am to 4 pm.

The best way to reach us is phone: (513) 896-7887

Office-based providers will give you their extension. For Community-Based providers you will receive their work cell phone number.

For all Med-Som concerns, please use our nursing line extension at x3117.

After Hours and Crisis Care

If you have a behavioral health emergency and need assistance, call our Mobile Response Teams at (513) 881-7180. If the emergency is life threatening, please call 911 or go to the nearest hospital emergency department.

Network Benefit Plan for Citizens of Warren & Clinton Counties

Mental Health Recovery Board Serving Warren & Clinton Counties (MHRB) oversees and pays for behavioral health services for local citizens based upon need. The benefits that MHRB provides are available to the residents of Clinton and Warren Counties through our network of provider agencies. MHRB and its agency network work together to ensure quality services.

What is the Network Benefit Plan?

The Network Benefit Plan provides public funds to help pay for behavioral health services. These may include counseling, medication, case management, housing, job training, consultation with schools, social supports, and developing everyday living skills. The MHRB network is designed to help individuals and families deal with the behavioral health crises that they sometimes face.

How is the MHRB Network funded?

The MHRB network is funded by federal and state tax dollars (through the Ohio Department of Mental Health & Addiction Services) and a local levy.

What help does the Network Benefit Plan offer?

The Network Benefit Plan provides funding for quality behavioral health services, outpatient, and residential services to residents based on clinical and financial need.

What about more serious mental illnesses?

Serious mental illnesses, sometimes referred to as brain disorders, are conditions such as major depression, bipolar disorder, schizophrenia, and obsessive compulsive disorder. These conditions may range from mild to severe and are treated by qualified providers in the network. MHRB encourages you to work with your provider to create and participate in your treatment plan, as this increases the likelihood of progress.

How can I receive these services?

Contact the agency from which you would like to receive services. You can check agency hours and locations at our website, MHRBWCC.org. A staff person will ask you about your situation to make sure the services the agency provides are appropriate for your needs.

What if I can't afford to pay for services?

Your agency will ask you for some financial information. This will be used to determine the amount of financial help needed. You must be a resident of Warren or Clinton Counties to receive financial assistance.

How do I become part of the Network Benefit Plan?

Warren and Clinton County residents who request clinical services will be given the opportunity to enroll in the Network Benefit Plan.

What does enrollment in the Network Benefit Plan involve?

When you enroll you will be asked to sign a billing authorization statement and a Notice of Enrollment. These forms permit the provider to bill MHRB, which accesses public funds. You will be asked during intake about your income, family size, whether you have private health insurance, or whether you are covered by Medicaid or Medicare. This information will be entered into a computerized billing system operated for MHRB.

Will my private insurance cover my care?

Most agencies accept private insurance. Those agencies will work with you to determine if your treatment is covered under your private insurance plan. Keep in mind that you may be responsible for paying any applicable deductibles and co-pays.

Do I have to enroll in the Network Benefit Plan?

No. You may choose not to enroll. If you choose not to enroll, you will not be considered for public funds. You will need to make other arrangements for covering the cost of your treatment, and you may be billed for those services.

(over)

What if I receive a bill for my "in-network" benefit services?

If you are in the Network Benefit Plan and you receive a bill for services, please contact that agency and request that they review the billing for your services. Adjustments can be made if an error has been made.

How will I know I'm getting the best services?

MHRB and the Ohio Department of Mental Health and Addiction Services review network agencies on a regular basis. Many agencies are also accredited by various professional organizations. Treatment staff must have specific educational degrees, certifications and trainings.

Can my family and I help decide on my treatment?

We encourage you to be involved in any decisions regarding your treatment. This is a right under state law. When there is no conflict with confidentiality, families are encouraged to be involved with the treatment being received. In most cases, the more a family is part of the individual's care, the more progress can be made.

What family supports are available?

Families dealing with a loved one's mental illness may wish to join the local chapter of the National Alliance on Mental Illness (NAMI) and other local support groups. Agencies also may have information available for alcohol and drug use support groups. In addition, support and education may be available for other mental health issues.

Can I help to make sure my treatment is successful?

Absolutely. In order for you and your family to receive the most benefit from services, you must think of yourself as part of the treatment team.

What If I seek services outside my network?

Enrollees are encouraged to use local county providers that are part of the network. If services are sought in another county or outside the network, and you are not Medicaid eligible, special requests can be considered but some benefits may not be available.

Is my information kept confidential?

Yes. MHRB and each provider must comply with state and federal laws regarding confidentiality.

What if I'm not satisfied with my care?

The network aims to provide only quality services, but you are encouraged to discuss any concerns regarding treatment with your provider. If the problem continues, you can file a formal grievance. MHRB and each provider have a plan for dealing with such complaints. To begin this process, ask to speak to the agency's Client's Rights Officer. Your rights are also fully explained in the Client's Rights Policy and Grievance Procedure. A copy is available on our website, or you can call us at 513-695-1695.

For a complete list of provider agencies, visit our website at MHRBWCC.org

Mental Health
Recovery Board
Serving Warren & Clinton Counties

Updated May 2020

Butler Behavioral Health

Prevention. Healing. Wellbeing

Notice of Privacy Practices

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights relating to your protected health information:

To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restriction on our use/ disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To choose how we contact you: You have the right to ask that we send you information at an alternative address or by alternative means. We must agree to your request as long as it is reasonably easy for us to do so. We will avoid using your answering machine if you inform us of such a request.

To inspect and request a copy of your PHI: Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your writ-ten request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, **a charge for copying will be imposed,** depending on your circumstances. You have the right to choose what portions of your information you want copied and to have prior information on the cost of copying.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 30 days of receiving your request. We may deny the request if we determine that the PHI is (1) not created by us and/or not part of our records; or (2) not permitted to be disclosed. Any denial will state the reasons for the denial, along with any statement in response that your provide, appended to your PHI. If we approve the request for amendment, we will add your written amendment to the PHI and so inform you, and tell others that need to know about the changes in the PHI.

To find out what disclosures have been made: You have the right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of routine disclosure for payment, and operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14, 2003. We will respond to your written request for such a list within 30 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

USES AND DISCLOSURES OF PHI FROM MENTAL HEALTH RECORDS NOT REQUIRING CONSENT OF AUTHORIZATION

The law provides that we may use/disclose your PHI from mental health records without consent or authorization in the following circumstances:

When required by law: We may disclose your PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

For public health activities: We may disclose your PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

For health oversight activities: We may disclose PHI to our central office, the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.

Relating to decedents: We may disclose PHI related to a death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, tissue donations or transplants.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For specific government functions: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefits programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

USES AND DISCLOSURES OF PHI REQUIRING AUTHORIZATION

For uses and disclosures beyond treatment, payment and operation purposes **we are required to have your written authorization**, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon you authorization.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose Personal Health Information for a variety of reasons. We have a limited right to use and/or disclose your PHI for the purposes of treatment, payment and for our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity in order for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that it will extend the same degree of privacy protection to your information that we must apply to your PHI. However, the law provides that we are permitted to make some uses/disclosures without your consent or authorization. The following describes and offers examples of potential uses/disclosures of your PHI.

USES AND DISCLOSURES REQUIRING YOU TO HAVE AN OPPORTUNITY TO OBJECT

In the following situations, we may disclose a limited amount of your PHI **if we inform you about the disclosure in advance and you do not object**, as long as law does not otherwise prohibit the disclosure.

To families, friends or others involved in your care: We may share with these people information directly related to their involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Generally, we may routinely use or disclose your PHI as follows:

For treatment: Your PHI will be shared among members of your BBHS treatment staff. Your PHI may also be shared with certain outside entities performing services relating to you treatment, such as lab work, consultation with your pharmacist or the Mental Health Board involved in the provision or coordination of your care. In the event of an emergency we may disclose PHI to other healthcare personnel involved in provision of emergency services.

To obtain payment: We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to the Medicaid program, the ODMH central office, the local ADAMH/CMH Board through the Multi-Agency Community Information System (MACSIS), and/or a private insurer to get paid for services that we delivered to you. We may release information to the Office of the Attorney General for collection purposes.

For health care operations: We may use/ disclose your PHI in the course of operating our programs. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes. Release of your PHI to the Multi-Agency Community Service Information System will be necessary to determine your eligibility for publicly funded services.

Appointment reminders: Unless you provide us with alternative instructions, we may call and leave on answering machine or voice mail appointment reminders. If this is not acceptable, you should inform program staff and request a restriction.

YOU HAVE THE RIGHT TO RECEIVE THIS NOTICE

You have the right to receive a paper copy of this notice and/or an electronic copy by e/mail upon request.

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present, or future health or condition, the provision of health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, **we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure**.

We are required to follow the privacy practices described in this notice though **we reserve the right to change our privacy practices and the terms of this notice at any time.**

HOW TO FILE A GRIEVANCE IF YOU THINK YOUR PRIVACY IS VIOLATED

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a grievance with the person listed below. You may also file a written grievance with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, D.C., 20201 or call 1-877-696-6775. We will take no retaliatory action against you if you make such grievances.

CONTACT PERSON FOR INFORMATION OR TO SUBMIT A GRIEVANCE

If you have questions about this notice or any grievances about our privacy practices, please contact your Client Rights Advocate at:

Butler Behavioral Health
1502 University Boulevard
Hamilton, Ohio 45011
Attn: Client Rights Officer
(513) 896-7887 ext. 3130

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