Circle of Life Behavioral Health Network

INTAKE FACESHEET

Referral Date: _____ Referral Type: ☐ Urgent ☐ Emergent ☐ Routine **Admission Date:**_____

Client has been in treatment previously with COL? ☐ No ☐ Yes: ☐ Less than one year ago ☐ More than one year ago

CLIENT INFORMATION:	**CLIENT FILE #:**
Name:	Date of Birth: Gender:
Physical Address:	SS#:
Mailing Address:	School/Employer:
City: Zip:	Primary Care Physician:
County:	**Tribe of Enrollment:**
PHONE (home):	PHONE (work/cell):
EMERGENCY CONTACT:	
Name:	Relationship:
Physical Address:	Phone (home):
City: Zip:	Phone (work/cell):
PARENT/GUARDIAN NAME(S):	
Father:	Tribe:
Mother:	Tribe
CLIENT INSURANCE INFORMATION:	ELIGIBLE: ☐ Yes ☐ No ☐ Maybe
ID #:	Date Verified:
COORDINATION OF CARE:	
CYFD/Tribal Courts Involved: ☐ No ☐ Yes	**JPPO Involved:** ☐ No ☐ Yes
Contact Person:	Contact Person:
Phone:	Phone:
REFERRAL INFORMATION:	
Agency Name:	Address:
Contact Person:	Telephone:
Reason for Referral:	
Client Allergies: ☐ None ☐Yes (specify):	
Client Medications: ☐ None ☐ Yes (specify):	
HIV: ☐ Neg ☐ Pos ☐ Unknown TB: ☐ Neg ☐ Pos ☐ Unknown Pregnant: ☐ Pregnant ☐ Not Pregnant ☐ Unknown Drug of choice: ☐ Alcohol ☐ Substance Other than Alcohol ☐ Alcohol/Substance	IV Drug Status: ☐ Current ☐ Former User ☐ Never Used Does Client have transportation? ☐ Yes ☐ No Does Client have housing? ☐ Yes ☐ No
Services Requested/Recommended: ☐ OPS ☐ OPN ☐ NML ☐ BHC ☐Other:	

Circle of Life Behavioral Health Network

Informed Consent for Care & Admission Agreement

Client name: _____ DOB: _____ SS#: _____

Parent(s)/Legal Guardian(s), if applicable:

_____ _____

Print Name **Date**

_____ _____

Print Name **Date**

I/We, hereby consent to the admission and participation of myself or the above mentioned child into COLBHN. With the admission of myself or child, I understand that COLBHN and I/my child treatment team will have the right to assess the needs of, and provide appropriate treatment for myself / my child as described below:

I also understand and agree to the identified policies and procedures governing the program and I/ my child participation therein.

Please **initial each blank** indicating you have read, understand, and consent to each policy.

_____ **Consent for Care:** I hereby give consent to COLBHN to place myself/ my child into Outpatient Services. I understand what is required of myself / my child to be successful in completing the programs.

_____ **Consent for Psychiatric Services**: I hereby give consent to COLBHN to place myself/my child into Outpatient Psychiatric Services if clinically recommended by my therapist/my child's therapist or by self-referral. By consenting to Outpatient Psychiatric services with COLBHN, I understand that a board certified adult and child Psychiatrist can provide evaluations, assessments, on-going treatment, and medication management services.

_____ **Consent for Telemed and/or Phone Services**: I hereby give consent to receive outpatient services from COLBHN via Telemed and/or Phone services. By consenting to Outpatient Telemed and/or Phone services with COLBHN, I understand that there may be limits of confidentiality, technical failures, and hold times as my/my child's Therapist consults with Supervisors of my/my child's behalf. Additionally, if at any time my/my child's Therapist deems that my/my child's care can no longer be managed through Telemed and/or Phone services, a reevaluation of how best to meet my/my child's behavioral health needs will be conducted.

_____ **Treatment Setting:** I consent to the admission and placement of myself / my child into COLBHN. I understand that COLBHN will utilize licensed and appropriately trained staff to provide structured therapeutic treatment in a safe and nurturing environment.

_____ **Treatment:** COLBHN and I agree that the treatment of myself / my child shall be carried out to the best of our ability. I consent to the utilization of community resources which

contribute to the wraparound care of myself / my child as deemed necessary by COLBHN staff. I understand that I will participate in the development and coordination of my / my child plan of care. I will be kept informed as to what is required of me and my child to be successful in completing our work with COLBHN.

_____ **Confidentiality:** I acknowledge that my treatment with COLBHN will be kept confidential to protect my right to privacy (please see #9 of Client Rights on Program Orientation Form).

_____ **Client Rights and Responsibilities:** I hereby acknowledge I have received my Client Rights and Responsibilities. I have read and I understand my rights and responsibilities.

_____ **Client Grievance Process:** I hereby acknowledge that I was given a copy of the COLBHN Grievance Process. I understand that I have the right to file any grievances that I may have, even after I have been discharged from the program.

_____ **Notification of Privacy Practices:** I acknowledge that I was offered and/or provided a copy of the COLBHN Notice of Privacy Practices. I was given an opportunity to ask questions.

_____ **Charitable Choice:** I hereby acknowledge that I have received and understand the COLBHN's notice of Charitable Choice.

_____ **Emergency Medical Release:** I hereby delegate to COLBHN, the authority to consent to any emergency psychiatric treatment or medical treatment deemed medically necessary for myself, my child if I am rendered unable to consent for myself, my child by a duly licensed physician or in the event that COLBHN is unable to immediately contact me to get such consent. This includes admission of myself / my child to any hospital, when deemed medically necessary. Every effort shall be made to notify me or an emergency contact as soon as possible.

_____ **Orientation:** I hereby acknowledge I have received an Orientation to each program I am enrolling myself/ my child in. I agree to abide by the guidelines and requirements set forth in the Orientation.

_____ **Contact:** I agree to keep COLBHN informed of my current address and phone number(s) so that contact may be maintained and I may participate in the care for myself/ my child.

_____ **Primary Care Physician (PCP Notification):** I consent to the disclosure of medical or other pertinent information to my primary care physician for collaboration of treatment. If this is required, a Request for Information (ROI) will be signed.

_____ **Transportation Release:** I hereby authorize staff from COLBHN to transport myself / my Child as necessary for treatment. I hereby absolve COLBHN from any and all liability, claims, damages, rights and actions which I, my conservators, guardians, heirs, or personal

representatives may have for any such injuries and damages that may result directly or indirectly from any employee of COLBHNs, operation of a motor vehicle while myself, my child are a passenger in said motor vehicle. This authorization is intended only to release COLBHN and staff acting on the Agency's behalf from liability.

_____ **Transportation Guidelines:** I understand that COLBHN may offer transportation services to assist myself/my child in getting to and from care. In the event that I/my child utilize these services, I/my child agree to adhere to the COLBHN Transportation Guidelines outlined in the Program Orientation.

_____ **Discharge:** COLBHN will keep me involved with the discharge planning process. In the event that I am discharged to another Therapist or program, COLBHN will communicate and collaborate with the receiving Therapist/program regarding my treatment. If I am not able to be safely treated at my current level of care, COLBHN will make prompt referral to the appropriate level of care on my behalf. My discharge plan will include reason(s) for treatment and the extent to which treatment goals were met. It will also include an aftercare and safety plan that describes specific follow up activities.

_____ **Insurance Disclosure:** I agree to disclose to COLBHN all insurance policies that I am covered by, including, but not limited to, Private/Commercial, Medicare, and Medicaid. Failure to disclose this information may be considered insurance fraud. The client will never pay a co-pay or be charged directly for services provided by COLBHN.

_____ **Term:** This agreement shall be in effect for the duration of your, your child's participation in COLBHN.

Client Signature: _____ Date: _____

Parent(s)/Legal Guardian(s) Signature: _____ Date: _____

Parent(s)/Legal Guardian(s) Signature: _____ Date: _____

Witness: _____ Date: _____

Circle of Life Behavioral Health Network

Program Orientation

Welcome!
Thank you for choosing Circle of Life Behavioral Health Network (COLBHN). This is an opportunity to acquaint you with information relevant to treatment and agency policies. Our Intake Coordinator will answer any questions you have regarding these policies.

COLBHN Mission: To provide the highest quality behavioral health care in Native America.

COLBHN Vision: We envision a future where communities are self-sufficient and have the power and resources to sustain traditional and holistic wellbeing for generations to come.

COLBHN Values:

We Believe In:

- Focusing on the people
- The right and responsibility to work
- Strong and reparative relationships
- Holding space for people to explore their culture, tradition and spirituality in whatever way bests suits them
- People's intrinsic ability to heal
- Personal responsibility and transparency
- Working until the work is done.

Aims and Goals
Our major goal at COLBHN is to help you and/or your family identify what you need to thrive in your daily life.

Outpatient Therapy
Circle of Life offers counseling services to individuals, couples, and families. We work with children, adolescents and adults who are in need of behavioral health and/or substance use services. COLBHN strives to enhance personal growth, development and strengthen the family system by providing services that align with the client's cultural beliefs. Services are delivered according to an individualized treatment plan. Treatment supports the enhancement of the client's resilience, self-reliance and self-esteem and is built upon individual, family and community strengths.

Our agency's hours are (Monday – Thursday 8:00 am – 6:00 pm and Friday by request/availability; and 24-hour crisis availability).

New Moon Lodge Residential Treatment Center
COLBHN offers up to 90-day residential substance abuse and co-occurring treatment for Native American adult males from tribes throughout the United States. Residents participate in a structured healing curriculum with special emphasis on Native American culture and identity, traditional and spiritual involvement with comprehensive individual and group counseling.

Butterfly Healing Center
Butterfly Healing Center is a residential program for Native youth. Youth ages 13 through 18 are candidates for admission. BHC provides accredited education options for each resident. We provide services for co-occurring diagnosis, as well as behavioral and mental health issues absent of substance use. The typical stay at Butterfly Healing Center is 90 to 120 days.

Client Safety and Level of Care

- If client's behavior warrants a higher level of care, the client and family will be consulted and may be referred to appropriate services.
- If the client/family refuses to comply with clinical recommendations of therapist and/or medication management practitioners, and this places client at risk for harming self or others, the client/family may be referred to another agency.
- COLBHN believes that discharge begins at admission and in order to support resiliency and achieve sustained recovery, a robust and comprehensive discharge and aftercare program is required. COLBHN will support your efforts to participate successfully in your communities long after your treatment has ended. COLBHN believes that in order to best serve our communities, we must constantly strive to improve our services. Our follow-up program helps us achieve this goal.

Client Responsibilities:
It is the policy of Circle of Life Behavioral Health Network (COLBHN) that each client will be given a clear statement of expectations regarding the client's responsibilities while receiving treatment with COLBHN.

1. Clients will respect the rights of staff and other clients, including their rights to confidentiality and privacy.
2. The client will treat others on the premises with respect and courtesy and will not threaten clinicians or staff.
3. The client will provide necessary information so that COLBHN staff can adequately care for them.
4. The client will participate in the development of treatment goals, and follow through with treatment recommendations.
5. Client will keep scheduled appointments.
6. Client will let staff know if they are not available for an appointment at least 24 hours before their appointment, or as soon as reasonably possible.
7. Client will make every effort to respond to attempts by the COLBHN staff to make contact; answer phone calls, respond to messages left, and update therapist if/when phone numbers change.
8. You are required to provide a Certificate of Indian Blood (CIB) or Proof of

eligibility of a Nationally Recognized Tribe or sign a Release of Information (ROI) so COLBHN staff can obtain a CIB on your behalf.

9. If the client does not have Medicaid, COLBHN requests that the client sign up for Medicaid. COLBHN has personnel on staff to sign clients up for Medicaid.
10. COLBHN strives to be a drug and alcohol free environment and requests that drugs and/or alcohol are not consumed on our premises.
11. The client will not loiter on the premises.
12. The client will not bring any weapons, or items that could be misconstrued as weapons, onto the premises.
13. The client will respect, and not violate, the confidentiality of other clients receiving services with COLBHN.
14. When engaged in couples therapy or co-parenting therapy, the client agrees to a "no-secret" policy. This means that COLBHN therapists do not keep secret information gathered in individual conversations (whether on the phone or in an individual session).
15. The client understands that COLBHN does not voluntary participate in any litigation or custody dispute. The client agrees not to ask a COLBHN staff member to testify on their behalf or on the behalf of a client's family member in a court of law.

Client Rights:

1. You have the right to receive program services that are unaffected by your race, sex, creed, color, handicap, or national origin.
2. I have the right to withdraw myself / my child from all services at any time**.** If I choose to do so, a COLBHN staff member will inform me of the risks of my decision and assist me with a referral to another program, if requested.
3. Client has the right to give informed consent prior to starting any services.
4. Client has the right to be treated with dignity and respect.
5. Client has the right to have an orientation to/explanation of, the program in which they are being enrolled.
6. Client has the right to receive information and have it explained to them in a language that they, and their family understand.
7. Client has the right to receive services in a smoke free facility.
8. Client has the right to file a grievance against COLBHN.
9. Client has the right to receive confidential services. In the event that the client presents as a harm to self/others, the COLBHN staff has a duty to report to ensure safety for client/others.

Client Grievance Process

If you believe any of your rights have been violated, we encourage you to discuss it promptly with your Therapist, or a member of our staff. If after speaking to your Therapist, or a member of our staff, you still feel that your concerns were not addressed, please request a Grievance Form from a COLBHN staff member.

COLBHN takes the concerns of our clients seriously. As such, be assured that your grievance will be heard and given prompt attention by our Grievance Committee.

No retaliation or barriers to the services that COLBHN is providing to you, will occur as a result of you exercising your right to file a grievance.

Transportation Guidelines
COLBHN may offer non-emergent medical transportation for our active clients. This includes, but is not limited to transportation to and from: therapy appointments, to attend groups, off-site AA meetings; and at the direction of a Case Manager who is assisting a client with life skills, for example, to pick up a prescription or take a client to the Social Security office to complete paperwork.

COLBHN Transportation will **not** be used for the following, but not limited to:

- Taking client to/from work.
- Taking client to/from personal errands such as the grocery store, bank, to pay bills, dropping off/picking up of client's child from school, etc.
- Taking client to/from picking up fast food or to/from restaurants.
- Taking client to/from the casino.
- Client will not ask the driver to alter their route, or make stops in between their pick up and drop off destinations.

When utilizing COLBHN Transportation, the client agrees to abide by the Client Responsibilities listed in this COLBHN Program Orientation and all applicable laws in regards to traveling in a motor vehicle.

Charitable Choice
As a treatment provider of substance abuse services receiving Federal funds we are required to inform you of "Charitable Choice". This means COLBHN is a non-religious program and the services provided are not based in any religious affiliation.

COLBHN may not discriminate against you on the basis of religion, a religious/cultural belief, a refusal to hold a religious/cultural belief, or a refusal to actively participate in a religious or cultural practice.

Psychiatric Evaluation and Medication Management
Upon completion of a comprehensive assessment by a licensed clinician, a client may be referred to and benefit from a Psychiatric Evaluation. COLBHN employs a board certified adult and child Psychiatrist who provides psychiatric evaluations, regular psychiatric sessions and medication management.

We look forward to partnering with you in your journey. Thank you for choosing Circle of Life Behavioral Health Network. It is our honor and pleasure to serve you.

Circle of Life Behavioral Health Network

Notice of Privacy Practices

This notice describes how your Protected Health Information (PHI) may be used, kept and disclosed and what information the client has access to, and how the client can get access to the information. Please review carefully.

COLBHN is required by law to protect your past, present and future medical information. We are also required to abide by the practices described in this notice.

How your Protected Health Information (PHI) may be used:

We will use your PHI to provide treatment to you, to submit claims for payment for services provided to you, and in our healthcare operations.

- We may use your PHI if we contact you to remind you of an appointment or to confirm an appointment
- We may use your PHI to mail you correspondence regarding your treatment

How your Protected Health Information (PHI) will be kept:

- Paper files will be accessible to staff for the purposes of treatment, processing a claim for payment and as needed to conduct program operations. Paper files will be secured in a locked file cabinet within a locked file room. Access to the file room will be documented, as well as the removal and return of any files. Paper files will be kept as follows:
  - Adult records will be destroyed 10 years from the date of discharge
  - Ages 9 and over will be destroyed 10 years from the date of discharge
  - Ages 8 and under will be destroyed 19 years from the date of birth
- Electronic files will be accessible to staff for the purposes of treatment, processing a claim for payment and as needed to conduct program operations. Electronic files will only be accessible to those staff whose role it is to treat, bill, or as needed for program operations. Electronic files will be viewed via a secure server, with password protection required for admittance to view the record. Electronic files will be kept as follows:
  - Record retention will be the same as for paper files.
  - Electronic files will not be purged from the system.

How your Protected Health Information (PHI) may be disclosed, without authorization, but not limited to:

- Disclosures of a client's PHI must be limited to the minimum necessary to comply with the request, except when COLBHN has received a signed Release of Information from the client authorizing specific information.
- Military, see Military Disclosures
- Public health officials as needed for the purpose of preventing, or controlling disease, injury or disability; also for medical surveillance or the evaluation of work related illness or injury; or for quality, safety, or effectiveness of a product or activity regulated by the FDA.
- Auditors and/or oversight entities that inspect COLBHN records and facilities
- Authorized federal officials who are conducting national security activities
- State workers compensation as required by law
- COLBHN may use your PHI as long as all identifying information has been removed

COLBHN requires a signed detailed Release of Information to disclose PHI to any of the following entities, but not limited to:

- Disclosure to a client's facilitator, such as a translator or any individual assisting the client to understand their medical needs or a client's representative who is involved in the client's treatment, or payment for such treatment
- Courts and or Probation office

- CYFD
- Primary Care Physician
- Tribal enrollment office
- Social Security Administration
- School (excuses for missing school due to appointments)
- Workers Compensation, if client wants information shared
- In the event of a client's death, an ROI needs to be signed by the client if they want a representative to have access to their PHI in the event of their death (PHI records are protected for 50 years from date of client's death)
- Another behavioral health program or provider
- Marketing, Clinical Research or Fundraising

The Release of Information authorization will describe the intended disclosure in specific terms and may not condition treatment on the client signing the authorization. Also, the term that the ROI is in effect for, must be noted.

Individuals have the right to request access to, and request copies of, their PHI, with the exception of psychotherapy notes. COLBHN will not release psychotherapy notes to the client, nor to a third party, even with a signed Release of Information.

COLBHN must receive a written request by the individual that wishes to access their PHI. COLBHN will have 30 days from the date the written request is received, to grant the information. COLBHN may also request an additional 30 day extension to provide these documents.

Individuals have the right to request that COLBHN amend their PHI if they believe it is inaccurate or incomplete. This request must be received by COLBHN in writing, in order to be considered.

Individuals have the right to request an accounting of disclosures of their PHI for up to three years preceding their request. The information is not required to be provided in any specific format by COLBHN.

Individuals should understand that there may be incidental exposure to their PHI such as their name being seen on sign in sheets or meeting up with someone they know on the COLBHN facility grounds.

Electronic communications via text may not be a secure means of corresponding with COLBHN. Therefore, confidentiality cannot be assured when texting. The client should be aware of this information to make an informed decision as to how to communicate with, and what content they choose to share with their Therapist via text.

COLBHN and our Business Associates are prohibited from receiving direct or indirect payment in exchange for a client's PHI, even with a signed authorization.

COLBHN must comply with a client's request to not disclose their PHI related to treatment or service, to a health plan or third party payer if the individual pays for the treatment of service out of pocket in full at the time of the service.

The effective date of this Notice of Privacy Practices is October 2, 2018. We may change our privacy practice as needed. All changes will apply to PHI that COLBHN is already in possession of. If we change the notice, we will display the revised notice at all COLBHN locations.

If you believe your rights have been violated, you may file a complaint with COLBHN Quality Manager. Your decision to file a complaint will not affect the services being provided to you by COLBHN, nor will your decision to file a complaint be held against you.

Circle of Life Behavioral Health Network

GRIEVANCE POLICY

As a consumer you have the right to initiate a grievance, up through the appeals process and must use the following chain of authority:

1. Your assigned primary therapist

    a. Client Grievance Committee comprised of your Primary Therapist, Residential Coordinator (if grievance involves residential programming), Clinical Supervisor, and Director of QM.

2. Prior to the filing of a formal written grievance, you must informally confer with your Primary Therapist (if applicable) to discuss the issue in a good faith attempt to resolve your concern. You are encouraged to informally resolve the concern at this level.

3. If your complaint or grievance is against or related to your Primary Therapist, your complaint/grievance should go directly to the Director of QM.

4. If you are not able to resolve the concern within the initial meeting with your Primary Therapist, you must submit your grievance in writing to the Clinical Supervisor onsite/Program Manager. If there is an obstacle to writing, the Primary Therapist (if appropriate) may take your verbal information and assist you to complete the process.

5. The Grievance Committee designee will initiate the investigative process immediately upon receipt of the information regarding the issues and interview you within two days.

6. A disposition of the investigation will be given to you within ten business days of the receipt of the grievance.

7. There shall be no retaliation, consequence either formal or informal, against you.

8. An appeals process is available to you which elevates the grievance to the next level, to the Program Director. At this point, the appeals process has been exhausted and the decision by the Program Director is final.

Circle of Life Behavioral Health Network

CHARITABLE CHOICE

As a treatment provider of substance abuse services receiving Federal funds

1. We are required to inform you of “Charitable Choice”

    a. This means COL is a non-religious facility;
    b. The services provided at the COL are not based in any religious affiliation.

2. We may not discriminate against you:

    a. On the basis of religion;
    b. A religious/cultural belief;
    c. A refusal to hold a religious/cultural belief;
    d. Or a refusal to actively participate in a religious or cultural practice.