Referral Information

The Program requires a complete admission application to assure that the consumer needs and best interests of each applicant are met. The following information is needed to begin the application process.

Date of Referral:		**Referring Source:**	

Client Name:		**DOB:**		**SS#:**	

Is client their own legal guardian?	☐ Yes	*If no, please give name of legal guardian:*

Guardian Name:		**Phone#:**			
Client/Legal Guardian Address:					
City:		**State:**		**Zip Code:**	

Primary Insurance No.:		**Secondary Insurance No.:**	

Criminal Record:	☐ Yes ☐ No	*(If so please attach a brief explanation)*

Current Symptoms/Behavioral Observations

☐ Anxiety ☐ Attention problems ☐ High Risk activities	☐ Gets Angry easily ☐ Impulsivity ☐ Mood Swings	☐ Substance use ☐ Suicidal thoughts ☐ Tantrums/Rages	☐ Schoolwork problems ☐ Relationship concerns ☐ Hopelessness ☐ Other-Depression

Services Requested

☐ Comprehensive Clinical Assessment ☐ Outpatient Therapy ☐ Intensive In Home	☐ Substance Abuse Services ☐ Community Support Team ☐ Therapeutic Foster Care	☐ Supportive Employment ☐ Residential Level III ☐ Peer Support Services

Known Diagnosis/Treatment:	
Known Medical Problems:	
Medications:	
Notes:	

A determination as to the most appropriate services for each consumer will be made based on this information; therefore, it is important to know as much as possible about each applicant. We ask that you provide the above information in its entirety before we start working with the client, so that we can make an accurate assessment of services needed.

Please forward all information to:
Primary Care Solutions of Ohio
500 Madison Avenue, Suite 200, Toledo, OH 43604

For Office Use Only: ____
Intake Specialist: ______________________________**LP** Name/Number: ______________________________

DOB: CLIENT NAME: MEDICAID NUMBER:

ORIENTATION CHECKLIST

The following information has been provided as part of the consumer orientation. A check of the item and the signatures of client indicate that all has been explained and is understood by the client.

- ❑ Client Handbook
  - *Mission*
  - *Drug Free & Safe Environment*
  - *Opportunity for Involvement and Input*
  - *Code of ethics/conduct*
  - *Abuse or Neglect*
  - *Fee for Service*
  - *Assessment*
  - *Treatment Plan*
  - *Infection Control*
  - *Regaining Entry Once Discharged*
  - *What is Mental Health*
  - *Community Based Services*
  - *Access to emergency services, after hours*
  - *Policy on tobacco products*
  - *Policy on illicit or licit drugs brought into the program*
  - *Policy on weapons brought into the program*
  - *Rights of the clients & Grievance procedures*
  - *Services provided, days and hours of operation*
- ❑ Confidentiality policy, limits of confidentiality
- ❑ Fire, safety, and emergency precautions
- ❑ Grievance procedure
- ❑ Discharge/Transition Planning (Stage 1)
- ❑ Authorization to disclose Information to Primary Care Physicians
- ❑ Authorization to Use and Disclose Health Information
- ❑ Release of Information
- ❑ Client Choice of Services and Providers
- ❑ Identification of the person responsible for service coordination
- ❑ Consent for Services/Family Involvement/Follow Up Contact
- ❑ Individual Service Plan
- ❑ Discharge/transition criteria and procedures (After Care)
- ❑ Do you currently have any type of Advance Directives ☐ Yes ☐ No

Client Signature______________________________ Date:________________________

DOB: CLIENT NAME: MEDICAID NUMBER:

CONFIDENTIALITY POLICY

Name ____D.O.B ___________________

It is the policy of Primary Care Solutions of Ohio to ensure that all verbal and written information of consumers served is released in a manner that protects the individual's right to confidentiality and adhere to all HIPAA requirements. Information may not be released without the individual's written permission, except as the law permits or requires.

Primary Care Solutions of Ohio will make reasonable efforts to limit use, disclosure of, and requests for private health information to the minimum necessary to accomplish the intended purpose.

Client Signature: ____ Date Signed: __________________

Guardian Signature: ______________________________________ Date Signed: __________________

Staff Signature: ____ Date Signed: __________________

DOB: CLIENT NAME: MEDICAID NUMBER:

FIRE, SAFETY AND LIABILITY

Policy: Primary Care Solutions of Ohio assure that all Primary Care Solutions of Ohio employees understand the safety and liability issues associated with delivering services.

All Primary Care Solutions of Ohio programs meet state and local fire, health, and safety codes and:

Primary Care Solutions of Ohio programs are inspected and approved by appropriate local and/or state fire, health and safety agencies at least annually (within the anniversary month of the last inspection), and there is written records at each site of fire and health inspections.

Documentation by appropriate fire and health authorities that noted citations have been corrected must be maintained at each site.

Programs with an existing sprinkler system shall have annual inspection by a licensed company or the local fire authorities. There shall be documentation of annual inspection by a licensed company.

Primary Care Solutions of Ohio shall provide evidence and documentation of a systematic pest control program. This documentation shall be maintained at each site.

Programs shall have an established method of scheduled fire equipment inspection that includes:

An annual inspection by an outside source (i.e., fire marshal, fire department representative, fire/safety company) that results in a dated tag on each piece of equipment inspected; and
A monthly inspection by a staff person to verify that equipment is properly charged that is documented in a log or on the extinguisher itself that includes the extinguisher serial number and location plus the date and initials of the person completing the inspection.

Programs has operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the facility, and document that all fire extinguishers are properly maintained and serviced. Facilities must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

Each program has at minimum, operable fire extinguishing equipment and alarms/detectors located throughout the facility in all areas where conditions warrant (i.e., flammable storage areas, kitchens, laundry areas, garages, gas water heater locations) and is mounted in a secure manner.

Each program has at a minimum, operable carbon monoxide detectors located in any building where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

Exits:

Diagrams of escape routes are easy to read from a short distance and posted in highly visible locations throughout the environment, clearly indicating where a person is located in relation to the nearest exit(s).

Every exit is clearly visible, or the route to reach every exit shall be conspicuously indicated. Each means of egress, in its entirety, is arranged or marked so that the way to a place of safety is indicated in a clear manner.

Two (2) means of exit per service area is provided which are readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition.

Exits are marked by a lighted sign with lettering, at a minimum, six (6) inches in height on a contrasting background in plain lettering that is readily visible from any direction of exit access. The signs are lighted at all times. The illuminated lights must have battery backup in order to be readily visible in the event of electrical failure. The system shall be tested on an established schedule with documentation of testing maintained onsite.

Any accessible window(s) are operable from the inside without the use of tools and provide a clear opening of not fewer than twenty (20) inches in width and twenty-four (24) inches in height (with the exception of CSUs).

DOB: CLIENT NAME: MEDICAID NUMBER:

No door in any path of exit, or the exit door itself, is locked when the building is occupied unless an emergency system is in place in the facility that will allow the door to unlock in an emergency.

Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met (Exclusion: Supporting Living Services, Supervised Living in apartment settings, and Host Home Services):

A readily visible, durable sign in letters not less than one (1) inch high on contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED.
The locking device is one that is readily distinguishable as locked.
Each staff member inside the building must have a key on their person when the egress door is locked.
There may only be one locked door per means of egress.

Safe and Sanitary Conditions

The interior and exterior of each facility must be maintained in a safe and sanitary manner. Furnishings must be kept clean, well-kept and in good repair.

All programs have operable hot water. The water temperature in all water heaters in facilities providing services directly to individuals enrolled in ODMHAS programs is set at no higher than one hundred twenty degrees (120 degrees) Fahrenheit and no lower than one hundred (100) degrees Fahrenheit. A temperature measurement taken quarterly at each fixture in all other service/program types (i.e. outpatient service locations, day program locations) shall be entered into a log and signed and dated by the person making the entry.

Emergency lighting systems (appropriate to the setting) are located in corridors and/or hallways and are provide the required illumination automatically in the event of any interruption of normal lighting such as failure of public utility or other outside power supply, opening of a circuit breaker or fuse, or any manual act which disrupts the power supply. Emergency lighting systems and egress lighting systems are tested for a continuous length of at least thirty (30) seconds per month and one continuous ninety minute test per year. Providers shall maintain documentation of testing, including the date of the test and the signature of the person conducting the test.

Restroom door locks are designed to permit the opening of the locked door from the outside.

All supplies, including flammable liquids and other harmful materials, are stored to provide for the safety of the individuals enrolled and the staff working in the program.

Each facility has floor space for the lounge/dining/visitation area(s) that is easily accessed/exited in case of emergency.

All facilities have operational utilities (water/sewer, air conditioning/heat, electricity). Facilities must also have a written plan of action in place at each site in case utilities fail. The plan must be readily available for review.

Client (Guardian) Signature: ___________________________ Date: ______________

DOB: CLIENT NAME: MEDICAID NUMBER:

GRIEVANCE PROCEDURE

a) Consumers served will be fully informed of the grievance procedures during their orientation to services. In addition, they will receive printed materials that will provide an overview of this process for later reference.

b) Day-to-day issues affecting the consumers served shall be resolved informally between the person served and the primary staff member responsible for his/her service coordination. If the problem or complaint is not resolved to the satisfaction of the person served, the Owners will adhere to the guidelines contained in this policy and assist the person served in accessing the procedures necessary to resolve the concern.

c) If the client does not feel comfortable addressing issues with PCS OH staff persons you may call (888)-380-9990.

d) Consumers served have the right to due process with regard to grievances, and the organization will afford every reasonable opportunity for informal and/or formal resolution of the grievance.

e) Consumers who may bring grievances include, but are not limited to:

   1) The person served.

   2) The guardian of the person served.

   3) The attorney, designated representative, or a representative of a rights protection or advocacy agency of the person served.

      a) A grievant shall in no way be subject to disciplinary action or reprisal, including reprisal in the form of denial or termination of services, loss of privileges, or loss of services as a result of filing a grievance.

      b) Notices summarizing a person's right to due process in regard to grievances, including the process which grievances may be filed and copies of forms to be used for such purpose, shall be available within each facility and program area.

      c) Each person served will be informed of his/her right to grieve and the right to be assisted throughout the grievance process by a representative of his/her choice, in a manner designed to be understandable to the person served.

      d) During a formal grievance procedure, the person served will have the right to the following:

4) Assistance by a representative of his/her choice.
5) Review of any information obtained in processing the grievance, except that which would violate the confidentiality of another person served.
6) Presentation of evidence of witnesses pertinent to the grievance.
7) Receipt of complete findings and recommendations, except those that would violate the confidentiality of another person served.
   a) In all grievances the burden of proof shall be on the organization, facility, or program to show compliance or remedial action to comply with the policies and procedures established to ensure the rights of consumers served.

   b) All findings of a formal grievance procedure shall include:

1) A finding of fact.
2) A determination regarding the adherence of the organization, program, or employee, or the failure to adhere, to specific policies or procedures designed to ensure the rights of consumers served.
3) Any specific remedial steps necessary to ensure compliance with organizational policies and procedures.

   a) The steps of a formal grievance are as follows:

4) Formal grievances shall be filed first with the supervisor/director of the service unit or program in which the grievance arises.
5) The grievance is required to be in written format.
6) A copy of the grievance shall be forwarded to the administrative head of the organization.
7) The supervisor/director of the service unit or program will meet with the grievant, and/or representatives, immediately following the filing to brainstorm resolution of any related issues that may get in the way of full participation in services. Actions may include, but not be limited to, a change in direct care providers or an adjustment in programming scheduPCS and/or program environments.
8) The organization will issue a formal written response to the grievant, and/or the designated representatives, within five working days, excluding weekends or holidays, of the complaint.
9) The grievance must be signed, dated by client, or individual filing the grievance on behalf of the client.

10) The grievance statement must include;
   a) Date

b) Approximate time of incident
c) Description of incident and names of individuals involved.

The steps to appeal a written response to a grievance:

11) If the grievant is unsatisfied with the findings of the written response to a grievance, he or she may appeal the decision to the Owner/CEO within five days, excluding weekends or holidays.

12) The Owner/CEO will issue a formal written response to the grievant, and/or the designated representatives, within five working days, excluding weekends or holidays, of the complaint.

13) If the grievant is unsatisfied with the findings of the written response, he/she will be referred to a third party outside of the organization. Third parties may include organizations such as children's or adult protective services, professional licensing boards, nursing home ombudsmen, or other appropriate organizations that may serve as an advocate for the person served.
    a) All staff members of Primary Care Solutions of Ohio will be trained in the implementation of this policy and procedures during orientation, and will receive ongoing training of the procedures to ensure the process is applied in a comprehensive manner is a grievance is filed.
    b) Grievances regarding the actions of specific staff members will be handled in accordance with personnel rules and contract provisions. No disciplinary action may be taken, nor facts found with regard to any alleged employee misconduct, except in accordance with applicable personnel rules and labor contract provisions.
    c) A Grievance Log will be maintained by the organization detailing the nature of the complaint, relevant information obtained in the investigation, and the outcome of the process. All information contained will maintain the confidentiality of the participants in the process. This record will be reviewed annually by the Consumer Right Committee to determine if there are trends in the complaints, and to identify areas to initiate performance improvement activities. All grievances will be maintained for at least 2 years, records of client grievances will include:

        (1) A copy of the grievance.
        (2) Documentation reflecting the process used and resolution/remedy of the grievance.
        (3) Documentation of extenuating circumstances for extending resolution beyond 21 days.

Client Signature: ___________________________________ Date: _____________

DOB: CLIENT NAME: MEDICAID NUMBER:

Client Name: ______________________________**Date**: ______________________________

Discussion of discharge should be initiated as early as possible. It is important for you to be a part of this process and to make you aware of the timeframe of services provided.

You will receive an appointment for an assessment. After the assessment and depending on your needs, you may receive one or all of the following services

1. Therapy ❑ Case Management Substance Abuse Treatment ❑ Other:__________________

You will most likely be involved in services at least 3 months but up to 18 months. The time largely depends on your progress toward meeting your goals.

If in the event you decide to not continue services or you transition out of services and are in need of assistance during a crisis please see the information below for additional services OR contact your

Primary Care Physician:

Physician Name: ___________________________ Phone: ____________________________

Local Hospital

Rescue Crisis
(419) 255-9585

Mercy St. Charles Hospital
2600 Navarre Ave, Oregon, OH 43616
Open 24 hours
(419) 696-7200

My signature indicates I have participated in this plan and have been offered a copy of it.

Client Signature: ____ **Date:** _________________

DOB: CLIENT NAME: MEDICAID NUMBER:

Authorization to Disclose Information to Primary Care Physician

Communication between those who care for your mental health (Psychiatrist, Psychologist) and those who care for your physical health (Primary Care Physician) is important!

By signing this form you are giving Primary Care Solutions (PCS) permission to share information regarding mental health services and treatment with your primary care physician. This information may include diagnosis, treatment plan, and your progress. We will not release any information without your written permission.

I ____authorize Primary Care Solutions to release and/or communicate with the Physician listed below regarding my treatment:

Physician Name____________________________ Phone________________________

Address:
____

Client Rights: You can end this authorization (permission to use or disclose information) any time by contacting PCS. If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.

You cannot be required to sign this form as a condition of treatment, enrollment, or eligibility for benefits.

Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.

Patient Authorization: I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire (1 year) from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

(CLIENT PLEASE CHECK ONE)

________ I DO give authorization to release mental health information to my primary care physician.

________ I DO NOT give my authorization to release any information to my primary care physician.

____ ______________
(Client Signature) (Signature of Patient's Authorized Rep) (Date)

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DOB: CLIENT NAME: MEDICAID NUMBER:

Primary Care Solutions, Inc.

Client Choice of Services and Providers

Primary Care Solutions is committed to ensuring that consumers have the right to choose the application of the service they qualify for, to decide the provider of the services they qualify for, and to select, if they desire, a change in services and/or providers.

By signing this form, you are stating you understand that you, as the consumer, have the right to choose relevant services and which provider delivers those services and that Primary Care Solutions has provided you that choice. Further, you acknowledge that no Primary Care Solutions employees have, in any way, advertently or inadvertently influenced your choice of services or providers.

Our services have been explained in simple, non-technical language including risks, benefits and alternatives to proposed treatment. My signature below indicates my consent to treatment for services.

Chosen Provider: Primary Care Solutions of Ohio

I understand that Primary Care Solutions has not influenced my decision in any way.

______________________________ ______________________________

Client/Guardian Signature Date

__________Please initial: By placing your initials on this form you are stating you have received a list of local mental health and substance abuse providers.

DOB: CLIENT NAME: MEDICAID NUMBER:

Date: ____________________

Name:___________________________ DOB_____________________________

Consent for Services

I apply for and consent to such medical, psychiatric and / or other service as the staff of Primary Care Solutions may indicate, including diagnostic tests and counseling. I agree to co-operate in the implementation of the services. I have been informed that statistical information concerning my treatment will be submitted to the insurance company for compilation of statistical information statewide.

Family Involvement Consent / Denial

[ ] **I consent** to have the family members listed below involved in the planning and delivery of the services that I shall be receiving for this period of service. I understand that, without this consent, the agency's employees will not be allowed even to acknowledge to any family member that I am a consumer of their services.

Family members to be involved:

Name__________________________________**Relationship**____________________
Phone#________________

Name__________________________________**Relationship**____________________
Phone#________________

(If parent or legal guardian is indicated under "Relationship" then that individual may sign future forms as the representative of a child consumer)

[ ] **I do not consent** to have family members involved in the planning or delivery of the services I shall be receiving in this period of service.

Follow-up contact consent

[ ] **I consent** to staff of Primary Care Solutions contacting me within 90 days of the termination of this period of service, in order to collect information on the outcomes of that service.

[ ] **I do not consent** to follow-up contact.

I/We agree to give 24-hour notice of cancellation if not participation in planned services and understand that not showing up for planned services, the treatment plan may be reviewed by treatment staff to determine the appropriateness of continued treatment, or discharge.

____ ________________
Signature of client/Legal Guardian **Date**