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| 1. **GENERAL:**

Fresno County oversees a network of County-funded providers offering substance use disorder (SUD) services within a continuum of care. The continuum of care includes the following services:* Outpatient, Intensive Outpatient, Residential, Withdrawal Management, Opioid (Narcotic) Treatment Programs, Recovery Services and Medication Assisted Treatment.
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| 1. **NON-DISCRIMINATION:**

The County and its provider network do not discriminate against any individual seeking admission or readmission into any of its treatment programs based on race; religion; sex; ethnicity; age; disability; sexual preference; and ability to pay. Title VI of the Civil Rights Act of 1964 (section 2000d, Title 42, United States Code); The Rehabilitation Act of 1973 (section 794, Title 29, United States Code); The Americans With Disabilities Act of 1990 (section 12132, Title 42, United States Code); section 11135 of the California Government Code; and Chapter 6 (commencing with Section 10805), Division 4, Title 9 of the California Code of Regulations.  |
| Person Served Initials: \_\_\_\_\_\_\_\_\_\_ | Parent/Guardian Initials (if applicable): \_\_\_\_\_\_\_\_\_\_ |

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| 1. **SERVICES:**

**The provider will facilitate the following services to each person served in the network as medically necessary and appropriate:** safe, nurturing and supportive environment; assessment; intake health screening; treatment planning; individual counseling; group counseling; family support services/group; case management; relapse prevention and coping skills; social skills and enhancement; urinalysis/drug screening; peer counseling; crisis intervention; discharge planning; recovery services **MAT services may include but are not limited to:** dosing; assessment; physical examination; individual counseling; treatment planning; referrals for ancillary services**Providers within the network may also coordinate the provision of the following services by referrals to appropriate community-based agencies:** medical/dental care; psychological/psychiatric testing, evaluations, assessments and/or counseling when necessary; support groups; vocational/educational training and needs; legal assistance; financial assistance; housing assistance Providers shall utilize evidence-based practices including Motivational Interviewing (MI) and at least two of the following: Cognitive Behavioral therapy (CBT), Trauma-Informed Care, Relapse Prevention or Psycho-Education. Evidence based curriculum will also be utilized by providers including, but not limited to Hazelden, Stephanie Covington and the Matrix Model. Additionally, for persons served that are open to faith-based or spiritual services, the 12-step model and groups may be utilized. Whenever possible, non-religious services should also be offered such as Smart Recovery or a holistic, non-traditional approach. Criteria for Admission is made available to the person served at the time of admission or sooner and to the public upon request. a) Medical necessity established by the Medical Director or Licensed Practitioner of the Healing Arts.b) The person served is willing and able to participate in all therapeutic activities. c) The person served is not a danger to themselves or others.  d) Documentation of social, psychological, physical and/or behavioral problems related to alcohol and/or other  drugs. |

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| 1. **PERSONS SERVED MAY EXPECT**
* To achieve and maintain abstinence from all mood-altering chemicals, to reduce the use of substances and alleviate symptoms and harmful behavior.
* To learn about the disease concept of addiction.
* To improve self-esteem.
* To recognize and reduce substance use behavior and defense mechanisms.
* To accept responsibility for and develop a plan for recovery.
* Persons served are expected to participate in program activities.
* To learn relapse prevention and coping skills.
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| 1. **CONFIDENTIALITY**

The confidentiality of alcohol and drug use person served records maintained by the County and its providers is protected by Federal and State law as well as County policies. Generally, any program or person within the provider network may not disclose to a person outside the program that a person served attends the program, or disclose any information identifying a person served as having a SUD. Exceptions: a) The person served consents in writing; b) The disclosure is allowed by a court order; or  c) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research,  audit, or program evaluation.Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Legal Mandates for Disclosure: 1. If it is determined abuse or neglect has occurred, is occurring, or may occur with children (under the age of 18 years old), dependents or elders. The provider will report this to the appropriate agency (Child Protective Services, Adult Protective Services and/or Law Enforcement).2. If it is determined that you pose a danger of violence towards others, the Tarasoff rule (Tarasoff v. Regents of the University of California (1976) 17 Cal.3d 425) will be enacted and all providers will have a duty to warn any identifiable victim(s). 3. If you state or we have reason to believe that you will harm or kill yourself. All providers will take the necessary steps to protect the person served.4. In certain legal cases, if ordered by the Court. (42 CFR Part 2 for Federal Regulations)  |
| Person Served Initials: \_\_\_\_\_\_\_\_\_\_ | Parent/Guardian Initials (if applicable): \_\_\_\_\_\_\_\_\_\_ |

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| 1. **FEE ASSESSMENT:**

I understand that the maximum cost per service is equal to the current Drug Medi-Cal rate: Persons served that have paid in advance and leave the program are entitled to receive a refund for services that were not received. Refunds will be paid within ten (10) business days following the discharge and made payable to the responsible party that signed this agreement. I understand that payment is due when the service is provided. It is understood that this financial agreement may be reassessed if my financial status changes. If I do not pay the fees as due, I agree that information concerning my indebtedness may be sent to the Provider’s collection agency or legal proceedings may be utilized to recover monies owed. I acknowledge that I do [ ]  /do not [ ]  have outside funding source(s) to reimburse my fees for services and treatment to the Provider in a timely manner. In the event that I am a Medi-Cal recipient, I understand that except where a share of cost (per Title 22, Sect. 50090) is applicable, the Provider accepts proof of eligibility for Drug Medi-Cal as payment in full for treatment and services rendered under the Drug Medi-Cal program. As condition of agreement to enter the treatment program, I as a participant understand my fees for treatment and services are $       per group session I attend and $       per individual session I attend. Each program shall develop and inform participants regarding payment provisions and a payment schedule. |
| Person Served Initials: \_\_\_\_\_\_\_\_\_\_ | Parent/Guardian Initials (if applicable): \_\_\_\_\_\_\_\_\_\_ |

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| 1. **PERSON SERVED RIGHTS:**

Each person served shall have rights that include, but are not limited to, the following: * The right to confidentiality. This means that, other than exceptions defined by law, such as those in which public safety takes priority, without my explicit consent to do so, the program may not release any information about me, including confirmation or denial that I am a program person served. Any information regarding my identification and participation in the program will be treated confidentially as provided for in Title 42, Sections 2.1 through 2.67-1, Code of Federal Regulations.
* I have the right to discharge myself from the Provider at any time.
* To be accorded dignity in contact with staff, volunteers, board members and other persons.
* Treatment appropriate to my needs.
* To be informed, in writing, and prior to entering the program, of all existing policies, rules, and regulations.
* To be informed, in writing, and prior to entering the program, of any sanctions, disciplinary measures, modifications of rights, and the rules for conduct at the program.
* To be accorded safe, healthful and comfortable accommodations.
* To be free from verbal, emotional, physical abuse; corporal punishment; involuntary physical confinement; and/or inappropriate sexual behavior.
* Appeal a discharge by requesting, in writing, an appeal at the program level, which may include an interview with the Program/Executive Director. If both parties do not obtain satisfaction, the appeal process with the County will begin.
* Have the right to grieve actions and decisions of program staff that I believe are inappropriate, including but not limited to, actions and decisions that I believe violate my rights as a program person served. The program is obligated to have a grievance procedure for timely resolution of complaints and must post grievance procedures in a place where it shall be immediately available to me. I have the right to freedom from retribution, retaliation or other adverse consequences because of filing a grievance.
* To be free from discrimination based in ethnic group identification, religion, age, sex, color, sexual preference, or disability.
* To be accorded access to his or her file upon request.
* To be informed of my rights as a program person served. (The foregoing are to be posted in the facility in a place where they are immediately available to you, as you are to be informed of these rights and given a copy of them as soon as it is practically possible upon your beginning of treatment).
* Medi-Cal is payment in full, except when a share of cost is present.
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| Person Served Initials: \_\_\_\_\_\_\_\_\_\_ | Parent/Guardian Initials (if applicable): \_\_\_\_\_\_\_\_\_\_ |

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| 1. **CONSENT TO FOLLOW-UP:**

I agree to allow provider staff to complete a follow-up survey on the effectiveness of treatment services provided to me at the end of my participation in the program: I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to provider staff and/or County personnel to contact me via by phone or mail after discharge from the program to ascertain my progress and status regarding my treatment plan goals. I understand, at any time, I may revoke my authorization to be contacted by the provider. Further, I declare my current residence and phone number to be: Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior to completing my services, I will advise my provider if there has been a change in my address or phone number. Additionally, I will inform the program of any subsequent change of address and/or phone number. I understand that the purpose of completing this survey is to allow staff to gather information regarding the effectiveness of treatment and this information will not be used other than the purpose herein agreed upon. I further understand that should I contact or be contacted by the County or provider, in the future, the contacts will be documented and included in my confidential case file. This authorization shall remain in effect until 12 months post discharge. |
| Person Served Initials: \_\_\_\_\_\_\_\_\_\_ | Parent/Guardian Initials (if applicable): \_\_\_\_\_\_\_\_\_\_ |

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| 1. **Person served Handbook:**

I have been advised regarding the County of Fresno Member Handbook – Drug Medi-Cal Organized Delivery System.Please identify which printed version of the Handbook you would prefer: [ ]  I request a standard print format of the Handbook in:[ ]  English [ ]  Spanish [ ]  Hmong[ ]  I request a large print format of the Handbook [ ]  English [ ]  Spanish [ ]  Hmong[ ]  I decline a printed copy of the Handbook[ ]  I request a copy of the Handbook to be provided by:  [ ]  Mail; Person Served Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  E-Mail: Person Served E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Website: <https://www.co.fresno.ca.us/departments/behavioral-health/substance-use-disorder-services/looking-for-help> |
| Person Served Initials: \_\_\_\_\_\_\_\_\_\_ | Parent/Guardian Initials (if applicable): \_\_\_\_\_\_\_\_\_\_ |

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| **Person Served Name Printed:**      | **Person Served Signature:** | **Date:** |
| **Parent/Guardian Name Printed:**      | **Parent/Guardian Signature:** | **Date:** |
| **Counselor/LPHA Name Printed:**      | **Counselor/LPHA Signature:** | **Date:** |