



**RIVERSIDE COUNTY  
DEPARTMENT OF MENTAL HEALTH**

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**Mental Health Plan**

# **Outpatient Provider Manual**

# RIVERSIDE COUNTY MENTAL HEALTH PLAN

## Outpatient Provider Manual

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# Introduction

*We would like to welcome you as a Riverside County Mental Health Plan (RCMHP), Riverside County Health Care (RCHC), and Department of Public Social Services (DPSS) Project network provider.*

The RCMHP authorizes mental health services through the Community Access, Referral, Evaluation, & Support (CARES) to children and adults with Medi-Cal or Riverside County Health Care (RCHC) including those children who reside in Group Homes and Foster Family Agencies. The DPSS Project authorizes mental health services through the Assessment and Consultation Team (ACT) to children (excluding those placed in group homes/FFA placements) and adults who have open cases through the DPSS. Both CARES and the DPSS project also authorize services to adults eligible for RCHC. This new county program provides health and mental health care to low income adults ages 19-64.

We look forward to working with you to provide quality, cost effective mental health treatment to our Medi-Cal, RCHC and DPSS consumers.

The following document contains the guidelines that will assist you in meeting the standards set for the provision of mental health services for Riverside County.

## Mission Statement

The Riverside County Department of Mental Health (RCDMH) exists to provide effective, efficient, and culturally sensitive community-based services that enable severely mentally disabled adults, older adults, and children at risk of mental disability, substance abusers, and individuals on conservatorship that enable them to achieve and maintain their optimal level of healthy personal and social functioning.

In order to fulfill its mission, the Riverside County Department of Mental Health provides a wide range of outpatient and residential treatment services to meet the individual needs of severely and persistently mentally ill persons and substance abusers. The Riverside County Department of Mental Health provides many of these services directly. However, in some instance the Riverside County Department of Mental Health offers these services through contracts with qualified private providers.

## Medi-Cal/RCHC Medical Necessity Criteria

### Article I. Mental Health Plan (MHP)

Consumers must meet the following criteria for medical necessity and be Medi-Cal/RCHC eligible in order for services to be reimbursable. **All three criteria – A, B, and C – must be met.**

#### Diagnosis:

##### A. Included Diagnosis:

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
- Mood Disorders, except Mood Disorders due to a General Medical Condition
- Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnosis
- An Included Diagnosis when an Excluded Diagnosis is also Present

**B. Excluded Diagnosis:**

- Autistic Disorder
- Learning Disorders
- Motor Skills Disorder
- Community Disorders
- Autistic Disorder – Other Pervasive Developmental Disorders are Included
- Tic Disorders
- Delirium, Dementia, Amnesic, and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorder
- Sexual Dysfunction
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions That May be a Focus of Clinical Attention, Except Medication Induced Movement Disorders Which are Included
- Mental Retardation

**B. Impairment Criteria:**

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

Must have one of the following as a result of the mental disorder(s) identified in the diagnostic criteria.

- A significant impairment in an important area of life functioning.
- A probability of significant deterioration in an important area of life functioning.
- Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.

**C. Intervention-Related Criteria:  
Must have all of the following:**

- The focus of proposed intervention is to address the condition identified in impairment criteria
- It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate.
- The condition would not be responsive to physical healthcare-based treatment.

## Provider Services

Authorizing county clinician will inform the provider of the specific service code and number of visits authorized, frequency, and time frame. Providers must use the authorized service codes for billing purposes. The RCMHP will only reimburse providers for authorized services provided in a face-to-face setting. Phone therapy is not a reimbursable service.

Listed below are descriptions of some of the Mental Health Specialty Services used by Riverside County:

**“Consultation”** is defined as the evaluation and communication of the findings of the evaluation by a clinician considered to be a specialist in the particular area for which their expert opinion is being sought. The information obtained from the expert’s evaluation will be relevant to the consumer’s treatment.

**“Collateral”** is defined as those services intended to help family, significant support persons, or other responsible persons to understand and accept the individual’s mental health condition, involve them in service planning and discussion of the individual’s or families progress.

**“Crisis Intervention”** is defined as services to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral, and therapy. Without the crisis session, the beneficiary would be at imminent risk of hospitalization.

**“Group Psychotherapy”** is defined as a service provided to more than one individual at the same time consistent with the client’s goals. The group may be comprised of both Medi-Cal or RCHC beneficiaries, and client’s funded from other sources.

If a provider is delivering services to a group composed of both Medi-Cal and non-Medi-Cal eligible individuals, the provider must determine if the rate for the services is different for the Medi-Cal and the non-Medi-Cal eligibles. If the rate is the same, the provider would prorate his or her time for all individuals who participated. However, if services for a group of individuals are reimbursed at different rates, the provider must prorate the Medi-Cal and non-Medi-Cal individuals separately, e.g. if a provider delivers 63 minutes of services to a group consisting of 5 Medi-Cal and 2 non-Medi-Cal eligibles who are reimbursed at different rates, they would:

1. Calculate reimbursement by prorating their time (63 minutes divided by 7 = 9 minutes);
2. Multiply 9 minutes by 5 and apply the Medi-Cal rate to 45 minutes;
3. Multiply 9 minutes by 2 and apply the non-Medi-Cal rate to 18 minutes

**“Family Therapy”** is defined as a therapy session between the provider and the consumer’s family member(s) with the consumer present in which the focus of the session is related to the consumer’s treatment goals. (Medi-Cal and DPSS only)

**“Individual Providers”** are Licensed mental health professionals, including Board certified or Board eligible psychiatrists, clinical psychologists, licensed marriage and family therapists and



licensed clinical social workers. Credentialing for all licensed providers will be required prior to the provision of any services under this contract.

**“Group Provider”** is an organization that provides specialty mental health services through two or more individual providers who are licensed to practice independently. Group providers **do not use Interns or Trainees.**

**“Organizational Provider”** means a provider of specialty mental health services (other than psychiatric hospital services or psychiatric nursing facility services) that provides services to beneficiaries through employed or contracting licensed mental health or waivered/registered professionals and their staff. Cost Reports are required for organizational providers and separate Medi-Cal reporting units (RU) for each site, if the sites’ weekly hours of operation are 19 hours or more. Organizational providers are required to show proof of staff credentialing when they are certified for Medi-Cal by the DOMH and a copy of each staff credentialing must be sent to the DOMH before the individual clinician renders services. Organizations may use Interns or Trainees.

## RCHC Scope of Benefits

Note: The Scope of Benefits for Riverside County Health Care is listed below. The appropriate CPT Codes will then be utilized for billing purposes.

Riverside County HealthCare Mental Health Services Scope of Benefits	
<b>Covered Benefits</b> <i>(Limited to Network Providers and Contracted Hospitals)</i> Note: All services to individuals are based on medical necessity and subject to prior authorization. Medical necessity criteria includes a covered diagnosis, level of impairment and ability to benefit from services.	
<b>Service</b>	<b>Comments</b>
24-hour—Hospital Psychiatric Inpatient/Psychiatric Health Facility	Short term acute stay only; Admission by psychiatrist order, includes psychiatrist visit
24 hour—Adult Crisis Residential Treatment (CRT)	Maximum 14 day stay, only on referral from RCRMC-Arlington Campus or DMH clinics
24 hour—Adult Residential Treatment (ART)	Maximum 6 month stay, only on referral from DMH clinics
Outpatient—Case Management	Limited to those in specialized programs for the seriously mentally ill; Includes psychosocial services & supports
Assessment	Psychosocial interview to determine psychiatric diagnosis & treatment plan; Psychological & neurological testing is excluded
Individual Psychotherapy	Mental health treatment by clinical therapists (non physician) utilizing well established clinical practices, based on clinical assessment
Group Therapy	Mental health intervention by clinical therapists (non-physician) utilizing well established clinical practices, based on clinical assessment

Riverside County HealthCare Mental Health Services Scope of Benefits	
<b>Covered Benefits</b> <i>(Limited to Network Providers and Contracted Hospitals)</i> Note: All services to individuals are based on medical necessity and subject to prior authorization. Medical necessity criteria includes a covered diagnosis, level of impairment and ability to benefit from services.	
Service	Comments
Collateral Services	Services to family & significant others as a part of a consumer's care plan
Outpatient—Crisis Intervention	Urgent mental health evaluation, triage and treatment to avoid psychiatric hospitalization; Limited to short term intervention to address immediate treatment needs; Prior authorization is not required
Outpatient—Medication Support	Includes psychiatric evaluation to determine need for psychiatric medication; Ongoing psychiatric medication monitoring (includes necessary lab work) is authorized only when psychiatric medications are being prescribed; Medications provided are limited to formulary
Hospital Psychiatric Consultation Services	Hospital psychiatric consultation by a psychiatrist upon referral from the attending physician; Services are provided in the emergency room or medical/surgical inpatient units; Consultation includes psychiatric evaluation, diagnosis and treatment including psychotropic medication prescription and monitoring
Crisis Stabilization Services	Maximum 24 hour evaluation for psychiatric hospitalization

Riverside County HealthCare Mental Health Services Scope of Benefits	
Benefit Exclusions	
Service	Comments
Neurological Testing	
Psychological Testing	Exclude unless preauthorized specifically for complex diagnostic questions
Substance Abuse Services	
Nontraditional Therapies, including, but not limited to, Hypnosis, Regression Therapy, Eye Movement Desensitization Reprocessing (EMDR)	

Riverside County HealthCare Mental Health Services Scope of Benefits	
<b>Covered Benefits</b> <i>(Limited to Network Providers and Contracted Hospitals)</i> Note: All services to individuals are based on medical necessity and subject to prior authorization. Medical necessity criteria includes a covered diagnosis, level of impairment and ability to benefit from services.	
Service	Comments
Electro-Convulsive Therapy	
Skilled Nursing Facility, includes IMD (Institute for Mental Disease)	
Eating Disorder (Day or Inpatient Program)	
Family & Marriage Counseling	
Transgender Counseling	

Authorized Provider Codes

**Riverside County Mental Health Plan (RCMHP)  
Medi-Cal or RCHC Managed Care Services  
OUTPATIENT CPT CODES**

**LICENSED CLINICAL SOCIAL WORKERS  
AND MARRIAGE FAMILY THERAPIST**

CPTCODE	SERVICE FUNCTION	TIME
90801	Psychiatric Diagnosis Interview Exam Assessment	60 minutes
90806	Individual Psychotherapy	60 minutes
90847	Family Psychotherapy	30 minute increments
90853	Group Psychotherapy	15 minutes
90887	Collateral Service	30 minute increments

**PSYCHIATRIST**

CPTCODE	SERVICE FUNCTION	TIME
99205	Office Outpatient Visit New Patient	60 minutes
90862	Pharmacological Management	15 minute increments
90887	Collateral Service	30 minute increments

**PSYCHOLOGIST**

<b>CPTCODE</b>	<b>SERVICE FUNCTION</b>	<b>TIME</b>
90801	Psychiatric Diagnosis Interview Exam Assessment	60 minutes
90806	Individual Psychotherapy	60 minutes
90847	Family Psychotherapy	30 minute increments
90853	Group Psychotherapy	15 minutes
90887	Collateral Service	30 minute increments
96101	Test Admin, Scoring, Written Test Report	60 minute increments
96118	Neuropsychological Testing, Scoring, Written Report	60 minute increments

## HOSPITAL INPATIENT CPT CODES

### PSYCHIATRIST

<b>CPTCODE</b>	<b>SERVICE FUNCTION</b>	<b>TIME</b>
99222	Hospital Inpatient Initial Care - Comprehensive	50 minutes
99232	Subsequent Hospital Care - Expanded	25 minutes

## INPATIENT CONSULTATIONS AT A MEDICAL SURGICAL HOSPITAL CPT CODES

### PSYCHIATRIST

<b>CPTCODE</b>	<b>SERVICE FUNCTION</b>	<b>TIME</b>
99254	Initial Inpatient Consultation - Comprehensive	80 minutes
99262	Follow Up Inpatient Consultation - Expanded	20 minutes

## SKILLED NURSING FACILITIES AND IMD'S CPT CODES

### PSYCHIATRIST

CPTCODE	SERVICE FUNCTION	TIME
99305	Nursing Facility Evaluation and Management	50 minutes
99307	Subsequent Nursing Care Facility Evaluation and Management	15 minutes

## MEDICAL SKILLED NURSING FACILITIES AND IMD'S CPT CODES

### PSYCHOLOGIST

CPTCODE	SERVICE FUNCTION	TIME
90818	Insight Oriented Individual Psychotherapy Interview	60 minutes
90816	Insight Oriented Individual Psychotherapy Interview	20 minutes

## INPATIENT CONSULTATIONS AT A MEDICAL SURGICAL HOSPITAL CPT CODE

CPTCODE	SERVICE FUNCTION	TIME
99254*	Initial Inpatient Consultation Comprehensive	80 minutes
99262*	Follow Up Inpatient Consultation - Expanded	20 minutes

\* Approved and authorized PhD's only

## Lockouts

Mental health services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facilities Services are reimbursed, **except on the day of admission to either service.**

Mental health services are not reimbursable when provided during the same time that Crisis Stabilization – Emergency Room or Urgent Care is provided.

## Lockout Exceptions:

Most mental health services are not reimbursable on days when Inpatient Services are reimbursed *except* those that list “Inpatient” in the Service Function description such as Hospital Inpatient Initial Care Detailed, 30 minutes for psychiatrist and Follow-Up Inpatient Consultation Detailed, 30 minutes for psychologist, etc.

# General Information

## CHAPTER

# 3

## Coordination of Care

Providers are routinely expected to communicate with other providers for the consumer, including Primary Care Physicians (PCPs), in order to coordinate consumer's care. Providers are to encourage consumers to maintain contact with their PCP and receive annual physical exams to ensure that mental health issues are not being aggravated or caused by physical health problems. Contact with designated care managers at Molina, IEHP and RCHC are also encouraged as needed.

## Out of County (SB785)

Riverside Medi-Cal minors residing outside of Riverside County must have their services authorized by calling the CARES Line at 800-706-7500. Providers or the minor's caretaker must call the CARES Line to request mental health services. Minors who reside in Riverside County but whose Medi-Cal is from another county must have their services authorized by that county mental health plan.

## Crisis/Urgent Sessions

Prior authorization is not required for a crisis/urgent session. The session is for a condition that requires more timely response than a regularly scheduled visit. A crisis/urgent condition means a situation experienced by a beneficiary that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.

Services may be provided, but the provider **must call the following business day** to request retroactive authorization for the session and provide appropriate justification.

Supporting documentation should be included in the consumer's chart in all urgent care situations.

## Age-Related Guidelines – Therapeutic Services

For children under the age of four, individual therapy is not routinely authorized and will require evidence that indicates the child is capable of benefiting from this mode of treatment. Authorization is given for family and/or collateral sessions in order to work with the caretaker on parenting skills and behavior modification skills to effect a positive behavioral change in the child.



## Cultural and Linguistic Competence

Providers are expected to honor a consumer's request for culturally and linguistically appropriate services.

If the provider is not able to meet the consumer's cultural and linguistic needs, the provider is to contact CARES Unit or the ACT to arrange for an interpreter or a referral to another provider. The MHP strictly prohibits the expectation that a consumer will utilize a family member as an interpreter. However, the consumer may request that a family member serve as a cultural aid interpreter with the provider's approval.

## Medications and Special Procedures

Psychiatric Evaluations are authorized to determine the need for medication. After the initial psychiatric evaluation, ongoing psychiatric monitoring is authorized only when psychiatric medications are being prescribed. Requests for psychiatric evaluation are made using the Psychiatric Treatment Authorization Request. (Attachment 24)

### Medications for Dependents and Wards of Riverside Juvenile Court

Medications are reviewed to ensure compliance with RCDMH Medication Protocol Guidelines. If they do not meet the guidelines, additional information will be requested of the provider. Please refer to the **most current** Medication Guidelines dated located on the website ([www.rcdmh.org](http://www.rcdmh.org)) for a list of medications and their restrictions. These guidelines are used by Q.I. when performing quality of care reviews of both RCDMH psychiatrists and Managed Care psychiatrist.

Medications for all minors who are dependents and wards of the Juvenile Court will require a Medication Declaration Form (See Attachment #4). Medical doctors must receive a **court approved** Medication Declaration Form **prior** to administering medication. **In all cases, medications may be prescribed without court approval if the physician determines that an emergency exists.** A Medication Declaration, however, must still be submitted for ongoing medications.

The completed Medication Declaration Form will be faxed to QI at **(951) 955-7203**. The QI psychiatrist will review the Medication Declaration for appropriateness and will either recommend approval of the Medication Declaration as it stands or request further information. Once all information has been received and the QI psychiatrist has indicated his recommendations, QI will forward it to the appropriate juvenile court for approval or denial of the request. After the judge signs the Medication Declaration, QI will fax a signed copy to the medical doctor, group home, and clinic and will forward a copy to the ACT if the minor is an open DPSS case.

## **Subsequent Medication Declaration Authorizations**

A new Medication Declaration must be completed thirty **(30) days prior** to the expiration date of the current Medication Declaration.

## **Change in Medication**

Whenever there is a change in medications, and/or a change in dosage range, **a new Medication Declaration must be completed** and the above steps taken.

## **Medical History Forms**

A Medical History is required on all consumers. This must be completed at the time of the consumer's intake and is updated as changes occur.

### **Adult Medical History Form (See Attachments #10A & 10B)**

There are two parts to this form:

Part I. - This portion is to be completed by the consumer or consumer representative.

Part II. - This portion is to be completed by the clinician and/or treating physician.

### **Child's Medical, Medication, and Prenatal History Form**

**(See Attachments #11A & 11B)**

This form is to be completed by a child consumer's parent/representative and is reviewed by the provider and/or treating physician.

## **Psychological Testing**

The following policy and procedure will provide a uniform set of guidelines by which the CARES Unit and the ACT Unit will evaluate requests for psychological testing for consumers.

All beneficiaries for whom psychological testing is requested must be registered with the MHP and be receiving ongoing mental health services. Testing may be allowed after a clinical assessment, if there is sufficient justification concerning a diagnostic question that can only be answered through testing.

Psychological testing will require prior authorization. The ACT adult consumers may require a Court Minute Order for psychological testing (See Chapter 6, Psychological Testing ACT Consumers for additional requirements). Requests will be submitted on the Referral for Psychological Testing (See Attachment #5) or on the requesting provider's own form as long as it includes all the required information.

Referral questions must be specific, relevant, meet medical necessity criteria, and adequately documented. Psychological tests are considered as a procedure of last resort for answering clinical questions.

## **Testing Fulfills Specific Purpose(s) Concerning**

If the psychological testing information is available from other sources, Inland Regional Center or the school system, the testing will not be authorized.

Contract psychologists are expected not to refer to themselves for testing except for the unusual situations where a consumer in treatment with the psychologist suddenly experiences deterioration in functioning that cannot be adequately understood through the process of interview, observation, or further treatment. Objective testing by a non-involved psychologist is preferred.

## **Procedures**

Provider completes Referral for Psychological Testing or completes his/her own form that includes the information required on the RCMHP's form, and sends the referral to the appropriate office.

### **For Medi-Cal & RCHC Consumers:**

**Riverside County Department of Mental Health (RCDMH)  
Community Access, Referral, Evaluation, & Support (CARES)  
P.O. Box 7549  
Riverside, CA 92503  
Fax (951) 358-5352**

### **For ACT Consumers:**

**Riverside County Department of Mental Health (RCDMH)  
Assessment and Consultation Team (ACT)  
3125 Myers Street  
Riverside, CA 92503  
Fax (951) 687-5819**

**Documentation must be legible (typed or printed.)** If the form is incomplete or illegible, the form will be returned. The MHP psychologist will review the form to ensure that it meets the guidelines listed in the policy section.

If appropriate, testing will be authorized. If questions remain, authorization will be made to a contract psychologist for an additional assessment/clinical interview. The psychologist recommended on the form will be chosen if appropriate.

After completing the assessment/clinical interview, the contract psychologist completes the Referral for Psychological Testing (See Attachment # 5) and sends it to the MHP office that authorized the contract psychologist's assessment session with the consumer.

The CARES Unit or the ACT will authorize testing, scoring, and write up and send authorization to contract psychologist.

Contract psychologist is to submit a copy of completed psychological testing report to the authorizing unit within two weeks of completing the report. **Payment will be withheld by the authorizing unit until receipt of the completed psychological testing report.**

## **Transition Procedures**

### **Transitioning a CARES Consumer Over to the ACT**

A CARES Unit consumer (minor child) that now has an open Child Protective Services (CPS) case must be transitioned to the ACT. If the provider who was originally seeing the consumer is also an ACT provider, it is possible for the case to remain with the same provider. However, appropriate authorization process must be received from the ACT clinician **prior to** services being provided.

### **Transitioning an ACT Consumer Over to the CARES Unit**

If the ACT has closed their CPS case and the consumer appears to be in continued need of services, the consumer may request treatment authorization through the CARES Unit. This pertains to consumers who are eligible Riverside Medi-Cal or RCHC beneficiaries only.

The CARES Unit will verify Medi-Cal/RCHC eligibility and will authorize services if meets medical necessity. Consumers with Medicare, other health coverage, or Medi-Cal share of cost will not be authorized for the service unless the consumer first obtains a denial from the other insurance company stating either that the consumer has no mental health benefits or that the consumer has exhausted these benefits and met all share of cost requirements.

## **Discharges: Summary CARES/ACT**

A Discharge Summary is to be sent to the authorizing program (CARES or ACT) **no later than two weeks after the last session** (See Attachment #3). Providers cannot bill or charge consumers for no shows; however, you may discharge consumers for continued no shows. Group Home/FFA providers are also required to send a discharge summary when a child has left the home due to AWOL, placement at a less restrictive level of care, or reunification with their family, etc.

## Community Access, Referral, Evaluation, And Support (CARES)

### Consumer Access

**Riverside County Medi-Cal Beneficiaries** can access mental health services in one of two ways. The beneficiary can call the CARES Line for a referral to a provider, or they can contact one of RCMHP network providers directly for an initial assessment (See Direct Provider Access section on page 2 of this chapter). RCHC beneficiaries can only utilize option one since all services require preauthorization.

#### Option 1: CARES Referral Process

**CARES Unit Telephone Registration and Linkage:** Riverside County Medi-Cal or RCHC eligible beneficiaries, their families, their primary care physicians, hospital emergency rooms, law enforcement, or other county's psychiatric emergency team; may telephone the Riverside County MHP's 24 hour statewide toll-free number **(800) 706-7500** to request outpatient services, inpatient admission, or other disposition.

Authorization for treatment will be based on the beneficiary being Riverside County Medi-Cal or RCHC eligible. The beneficiary must also meet Medical Necessity Criteria defined in Chapter 1.

When a beneficiary or beneficiary's representative contacts the CARES Unit via phone, the beneficiary's Riverside County Medi-Cal or RCHC eligibility is verified. They will be asked to provide demographic information and information about their presenting problem. The beneficiary's request for a specific provider will be honored unless there is a clinical or administrative reason this cannot be done. Authorization letters will be sent to the selected provider. The beneficiary will receive a copy of the treatment authorization upon request.

Occasionally, a beneficiary may be referred who presents problems that are too severe for the contract provider level of care, or at times during treatment, the beneficiary's functioning may deteriorate to the point that they would more appropriately be treated within a County operated Mental Health Clinic. In these cases, the provider is encouraged to contact the CARES Unit to discuss treatment alternatives.

Providers will be authorized one of the following services, which are to start within twenty-one (21) working days of the authorization.

**Individual Therapist (Ph.D., LCSW, MFT):** One Psychiatric Diagnostic Interview Exam Assessments (60 minutes).

**Individual Psychiatrist:** One Office Outpatient Visit New Patient (60 minutes.).

**Group/Organization:** One Psychiatric Diagnostic Interview Exam Assessment (60 minutes) and one Office Outpatient Visit New Patient (60 minutes) to be provided by an M.D.

## **Option 2: Direct Provider Access**

(Medi-Cal and DPSS Only)

Beneficiaries may also access services by directly contacting a Riverside County MHP provider.

### **Exceptions to Direct Provider Access Are:**

- **Psychological services to beneficiaries in an IMD**
- **Beneficiary's requiring ECT services**
- **Psychological testing services**
- **Psychiatric services for beneficiary who is in an inpatient psychiatric unit**
- **Therapeutic Behavioral Services (T.B.S.)**
- **RCHC Beneficiaries & DPSS require prior authorization**

Services for the populations identified above must be requested by the provider and authorized before treatment is provided. Services provided in an acute psychiatric inpatient setting are subject to retroactive review of the hospital chart following discharge.

**Provider Responsibility for Verifying Medi-Cal Eligibility:** When beneficiaries contact the provider directly (other than those in the exception list above), the provider is authorized to provide the assessment services specified below as long as they verify that the beneficiary is Riverside County Medi-Cal eligible during the month of service.

Providers must verify the beneficiary's Medi-Cal eligibility using AEVS at (800) 456-2387 (See Attachment #23) or the Medi-Cal website via [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) (See Attachment #12). Riverside County Medi-Cal is indicated by a county number of 33. AEVS and/or the Medi-Cal website will alert providers when the beneficiary has Other Health Coverage (OHC), a share of cost, or Medicare coverage. For clarification on how this impacts provider reimbursement, refer to Chapter 10, Claims Instructions, Medi-Cal or RCHC Beneficiaries.

**The Assessment Services** that a provider may provide without authorization are:

**Individual Therapist (Ph.D., LCSW, MFT):** One Psychiatric Diagnostic Interview Exam Assessment (60 minutes).

**Groups or Organization:** One Psychiatric Diagnostic Interview Exam Assessment (60 minutes).

The assessment should start within twenty-one (21) calendar days of the beneficiary's contact with the provider.

If during the assessment phase, or at any time during treatment, the provider determines that the needs of the beneficiary would best be met by the County Mental Health System, the provider is to contact the CARES Unit to discuss treatment alternatives.

Providers also need to be aware, that upon receipt of the Provider's Initial Assessment/Care Plan: a screening will be performed to see if the beneficiary is already receiving services from another provider, or if they are an open CPS case.

If the beneficiary is open in the County Mental Health System, the clinic will be consulted and a decision made if additional services by the contract provider are necessary.

If the beneficiary is open to another contract provider, that provider will be consulted to determine if they are going to continue providing services.

If the beneficiary has an open CPS case, the provider will be instructed to inform the beneficiary to request mental health services through their DPSS Social Worker.

## **Treatment Authorization**

Within two (2) weeks of the initial assessment meeting, the provider is to complete and send to the CARES Unit, the Assessment/Care Plan: Initial Form (See Attachment 1A & 1B) and the CSI Data Collection Form (See Attachment 15) to:

**Riverside County Department of Mental Health (RCDMH)  
Community Access, Referral, Evaluation, and Support (CARES)  
P.O. Box 7549  
Riverside, CA 92513  
Fax # (951) 358-5352**

## **CARES Initial Authorization**

The CARES Unit will provide the initial treatment authorization within 14 business days after receipt of the provider's Assessment/Care Plan: Initial Form (See Attachments 1A & 1B). Psychiatrists will use the Psychiatric Treatment Authorization Request (See Attachment 24). Psychiatrist will be automatically given two initial services, one for sixty (60) minutes and one for thirty (30) minutes (These two initial services may NOT be used on the same day). **Ongoing services will not be reimbursed without treatment authorization issued by the CARES Unit.**

The authorization start date will be the date that the CARES staff receives **all the information necessary** to process the Assessment/Care Plan: Initial Form. In the event in which another provider is already providing the same treatment, the consumer is open to the County Mental Health System, or there is a current CPS case, the 14 day initial treatment authorization timeframe will be extended to allow final review by the CARES Unit.

If Medical Necessity Criteria cannot be determined, the CARES staff will send a letter indicating the area needing clarification. If the provider does not respond within ten (10) business days, a denial of services Notice of Action (NOA) will be sent. If medical necessity criteria can be determined, but other information is needed (i.e.: functional impairment/measurable goals) then a letter advising of the needed information will be sent, along with an authorization with a fixed number of visits. The provider must provide the requested information before any further sessions will be authorized.

## **Treatment Extensions**

To request additional services, the provider shall complete and send the Treatment Extension/Change Request Form (See Attachment 2) and CSI Data Collection Form (See Attachment 15). These forms are due to the CARES Unit **thirty (30) days prior** to the expiration of the current authorization period. **Extension request not sent 30 days prior may result in a disruption of treatment.**

## **Notice of Action (NOA)**

A NOA-A will be issued to a beneficiary/provider if the beneficiary is deemed not to meet Medical Necessity Criteria. The NOA will explain the beneficiary's rights to a Second Opinion, Appeal, or State Fair Hearing.

A NOA-B will be sent to the beneficiary/provider when services are denied, or are different in type or frequency from that requested. A NOA-B will also be sent when requests for ongoing services to a current provider are either denied or changed. The NOA-B will notify the Medi-Cal or RCHC beneficiary of the action taken by the CARES Unit and of their rights to a Second Opinion, Appeal, and State Fair Hearing should they disagree with the CARES decision.

The NOA-C (Post-Service Denials) will be sent to a beneficiary when a provider requests payment authorization for a specialty mental health service and the CARES Unit denies or modifies the provider's request and the beneficiary already received the service. The NOA-C clearly states that this is not a bill so that the beneficiary knows that he/she is not responsible for the cost of the service rendered, but that the service was retrospectively denied or changed the payment request to the provider.

The NOA-D (Delayed Grievance/Appeal Decisions) will be sent when Outpatient QI does not provide the resolution of a grievance, appeal, or expedited appeal within the required time frames.

The NOA-E (Lack of Timely Services) will be sent when Outpatient QI determines that services were not provided in a timely manner according to their own standards for timely services.

## **Psychiatric Consultation Procedures**

### **Psychiatric/Psychological Consultations for Medi-Cal or RCHC Beneficiaries on a Medical/Surgical Floor of a Hospital:**

This option does not apply to Medi-Medi beneficiaries [beneficiaries with both Medi-Cal and Medicare] nor does this apply to consumers who have Medi-Cal with other health care coverage.

When an attending physician requires a psychiatric evaluation/consultation, the CARES Unit will authorize services for the following purposes: A) diagnosis of a suspected mental illness; B) to determine any effects of mental illness or emotional factors on the physical illness; C) to determine the effects of physical illness on the mental illness; D) the purpose of selecting and/or titration of psychiatric medications, and E) to evaluate the effects of non-psychiatric medications on mental functioning.



The psychiatrist/psychologist may perform this service without prior authorization. However they must contact the CARES unit to input an authorization for this service prior to submitting their claim. It is the provider's responsibility to confirm current Riverside Medi-Cal or RCHC eligibility and to comply with the standard coordination of benefits rule. Reimbursement for any follow-up consultation is dependent upon review of the necessity of the follow-up, and the provider's notification to the CARES Unit prior to submitting their claim.

Beneficiaries with Medicare and/or any Other Health Coverage will not be authorized for the service unless a denial of benefits from the other insurance company is received first. Beneficiaries are responsible for paying any Medi-Cal share of cost.

The attending physician may request a specific psychiatrist/psychologist to perform the consultation; however, this professional must also be a provider on the MHP panel or be willing to enter into a Purchase Order arrangement with the MHP to provide this individual service.

Allowable Consultation Services – Psychiatrist

- Initial Inpatient Consultation-Detailed (80 minutes), or
- Follow-Up Inpatient Consultation-Expanded (20 minutes).

Claims are to be sent to the following address:

**Mental Health Plan (MHP)  
Managed Care Claims  
9731 Magnolia Avenue  
Riverside, CA 92503**

## **Referral for Additional Services**

The CARES Unit will review the request and if found appropriate, the CARES Unit will contact the consumer and locate a provider. The CARES Unit will also inform the referring provider of the name/phone number of the additional provider. However, psychiatric requests will be determined on a case by case basis.

**Age Five and Under:** For children age five and under, it is expected that an adequate trial of therapy will be tried first to ameliorate the problems. However psychiatric requests will be determined on a case by case basis.

## **Second Opinions**

Occasionally, the CARES Unit and/or consumer may request a Second Opinion by one of our RCDMH clinics who will provide a face-to-face evaluation of the beneficiary for purposes of determining if they need a System of Care approach due to significant and multiple problems which require this expansion of services. At times, these requests are made to verify appropriateness of treatment intensity and type when a provider's request significantly deviates from CARES Unit's treatment authorization guidelines.

When a Second Opinion is necessary, the CARES Unit will contact the provider and beneficiary to inform them of the request and give them the name, address, and phone number of the nearest clinic. The beneficiary is to contact the clinic and set up an evaluation appointment.

It is expected that our contract providers will cooperate and assist their beneficiary in making the appointment and attending the appointment.

Once the evaluation is complete, RCDMH clinic will notify the CARES Unit of the results and their recommendations. Occasionally, the recommendation will be to provide services to the beneficiary at the clinic. In these situations, the CARES Unit clinician will notify the provider and beneficiary of the decision. The authorization request will be terminated. A NOA-B will be sent to the beneficiary and provider. Termination sessions may be allowed. The consumer will be informed of their right to appeal the decision if they are in disagreement.

## **Inland Regional Center Beneficiaries**

For Inland Regional Center (IRC) beneficiaries, the CARES Unit will determine if the beneficiary can benefit from planned interventions AND ensure that planned interventions address a symptom that is due to their covered mental health diagnosis prior to issuing authorization to treat.

As part of the determination of these criteria, the CARES Unit has arranged with IRC that the beneficiary's IRC case worker and the CARES Unit clinician will consult to determine if the beneficiary would benefit from planned interventions (i.e., behavior modification, insight oriented therapy, cognitive behavioral therapy). Thus, the CARES Unit will request that a Release of Information be signed by the beneficiary allowing IRC to release information to make a decision regarding medical necessity criteria. This information is usually in the form of the

IRC Psychological Testing Report. The CARES Unit will notify the provider of the final decision.

When medication and/or therapy services are appropriate for an excluded diagnosis (i.e., Mental Retardation), Medi-Cal or RCHC providers' eligible to bill EDS may provide those services and bill EDS directly under the Primary Diagnosis.

### **Psychological Services for IMD Residents**

**Psychological services for beneficiaries in an IMD are subject to approval by the consumer's RCDMH case manager.** When an IMD staff or psychiatrist rendering services to the beneficiary determines that therapy services are necessary, they are to contact the consumer's RCDMH case manager and present their concerns. If appropriate, services will be authorized to the provider through the CARES Unit using (Attachment #26).

### **Psychiatric Services for IMD Residents**

An IMD psychiatrist may request an authorization for an initial psychiatric evaluation and ongoing services by submitting the IMD Treatment Request form (Attachment #26). A request for continued services is needed every six (6) months.

### **IMD Treatment Package**

#### **Psychiatrist Initial Assessment**

- 1 Initial Psychiatric Evaluation (60 minutes) or  
Psychiatric Evaluation (30 minutes)
- 6 Pharmacological Managements (30 minutes) 1x/month for six months or  
12 Psychiatric Evaluations (15 minutes) 2x/month for six months

Psychiatrist doctors may claim for a lower code if less than 30 minutes is spent with the consumer (i.e., Pharmacological Management, 15 minutes). If a psychiatrist feels that they need more than two 30-minute sessions per month, they may call the CARES Unit, make a request, and present their rationale.

**Once a beneficiary moves out of the IMD, the authorization will end on the date the beneficiary moved out of the IMD facility.**

## **Group Home (GH) and Foster Family Agency (FFA) Children Therapy Services**

Children living in an FFA or GH must first have a service request submitted on the FFA/GH (Attachment # 27). Therapists treating Riverside Medi-Cal children residing in a Group Home or an FFA inside Riverside County may see a beneficiary for one sixty-minute Initial Assessment Session. A completed Assessment/Care Plan: Initial and CSI Data Form is needed to request ongoing therapy services. Therapy services for minors in these settings are authorized in six-month increments. Service Requests must be submitted on the FFA/Group Home form (See Attachment 27).

Once an Assessment/Care Plan: Initial (Attachment 1A & 1B) and CSI Data Form (Attachment 15) are received; a clinical review will be performed. When all the information is received and

medical necessity criteria are met, a six-month authorization of two individual therapy sessions per month (Individual Psychotherapy, 60 minutes) will be made for FFA's and four Individual Sessions will be given for Group Home consumers. Additional services may be requested with adequate justification.

Group Home and FFA children residing within Riverside County, who do not have Medi-Cal, will be authorized services through the CARES Unit until their Medi-Cal is obtained. If at the time Medi-Cal is established and it belongs to another county, the authorization will be stopped and the provider will need to seek authorization through that county Mental Health Plan.

If at the end of the first six months of treatment, the minor is still residing in the facility and continues to require therapy services, the provider is to submit a Treatment Extension/ Change Request Form (See CARES Attachment #2) to the CARES Unit **thirty (30) days** prior to the expiration of the current authorization.

### **Psychiatric Services**

A Board Eligible/Certified Psychiatrist may initially provide an Office Outpatient Visit New Patient (60 minutes) and a Collateral Service (30 minutes) for the purpose of evaluating the child and gathering information necessary for assessment and treatment planning from the facility staff. Upon completion of these assessment sessions, if the psychiatrist is planning to prescribe medications, they must complete the Medication Declaration (See Medications and Special Procedures Section, Chapter 3) and send the form to Outpatient QI. The medications listed on the Medication Declaration must be approved by the Juvenile Court Judge, before medications can be prescribed to the minor. If a child changes FFA's/GH's as a result changes the psychiatric provider, the GH must advise the CARES Unit. Remaining sessions on the Medication Declarations will be transferred to the new provider.

Upon Outpatient QI's delivery of the approved Medication Declaration to the CARES Unit, CARES staff will authorize one Office Outpatient Visit New Patient/Pharmacological Management (30 or 15 minutes depending on provider's request) per month for six months (See Special Procedures section for details on when a new Medication Declaration is required). If a minor already on psychiatric medications moves into a group home or FFA, the psychiatrist of the current GH/FFA may request from Outpatient QI a copy of the previous Medication Declaration. If the Medication Declaration is still valid (within six months from Judge's signature) and the new psychiatrist would like to continue the current medications and dosages approved, the psychiatrist sends in a copy of the Medication Declaration AND a cover letter requesting authorization for the remainder of the Medication Declaration time period.

Group Home and Foster Family Agency (FFA) Children placed by Riverside County who do not have Medi-Cal will be authorized services through the CARES Unit until their Medi-Cal is obtained. If at the time Medi-Cal is established it belongs to another county, the authorization will be stopped and the provider will need to seek authorization through that county Mental Health Plan.

## **Electro Convulsive Therapy (ECT) Treatment**

### **(Medi-Cal Only)**

ECT must be pre-authorized by the CARES Unit. The requesting psychiatrist may contact the CARES Unit at (800) 706-7500 and make the request providing clinical justification. ECT authorization requires the agreement of **three psychiatrists**, one of which must be the RCDMH Medical Director. Authorization will cover only the psychiatrist services and excludes payment of equipment, room, or other associated costs, which is covered under Medi-Cal physical health.

## **Inpatient Psychiatric Services**

Professional services for beneficiaries while they are admitted to an inpatient psychiatric unit will be authorized retroactively upon review of the inpatient medical record.

Claims will not be paid until the Inpatient QI has received and reviewed the Inpatient Medical Record. Hospitals have fourteen (14) days after discharge to submit their medical record and TAR to Inpatient QI for retrospective review. After that is completed, the MDs or PhDs/Psy.Ds claim can be processed.

The Riverside MHP expects that psychiatrists or approved psychologists will provide an “initial evaluation” within the first 24 hours of the hospital admission. For psychiatrists, this is billed under Hospital Inpatient Initial Care (50 minutes). For psychologists, this is billed under Initial Inpatient Consultation Comprehensive (50 minutes).

For every inpatient day claimed, the MHP expects that either the psychiatrist or psychologist will have a session with the beneficiary. The MHP will not pay for two services on the same day. Thus, the M.D. and Ph.D./Psy.D. must coordinate their treatment so as to occur on alternating day.

For psychiatrists, daily visits are billed under either Hospital Inpatient Subsequent Care (15 minutes) or Hospital Inpatient Subsequent Care (25 minutes).

For Psychologists daily visits are billed under either Follow-Up Inpatient Consultation Expanded (20 minutes) or Follow-Up Inpatient Consultation Detailed (30 minutes).

## Assessment and Consultation Team (ACT) Department of Public Social Services (DPSS) Project

The Assessment and Consultation Team (ACT) is a collaborative program between the Riverside County Department of Mental Health (RCDMH) and the Department of Public Social Services (DPSS) to provide assessment, consultation, referral, and treatment for DPSS consumers. Specialty Mental Health services are authorized by the licensed ACT clinicians located throughout Riverside County at DPSS Child Protective Service offices.

The ACT program provides a coordinated treatment system for DPSS families and children, including a formalized process for clinical outcome measurement and for quality review of treatment services.

All consumers for the ACT program must be involved with DPSS by having a “**current open case**” and referred to the ACT program by a DPSS social worker. These cases will be formally screened between the DPSS social worker and the licensed ACT clinician to determine the need for services. Once approved, the ACT clinician will locate the appropriate provider for the needed services and complete an authorization. DPSS reserves the right to discontinue services to a provider at any time.

### Treatment Authorization

#### ACT Initial

Services are generally authorized for a **four-month** block of time that would include a variety of services pre-approved, such as individual, family, and collateral services. Although the provider has these pre-approved services, the provider is still required to send in a completed **Assessment/Care Plan: Initial** and the **specific Assessment and Consultation Team (ACT) Authorization Requesting Release/Receipt of Information and/or Records** (adult and voluntary minor), Attachments 1A/1B and 9A/9B respectively. These are due within two (2) weeks of **the initial session with** the consumer.

Please inform the referring **ACT Clinician** if you have a waiting list and **cannot schedule** the consumer **within two weeks** of the date of the referral.

**Mail or Fax the Documents to the authorizing ACT clinician:**

**Riverside County Department of Mental Health (RCDMH)  
Assessment and Consultation Team (ACT)  
3125 Myers Street  
Riverside, CA 92503  
Fax # (951) 687-5819 Office# (951) 358-6888**

## Release of Information and/or Records

The ACT **Authorization Requesting Release/Receipt of Information and/or Records** (Attachments 9A & 9B) is to be returned **within two (2) weeks with the Assessment/Care Plan: Initial** for all the adult consumers or voluntary minor cases. **You must use this form only – no substitution is allowed** due to the complexity of the DPSS cases and the sharing of information necessary. The Release is valid one year from the date listed and the provider must renew it yearly thereafter. If an original release is not received and/or the yearly renewal, the authorization for further services is subject to cancellation.

### To be a “valid” Release

- If the consumer *agrees* to release, they sign and date the form above the dotted line and fill in all the blanks, including the effective starting date.
- If the consumer disagrees, they sign and date at the bottom of the form to refuse all release of information and all services through the ACT/DPSS program. \*
- If the consumer decides later to revoke their original authorization, they should sign and date below the dotted line under “consent revoked.” \*
- The consumer and provider names and **all** information required **must be** printed legibly on the ACT Release.

\* (The ACT clinician must be notified and all authorized services discontinued immediately.)

This Release of Information allows all the parties involved in the consumer’s treatment to share information on adult and voluntary minors. Consumers may access services through their own resources, through Medi-Cal, or through RCHC, if they do not wish to participate in services provided through the interagency agreement between the RCDMH/ACT and the DPSS. An Assessment and Care Plan: Initial **should not be** sent in with the Release of Information if a consumer has refused to release information.

## Dependent Minors

A Court Minute Order is used in lieu of the Release/Receipt of Information and/or Records on dependent minors. A Court Minute Order authorizes mental health treatment of minor dependents and acts as the release to share information with all agencies involved in the minor’s DPSS case. The Court Minute Order may also contain specific treatment requirements ordered by the court on the minor’s behalf.

## Reauthorization/Continuation of Services Request

Providers are required to submit an **Assessment & Consultation Team (ACT) Quarterly Report/Reauthorization Request** (Attachment 8) to the ACT clinician within one month (30 days) prior to the expiration date of the current authorized services. This will help ensure continuity of treatment for the consumer and a timely reauthorization of services without any lapse of treatment.

## Communication

The Release of Information or the Court Minute Order (dependent minor) allow for the sharing of information between the DPSS Social Worker, DPSS Supervisor, the Court, and the ACT Program. Due to the very nature of the cases referred and the safety and welfare of the children involved, it is an expectation of DPSS and the court that a) consumer progress or lack thereof, b) quarterly reports, c) letters requested by the consumer for court, etc. will all be communicated to the case DPSS Social Worker on a regular and timely basis. If the Social Worker is unavailable, their immediate supervisor should be contacted. Each DPSS office also has a Regional Manager that can be contacted should the DPSS Social Worker or Supervisor be non-responsive to provider calls, letters or case/consumer concerns. The ACT clinician who authorized the services for DPSS can be contacted at any time to express any concerns, ask questions, or clarify information and/or procedures.

Please Note: Copies of all provider letters requested by the consumer for court must also be sent to the DPSS Social Worker simultaneously.

## Documentation

All required forms and documentation sent in must be legible e.g. typed, all fields thoroughly completed with the “current” consumer information or the document will be returned. Documentation should be completed according to the time frames listed and Medical Necessity criteria (see Chapter 1) or services could be temporarily discontinued or cancelled.

### Assessment/Care Plan: Initial

A consumer Assessment/Care Plan: Initial (See Attachments 1A & 1B) must be completed and sent to the authorizing clinician at the ACT clinician within two (2) weeks of the first consumer appointment. All of the information as seen on the Assessment/Care Plan: Initial must be included in the provider’s submission if the provider’s own form is being used. Diagnosis should be consistent with and/or justify continued treatment.

Please note that the authorization shows not only the number of sessions authorized, but the date span the service can be provided and the frequency.

**Clinician’s Signature:** Please sign and date the document, including notation of job title and/or highest degree/license earned. **Registered Psych Assistants or BBS** interns may sign all documentation but need a co-signature of a licensed supervisor. Non-licensed, non-BBS-registered interns/trainees cannot provide services to any ACT DPSS consumer.

**Consumer’s Signature:** All consumers must sign the Consumer Care Plan (last page of Assessment/Care Plan, Attachment 1A or 1B) and the Quarterly Report (Attachment 8) listing the consumer goals and timeframes. For minor consumers, the parent/caregiver must also sign acknowledging agreement of the care plan.



## Psychological Testing

Providers are expected to use the DPSS court reports sent to them by the DPSS social worker as part of their full consumer evaluation process. These reports should be requested directly from the DPSS social worker if not provided initially.

## ACT Quarterly Progress Report/Reauthorization Request

When requesting an extension of treatment authorization for an ACT consumer, a **Quarterly Progress Report/Reauthorization Request** (Attachment #8) must be completed, including full Axis 5 diagnosis (use current DSM DX), and sent to the ACT clinician no later than thirty (30) days prior to expiration of the current authorization. All of the information as seen on the Quarterly Report must be included in the provider's submission if the provider's own form is being used, including the updated CSI data.(Attachment ACT #15.) Goals should be measurable, objective, related to the focus of treatment and specific to the diagnosis. Timeframes should be within the "current" authorization period for goal attainment and/or problem resolution.

**CSI:** the California State Department of Mental Health requires this information. It is to be completed on the Assessment and Care Plan: Initial and then again with each quarterly reauthorization request. DO NOT leave blank spaces on the form. Information is to be obtained "directly" from the consumer. "Unknown" should only be used when the consumer has absolutely no idea of the information requested.

## Medical Necessity

Medi-Cal and RCHC require that specific "medical necessity" criteria be met, one of which is a covered diagnosis (See Chapter 1). Criteria are based on significant impairment in an important area of life functioning, i.e., home, school, or work. Children also qualify if there is a probability the impairment is preventing the child from normal age appropriate development or they are at risk of impairment of life functioning at home, school, or work.

## **Therapeutic Behavioral Services (TBS) Medi-Cal Only**

### **Definition of Therapeutic Behavioral Services (TBS)**

Based on a U.S. District Court decision in 1999, TBS is provided as a benefit for Medi-Cal beneficiaries' ages 0-21 and will be funded through Medi-Cal. TBS are supplemental services for children/youth with serious emotional problems who are experiencing a stressful transition or life crisis and need additional short-term support to prevent placement in a group home of Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs, including acute care; or to enable a transition from any of those levels to a lower level of residential care.

TBS are intended to supplement other Specialty Mental Health (SMH) services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or the planned transition to a lower level of placement. The purpose of providing TBS is to further the child/youth's overall treatment goals by providing additional therapeutic services during a short-term period.

TBS provide critical, short-term supplemental support for full-scope Medi-Cal children/youth for whom other intensive specialty mental health Medi-Cal reimbursable interventions and potentially in some cases, other human services, have not been, or are not expected to be, effective without these additional supportive services.

TBS is a planned therapeutic face-to-face intervention targeting specific behaviors as a part of the TBS Treatment Plan. A contract is considered therapeutic if it is intended to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that is the barrier to achieving residence in the lowest appropriate level.

The person providing TBS is available on-site in homes or the community to provide individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written treatment plan. The service is not intended to be for respite, supervision, or childcare purposes but is a therapeutic intervention.

### **Who Can Receive These Services?**

TBS are available for minors with full scope Medi-Cal ages 0-21 who meet the requirement to receive mental health services. This service is not available for minors on Minor Consent Medi-Cal or others not on Medi-Cal. Additional criteria for this service are as follows:

Without the service, the child/youth would require a more restrictive level of care such as a group home at RCL 12-14 or a locked program such as a psychiatric hospitalization.

**Or**

The service allows discharge from a psychiatric hospital or RCL 12-14 group home, or enhances transition from those facilities and reduces risk of placement.

Child/youth must be receiving a primary specialty mental health service paid for by Medi-Cal, which TBS can supplement, and which in and of itself, has been unable to address the behavior that puts the child/youth's placement at risk.

### **How Long Can a Child Receive This Service?**

This is a short-term targeted intervention to reduce risk of hospitalization or high-level placement. Services will be reviewed by the primary specialty mental health clinician, parent/caregiver, TBS Liaison and TBS provider at least monthly to evaluate progress and assess changes in the targeted behaviors that made the child at risk. It is anticipated services will be provided only for days or weeks, but if clinically justified can occur longer. Administrative review will occur regularly.

### **Process for Referral**

Contact the CARES Unit at (800) 706-7500 to request TBS Services. The CARES Unit will send the TBS referral packet (Attachments 18 TBS Referral; 19 Informed Consent and Consent For Treatment; 21 TBS Eligibility Criteria; and 22 Procedure for TBS Eligibility Criteria Section B; and 20A and 20B Consent for TBS Services English and Spanish to the specialty mental health clinician already providing Medi-Cal funded services for the child. If the specialty mental health clinician determines that the child/youth meets TBS criteria, then the TBS referral packet is completed. The TBS referral packet includes: the TBS Referral Form, the TBS Eligibility Criteria Form, an Assessment/Care Plan: Initial and Consent for TBS. The Consent for TBS is to ensure the parent is in agreement with the service. It must be noted that the parental Consent for TBS does not guarantee this service. The child/youth must meet TBS criteria in order to be eligible for TBS. If the child/youth is a ward or dependent, a Minute Order from the court authorizing "mental health services" is to be used in place of the signature on the Consent for TBS form or if the parent maintains parental rights they may sign the Consent for TBS form. The completed packet is faxed to the Therapeutic Residential Assessment and Consultation Team (TRAC) at (951) 358-6865 for logging, tracking, and TBS authorization. The RCDMH TBS Liaison will then review the TBS referral and forward it to the contracted TBS Provider, who will notify the Medi-Cal funded clinician and the parent/caregiver for the initial assessment and explain how to proceed.

It is extremely important to note that in order to receive ongoing TBS services, full scope Medi-Cal eligibility must be maintained for each child/youth receiving TBS services. This is

imperative since the minor is only eligible for TBS as long as they remain Medi-Cal eligible. The TBS provider will check Medi-Cal eligibility each month.

The child/youth receiving the TBS services must also continue to receive specialty mental health services that are funded by Medi-Cal. This is a mandatory prerequisite and should be tracked monthly since TBS is not a “stand alone” service but a supplement to mental health services already being provided and paid for by Medi-Cal. If you discontinue services with the child/youth, it is your responsibility to notify the TBS contract provider.

The referring Medi-Cal funded clinician will need to be involved in monthly TBS team meeting with the TBS provider, parent/caregiver and DMH TBS Liaison to reassess the progress being made toward the goals indicated in the TBS Treatment Plan. More frequent contacts should occur as needed for effective coordination. If you wish more information about these services, please contact (951) 358-5810 and ask for a member of the TRAC Team.

### **Department Procedure for Authorizing Non-Family Collaterals to Managed Care Providers for the Billing of TBS Treatment Team Meetings**

ACT/CARES managed care clinicians who are the primary therapist (also referred to as Specially Mental Health Provider – SMHP) for a child/youth receiving TBS must meet the requirements set by the County of Riverside to be involved in the monthly TBS treatment team meetings. In order to compensate for the time spent in the TBS treatment team meetings, TRAC will authorize two (2) 30-minute non-family collaterals per month for a 3 month period of time. TRAC will have already verified Medi-Cal eligibility and medical necessity at the time that TBS is authorized. The TRAC TBS Liaison Clinician will enter a clinical note stating collaterals have been added for the purpose of TBS Treatment Team Meetings and will link this note to the non-family collateral authorization.

TRAC will re-authorize the non-family collateral for any additional months, as needed, to the primary clinician (SMHP) as long as the minor is continuing with TBS. This non-family collateral is only to be used for the purposes of TBS. Each authorization generated shall include a note that reads,

“A copy of this authorization is to be included with any billing submitted for TBS collateral services in order for this service to be properly linked to its correct authorization and not be counted against any other collateral service authorized.”

Any questions regarding these additional collateral authorizations should be directed to Riverside County Mental Health TRAC Team at (951) 358-5810.

## **TBS Treatment Team Meetings**

ACT/CARES Managed Care clinician who is the primary therapist (also referred to as Specialty Mental Health Provider – SMHP) for a child/youth receiving TBS must meet the requirements set by the County of Riverside to be involved in the monthly TBS treatment team meetings. In order to compensate for the time spent in the TBS treatment team meetings, TRAC will authorize two (2) 30-minute non-family collaterals per month for a three (3) month period of time.

TRAC will re-authorize the non-family collateral for any additional months, as needed, to the primary clinician (SMHP) as long as the minor is continuing with TBS.

# Documentation Standards

## Introduction

Providers are required to produce timely, accurate, and complete documentation of consumer history and current treatment using County-approved forms listed as attachments to this manual. These forms are shown in the following pages. Fee-for-service providers are encouraged to use these forms, but are not required to do so (except for Attachment #10A & 10B). Irrespective of forms used, documentation must meet the standards set forth herein.

In all treatment documentation, language should be used which clearly describes actual behaviors and consumer statements. Subjective impressions must be supported by descriptions of the behaviors/statements, which led the provider to the impression.

Treatment services should be provided and documented in a culturally competent, age-appropriate manner and be in accordance with federal and state regulatory/statutory requirements. Only clinically necessary services authorized by the CARES/ACT clinicians should be provided.

### **Specific documentation standards are as follows:**

Each record includes the consumer's current address, employer or school, home and work telephone numbers (including emergency contacts), marital/legal status, appropriate consent forms, and guardianship information (if relevant). Each page in the treatment record contains the consumer's name or identification number. All entries in the treatment record are legible and include the date, the responsible clinician's name, professional degree, and relevant identification number, if applicable. Signed informed consent for treatment is required.

Presenting problems and relevant medical, psychological, and social conditions affecting the consumer's psychiatric status are documented in the treatment record. Special status situations (e.g., imminent risk of harm, suicidal ideation, and elopement potential) are prominently noted and updated as necessary. There is documentation that consumers who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to appropriate levels of care.

A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, relevant family information, and consultation reports. Prenatal and perinatal events and complete developmental history are documented for child and adolescent consumers. Past and present use of cigarettes and alcohol as well as use of illegal and prescribed drugs should also be noted in the record.

Each record indicates what, if any, medications have been prescribed including dosages, dates of prescriptions/refills, and informed consent for medications. If medications are prescribed, there is a medication log signed and dated by the psychiatrist, which is updated when changes occur. Progress notes for medication services must refer to compliance, medication effectiveness, and side effects. Allergies and or adverse reactions/sensitivities to pharmaceutical and other substances are prominently noted as well as a lack of known allergies.

An ICD 9 diagnosis is documented, consistent with the presenting problem, history, assessment data, and mental status examination. The Mental Status Examination (MSE) describes the consumer's affect, speech, mood, thought content, judgment, insight, attention/concentration, memory, and impulse control.

Cultural and linguistic needs must be addressed when applicable. If the consumer has Limited English Proficiency (LEP) a review for interpreter service must be offered and documented. When families provide interpreter services, documentation must show that interpreter services were offered first but that the consumer preferred to provide a family interpreter. Personal correspondences are in the consumer's preferred language. Cultural and linguistic needs must be addressed when applicable.

Consumer Care Plan is consistent with the diagnosis and has objective, measurable goals and objectives. Estimated time frames for goal attainment or problem resolution should also be noted. Preventive services such as relapse prevention, stress management, and referrals to community resources are also included in the record. The State Department of Medi-Cal Oversight has added the requirement on the Consumer Care Plan that the proposed type and duration of intervention must be presented on each Care Plan.

## **Progress Notes**

Progress notes must include relevant clinical decisions and interventions and describe the consumer's strengths/limitations in achieving the planned goals and objectives.

All entries must include:

- Date of service.
- Type of service delivered (individual, collateral, crisis).
- Location of service.
- Duration of service (in minutes).

Progress toward treatment goals should be documented as well as any changes in the status of medical necessity. Each entry should be signed by the person providing the service and include their title or degree.

## **Discharge Summary**

A discharge summary must be completed within two weeks of the consumer's last authorized therapy session. All information on the form titled Discharge Summary (See Attachment #3) must be included on the form submitted by the provider.

# Consumer Notices/ Grievances and Appeals

## Introduction

All beneficiaries/consumers of RCDMH services shall have the right to file a grievance. A beneficiary/consumer grievance process and a Medi-Cal or RCHC beneficiary appeal process provide mental health beneficiaries or their representatives and other consumers of mental health services, with a method for resolving their concerns. Throughout the grievance and appeal processes, beneficiaries/consumers will be informed of their rights and of the steps available to them to exercise those rights.

## Beneficiary Informing Materials

The RCDMH contract providers will provide beneficiaries with a copy of the informing materials upon request, when the beneficiary initially accesses services, and annually thereafter as long as they remain in treatment. The informing materials contain a description of services available, the process for obtaining the services, beneficiary rights, the right to request a change of providers, confidentiality rights, advance directive information, a list of network providers and a description of the beneficiary problem resolution process. The information provided will include both the grievance and appeals processes and will state that a Medi-Cal or RCHC beneficiary may request a State Fair Hearing after they have completed the problem resolution process. A complete list of the forms/posters is included on the Informing Materials Reorder Form (Attachment 29).

The Grievance Procedure and Appeal Procedure pamphlets and forms will be readily accessible and visibly posted in prominent locations in beneficiary and staff areas, including beneficiary waiting areas. Self addressed envelopes for mailing grievances and/or appeals to Outpatient QI will be located next to the descriptions of the Grievance Procedure and the Appeal Procedure. The grievance, appeals, and self-addressed envelopes must be available to the beneficiary and/or beneficiary representative without the beneficiary and/or beneficiary representative having to make a verbal or written request to anyone.

A notice will be conspicuously displayed in all mental health facilities advising beneficiaries to contact the contract provider, contract provider management, clinician, clinic supervisor, program manager, Patient Rights Advocate, CARES Unit, or Outpatient QI if they wish to register a grievance and/or appeal. Grievance and/or appeal information will be available through the CARES Unit's 24-hour statewide toll free number, (800) 706-7500, as well as through the Outpatient QI Grievance Line, (800) 660-3570.

The beneficiary may authorize another person to act on his/her behalf. For example, the beneficiary may ask the service provider, a friend, a family member, legal representative, or Patients' Rights staff. At the beneficiary's request, that person may act on the beneficiary's behalf in the use of the complaint grievance/appeal process.

Beneficiaries will not be subject to discrimination or any other penalty for a filing a grievance, appeal, or State Fair Hearing. The procedure for the process shall insure the confidentiality of a beneficiary's



record. Informed consent shall be obtained from beneficiaries when any information or records are released to anyone not specifically authorized by law to have access.

## **Grievance Process**

A beneficiary or beneficiary's representative or consumer may file a grievance, orally or in writing with his/her provider, the CARES Unit, or Outpatient QI. An example of a grievance might be as follows: the quality of care of services provided, aspects of interpersonal relationships such as rudeness of an employee, etc.

When a beneficiary/consumer submits a grievance to a contract provider, the contract provider will register the receipt of the grievance in their grievance log within one (1) working day and immediately fax a copy of the grievance to Outpatient QI at (951) 955-7203. Although a beneficiary is not required to complete a grievance form, it will be necessary for the provider to write pertinent information on the form to fax to Outpatient QI. Outpatient QI will also register the grievance in their grievance log within one (1) working day.

When the beneficiary/consumer mails a grievance form directly to Outpatient QI, the program will register the receipt of the grievance in the grievance log within one (1) working day.

The grievance log will indicate: (a) the name of the beneficiary/consumer, (b) the date of the receipt of the grievance, (c) the nature of the problem and (d) final disposition of the grievance, including the date the decision is sent to the beneficiary, or documentation of the reason(s) that there has not been final disposition of the grievance.

A letter acknowledging the receipt of the grievance will be sent by Outpatient QI to the beneficiary/consumer within ten (10) working days. Beneficiaries/beneficiary representatives can request assistance with the grievance process, or obtain information on the status of a pending grievance by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

Every effort to provide for resolution of the beneficiary's/consumer's grievance as quickly and simply as possible will be made by the recipient of the grievance. Resolution may be reached through discussions between the beneficiary/consumer, or the beneficiary's representative and the therapist, case manager, program supervisor, or other persons involved in the matter at hand. If the contract provider reaches resolution of the beneficiary's grievance, the contract provider will notify Outpatient QI of the resolution. Outpatient QI will review and approve the resolution.

The contract provider and/or Outpatient QI will insure that the person reviewing a grievance, also known as the decision-maker; will not have been involved in any previous level of review or decision making with a grievance.

The beneficiary/representative/consumer will be sent a written decision on the grievance within sixty (60) calendar days of receipt of the grievance by Outpatient QI. Outpatient QI will also send a written notification to those contract providers cited by the beneficiary/consumer or otherwise involved in the grievance regarding the final disposition of the beneficiary's grievance.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary/representative/consumer requests an extension, or if Outpatient QI on behalf of the MHP determines that there is a need for additional information and that the delay is in the beneficiary's/consumer's interest. Outpatient QI will send a written notification to the beneficiary/representative/consumer and the contract provider when an extension has occurred. The written notification will explain the reason for the extension.

Outpatient QI and the contract provider will record the final disposition of the grievance in their grievance log. The record will include the date the decision was sent to the beneficiary or document the reason(s) that there has not been a final disposition of the grievance.

If a beneficiary/beneficiary representative or consumer is dissatisfied with the grievance decision, the beneficiary/beneficiary representative or consumer may be referred to Outpatient QI for further review.

## **Notice of Denial, Termination, or Reduction of Services**

The provider shall fully inform beneficiaries orally and in language accessible to them of any proposed denial, termination, or reduction in their mental health treatment or service. Any written communication with a beneficiary regarding a denial, termination, or reduction of services will be written in clear, concise language, in a format understandable to the beneficiary/consumer.

Written notice shall be provided at the time of the change of service when a change in the level of mental health services is prescribed by the beneficiary's/consumers' treating professional (See Definitions Section for "denial," "termination," "reduction in services," and "notice of action").

The provider shall specify the service(s) to be denied, terminated, or reduced, the reasons therefore and the date of action. Reasons given may include:

The beneficiary/consumer no longer meets the medical necessity requirements for eligibility for a specific mental health service.

The beneficiary/consumer has obtained maximum therapeutic benefit and mental health services are no longer indicated.

The beneficiary/consumer has willfully and persistently failed to comply with the agreed-upon and prescribed treatment plan.

The program does not provide the services the patient requests.

The provider shall make all appropriate efforts to assist beneficiaries in preparing for the action, including, but not limited to, pointing out alternative resources and/or support such as self-help groups and free community services.

If the beneficiary/consumer disagrees with the action of the service provider they have a right to an Appeal.

## **Appeal Procedures**

### **Non-expedited Appeal – Medi-Cal or RCHC Beneficiaries**

An appeal may be filed, orally or in writing, with the contract provider, contract management, the CARES Unit or Outpatient QI. An appeal is a request for a review of an action by the authorization unit (CARES) or county clinic. An action is defined as the modification or denial of a requested service from a beneficiary and/or a reduction, suspension, or termination of a previously authorized service. An oral appeal must be followed up with a written, signed appeal. Medi-Cal or RCHC beneficiaries may file for a State Fair Hearing after they have completed the problem resolution process. Forms and self-addressed envelopes will be available at all county-operated or contracted mental health facilities. Beneficiaries/beneficiary representatives can request assistance with the appeal process or obtain information on the status of a pending appeal by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

The beneficiary/beneficiary's representative may begin the appeal process, orally or by completing an appeal request form and a release of information form, when applicable. Oral appeals must be followed up with written, signed appeal and a release of information form, when applicable. Self-addressed envelopes addressed to Outpatient QI will be available for beneficiary/beneficiary's representative to use to submit their appeal request.

The appeal form should indicate if the beneficiary is in any Medi-Cal or RCHC funded residential treatment program.

The beneficiary/beneficiary's representative will be given a reasonable opportunity to present evidence and allegations of fact or law in regard to the appeal requested in person or in writing to Outpatient QI.

The beneficiary/beneficiary's representative will also be given a reasonable opportunity, when requested, to examine the beneficiary's case file, including medical records and any other documents or records considered applicable to the appeal process.

Outpatient QI will receive and process all appeal requests. Contract providers will fax the appeal to Outpatient QI upon receipt of the appeal. The appeal will be processed as follows:

- Outpatient QI will enter the appeal into the Appeal Log within one (1) working day of receipt. The Appeal Log will indicate: (a) the name of the beneficiary, (b) the date of the receipt of the appeal, (c) the nature of the problem, and (d) final disposition of the appeal, including the date the written decision is sent to the beneficiary/beneficiary's representative, or documentation of the reason(s) that there has not been a final disposition of the appeal, including the date the written decision is sent to the beneficiary, or documentation of the reason(s) that there has not been a final disposition of the grievance.

- A letter acknowledging the receipt of the appeal will be sent to the beneficiary within ten (10) working days. The letter will also inform a Medi-Cal or RCHC beneficiary of his/her right to request a State Fair Hearing after they have completed the problem resolution process. Outpatient QI will be responsible for monitoring the appeal process to ensure that resolution of the appeal is within the appropriate timelines.

Outpatient QI will notify the involved inpatient facility or contract provider of the pending appeal. A decision about the appeal may be reached through discussions between the beneficiary, or the beneficiary's representative and the RCDMH program, contract providers, or other persons involved in the matter at hand.

Outpatient QI will insure that the person reviewing an appeal, also known as the decision-maker; will not have been involved in any previous level of review or decision making with the appeal.

Outpatient QI will be responsible for notifying the beneficiary/beneficiary's representative of the decision in writing within forty-five (45) calendar days of the receipt of the appeal. The notice will contain the following:

- The results of the appeal resolution process.
- The date that the appeal decision was made.
- If the appeal is not resolved wholly in favor of the Medi-Cal or RCHC beneficiary, the notice will also contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing for a State Fair Hearing. The notice will also inform the Medi-Cal or RCHC beneficiary of their right to request and receive benefits while the State Fair Hearing is pending and the procedure for making the request.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary request an extension and Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will also send a written notification to the beneficiary and/or the beneficiary's representative and all other affected parties when an extension has occurred. The written notification will explain the reason for the extension.

If the Medi-Cal or RCHC beneficiary/beneficiary's representative and/or provider are not notified of the appeal within the forty-five (45) calendar days of receipt of the appeal or have not requested an extension from the Medi-Cal or RCHC beneficiary, a Notice of Action form will be sent to the Medi-Cal or RCHC beneficiary/beneficiary's representative advising them of their right to request a State Fair Hearing. The Notice of Action letter will be sent on the date that the 45-calendar day period expires.

Outpatient QI will record the final disposition of the appeal, including the date the decision was sent to the beneficiary/beneficiary's representative, or document the reason(s) that there has not been a final disposition of the appeal in the Appeal Log. Notification efforts will be documented in the log if the beneficiary/beneficiary's representative cannot be contacted orally or in writing.

Outpatient QI will notify those providers cited by the beneficiary/beneficiary's representative or otherwise involved in the appeal of the final disposition of the beneficiary's appeal.

### **Expedited Appeal: Medi-Cal or RCHC Beneficiary**

An appeal will be handled in an expedited manner when Outpatient QI determines, or the beneficiary or the provider request that taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. The Expedited Appeals block should be checked on the appeal form. When this block is checked the appeal will be processed within the Expedited Appeal guidelines.

The beneficiary's mental health specialty services will continue until there is a response to the expedited appeal from Outpatient QI, unless the beneficiary poses a threat to the safety of other beneficiaries receiving services in a residential or outpatient facility. Expedited appeals received by RCDMH program or contract provider will be faxed to Outpatient QI.

A beneficiary/beneficiary's representative will be allowed to file the request for an expedited appeal orally, without a written follow-up, or by using the Appeal form and checking the "expedited appeal" box on the form.

Outpatient QI will register the receipt of the expedited appeal in the Appeal Log within one (1) working day of receipt and indicate that the appeal is an expedited appeal request.

When Outpatient QI receives the expedited appeal from the beneficiary/beneficiary's representative, Outpatient QI will have three (3) working days from receipt to review the expedited appeal and to seek resolution with the beneficiary/beneficiary's representative either in person or by telephone. Outpatient QI will insure that the person reviewing the expedited appeal, also known as the decision-maker, will not have been involved in any previous level of review or decision making with the expedited appeal.

By the end of the third (3<sup>rd</sup>) working day, a written notification summarizing the discussion and the proposed resolution of the expedited appeal shall be given to the beneficiary/beneficiary's representative. The letter will contain the following:

- The results of the expedited appeal resolution process.
- The date that the expedited appeal decision was made.
- If the expedited appeal is not resolved wholly in favor of the Medi-Cal or RCHC beneficiary, the notice will contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing a State Fair Hearing.
- The availability of assistance to complete the form for a State Fair Hearing will be given to any Medi-Cal or RCHC beneficiary/beneficiary's representative who wishes to appeal the expedited appeal decisions.

Timeframes may be extended up to fourteen (14) calendar days if the beneficiary request an extension or Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will send written notification to the beneficiary/beneficiary's representative and all other affected parties when either party has requested an extension. The written notification will explain the reason for the extension.

If Outpatient QI denies a request for an expedited resolution of an appeal, Outpatient QI will: (a) transfer the appeal to the timeframe for a standard appeal resolution and (b) make a reasonable effort to give the beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal process and follow up within two (2) calendar days with a written notice.

## **Grievances Regarding CARES or ACT**

When a complaint is received from the Department of Social Services (DPSS) against a contract provider of the MHP and/or an employee of the Department of Mental Health (DMH), the complaint will be logged by the recipient of the complaint and processed in accordance with the grievance procedure.

When a complaint is received from a beneficiary/beneficiary's representative about an employee of the CARES Unit and/or the ACT the beneficiary/beneficiary's representative will be encouraged to call the supervisor of that employee. The beneficiary/beneficiary's representative will be asked if they would like to file a grievance. All complaints/grievances will be processed in accordance with the grievance procedure.

If a beneficiary/beneficiary's representative is dissatisfied with the grievance decision the beneficiary/beneficiary's representative may be referred to QI for further review.

## **Outpatient Quality Improvement (Outpt QI) – Grievance Process and Appeal Process Review**

QI will have a process in place to monitor the grievance process and appeal process to identify and address systemic problems or weaknesses. QI will forward a summary of the issues identified in the grievance or appeal processes to RCDMH management for review and, if applicable, implementation of needed system changes.

## **State Fair Hearing**

State and Federal law guarantees Medi-Cal or RCHC beneficiaries a right to a State Fair Hearing after they have completed the problem resolution process. Beneficiaries are to be notified, orally if possible, and in writing when services are being denied, terminated, or reduced. The Notice of Action (NOA) will inform Medi-Cal or RCHC beneficiaries of their right to request State a Fair Hearing within ninety (90) calendar days of the date of the notice. In addition, if the beneficiary requests a State Fair Hearing within ten (10) days of the date of the notice, the beneficiary is entitled to continue to receive services until the Fair Hearing decision is made under the Aid Paid Pending clause when:

The CARES Unit reduces or terminates services, and  
The beneficiary is currently receiving services.

The request for a State Fair Hearing is completed by the Medi-Cal or RCHC beneficiary and mailed directly to the Administrative Adjudications Division in Sacramento. Hearings are held

within thirty (30) days of the request, and involved parties are notified ten (10) days prior to the hearing. The Department will prepare a position paper concerning the issues, which must be given to the beneficiary/beneficiary's representative at least two (2) days prior to the hearing.

### **Enforcement**

Mental health providers must abide by the decisions of the State Fair Hearing regarding treatment services provided to beneficiaries.

The Mental Health Director is responsible for assuring that the State Fair Hearing decision is followed. Failure to implement the recommendation or decision could result in disciplinary action, fines or revocation of contract as imposed by the Mental Health Director.

### **Confidentiality**

Grievance and Appeal procedures shall ensure the confidentiality of beneficiary/consumer records. Informed consent shall be obtained from beneficiaries/consumers when any information or records are released to anyone not specifically authorized by law to have access.

## **Consumer Problem Resolution**

RCDMH is committed to maintaining quality services for Riverside County consumers, and is mindful that there may be many factors contributing to a consumer's dissatisfaction. Complaints/Grievances about providers will be investigated by RCDMH Outpatient Quality Improvement.

Most complaints are minor and can be easily resolved on an informal level, while other situations may be more complex and may involve a written follow-up. In less frequent situations providers may be placed on a "QI Hold" while a situation is being investigated. Being placed on "hold" is dependent on the severity of the concern, pattern of past complaints, and the impact on the consumer(s). Providers will be notified in writing of the hold.

Providers will be notified via certified mail of contract termination.

## Definitions

**Reduction in Service:** Any reduction in the mode or method of services, including but not limited to a reduction in the frequency or duration or in accessibility of location of provider.

**Beneficiary/Consumer Assistant:** A person appointed by each provider of mental health services located at the provider site whose function it is to assist beneficiaries with the grievance procedure. The beneficiary/consumer assistant may be an employee of the provider and may have other responsibilities in addition to assisting beneficiaries.

**Denial of Service:** A refusal on the part of the provider, provider staff, or managed care system to deliver the type, mode or method of mental health treatment or services requested by the applicant of a requested service, beneficiary/consumer, or of a person lawfully entitled to consent for treatment on the beneficiary's/consumers' or consumer representative's behalf.

**State Fair Hearing (Medi-Cal or RCHC):** The formal hearing described in "Beneficiary/Consumer Notices," Section 431.200 et seq. of the federal Regulations and Section 10950 et seq. of the Welfare and Institutions Code.

**Mental Health Director:** The County-designated Mental Health Director or the County-designated Regional Program Manager providing the managed care service for a county.

**Notice of Action:** Formal written and whenever possible oral notification to the beneficiary/consumer of any denial, change or termination of treatment or services. The notice should specify the proposed action and reasons therefore, effective dates of the action and grievance procedures available.

**Patients' Rights:** The persons designated in the Welfare and Institutions Code Section 5500 et seq. to protect the rights of all recipients of mental health services.

**Termination of Service:** The cessation or suspension of any mode or method of treatment of services the beneficiary/consumer has been receiving due to a decision made by the mental health care provider and/or managed care system.



# Provider Problem Resolution

## CHAPTER

# 9

## Provider Informal Problem Resolution Process

Most complaints are solved quickly and easily on an informal level by discussing the issues with the people directly involved in the problem.

Providers with payment authorization issues or other complaints and concerns may call (951) 358-7797. Resolution may be reached through discussion between the provider and the Authorizing Unit (CARES or ACT), Provider Relations and/or Claims Unit.

If a provider is not satisfied with the outcome, the provider appeal process can be used through Outpatient QI when the complaint involves either a denied request for authorization or a claims payment issue. On claims paid through EDS, the provider should contact EDS directly.

**Providers have the right to access the Provider Appeal Process any time before, during, or after the Provider Problem Resolution Process has begun when the complaint concerns a denied or modified request for the MHP payment authorization or the processing or payment of a provider's claim to the MHP.** If a provider has received a denial letter, the provider's written appeal must be submitted to Outpatient QI within sixty (60) calendar days of the date of the postmark on the denial letter.

## Appeals

### Appeals Procedure for Providers

A provider may appeal a denied or modified request for the MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal shall be submitted to Outpatient QI within sixty (60) calendar days of the date of the postmark on the denial letter.

The appeal must include the following:

- A copy of the denial letter.
- A copy of the authorization letter, if applicable.
- A letter giving the reasons that the appeal is being requested and any supporting documentation, which would help determine the outcome of the appeal.

**The above information should be mailed to:**

**Riverside County Department of Mental Health (RCDMH)**

**Outpatient Quality Improvement (Outpt QI)**

**Attention: Appeals**

**P.O. Box 7549**

**Riverside, CA 92513**

**Telephone # (951) 955-7320**

**Fax # (951) 955-7203**

Outpatient QI will review all written information, including information from the authorizing unit and/or claims unit. Outpatient QI will notify the provider within sixty (60) calendar days from its receipt of the appeal in writing of their decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

If the appeal is granted, the provider may submit a revised Health Insurance Claim Form (CMS-1500) for MHP payment authorization within thirty (30) calendar days from receipt of Outpatient QI's decision to approve. The MHP will have fourteen (14) calendar days from the date of receipt of the provider's revised CMS-1500 for payment to take corrective action.

When an appeal concerning the denial or modification of a payment authorization request for specialty mental health services provided to a beneficiary during a psychiatric inpatient or a psychiatric health facility stay is denied in full or in part by Inpatient QI on the basis that the provider did not comply with the required timelines for notification or submission of the payment request or medical necessity criteria were not met, or that the requirements for approval of administrative days were not met, the provider may appeal the denial or modification to the State Department of Mental Health (SDMH). A hospital may not appeal the denial or modification of payment authorization to SDMH when the denial or modification is based on determination that a hospital has failed to comply with the mandatory provisions of the contract between the provider and the MHP/DMH.

Hospitals and individual, group or organizational providers who have provided specialty mental health services under the required timelines for notification or submission of the payment request and meeting medical necessity criteria to a beneficiary during a psychiatric inpatient or a psychiatric health facility stay and it is the subject of the appeal may appeal separately to the SDMH unless they have agreed to another arrangement as a term of their contact with MHP/DMH.

If a provider chooses to appeal a denial or modification of payment authorization for services provided during a psychiatric inpatient or a psychiatric health facility stay, the provider shall submit an appeal to SDMH in writing, along with supporting documentation, within thirty (30) calendar days from the date of MHP/County's written decision of denial or modification is submitted to the provider. If Outpatient QI fails to respond to an appeal after sixty (60) calendar days from the submission of the appeal, the provider may appeal to SDMH within thirty (30) calendar days.

The appeal should include, but not be limited to:

Any documentation supporting allegations of timeliness, if as issue, including fax records, telephone records or memo.

Clinical records supporting the existence of medical necessity if at issue.

A summary of reasons why the MHP/DMH should have approved the MHP payment authorization.

A contact person(s) name, address, and phone number.

**This information should be mailed to:**

**Department of Mental Health  
Hearing Office  
1600 9<sup>th</sup> St.  
Sacramento, CA 95814  
(916) 654-3067**

The SDMH will notify the MHP/DMH and the provider of its receipt of a request for appeal within seven (7) calendar days. The notice to the MHP/DMH will include a request for specific documentation supporting denial of the payment authorization and a request for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal. MHP/DMH will submit the requested documentation to SDMH within twenty-one (21) calendar days of the date the notice was received by MHP or the SDMH will decide the appeal based solely on the documentation filed by the provider. The SDMH may allow both a provider representative(s) and the MHP/DMH representative(s) an opportunity to present oral argument to the SDMH.

SDMH will have sixty (60) calendar days from the receipt of the MHP/DMH's documentation or from the 21<sup>st</sup> calendar day after the request for documentation was received by the MHP, whichever is earlier, to notify the provider and the MHP, in writing, of its decision. SDMH will include a statement of the reasons for the decision that addresses each issue raised by the provider and the MHP, and any actions required by the MHP or the provider to implement the decision. At the election of the provider, if the SDMH fails to act within the sixty (60) calendar days, the appeal may be considered to have been denied by SDMH.

If the appeal is granted, the provider may submit a revised CMS-1500 for payment authorization within thirty (30) calendar days from receipt of SDMH's decision to approve. RCMHP/DMH will have fourteen (14) calendar days from the date of receipt of the provider's revised CMS-1500 for payment to process the payment.

## **Adverse Incidents Standard Practices and Procedures**

### **Purpose**

To provide a system of continuous quality improvement and preventive maintenance in a systematic way. To provide a uniform method of reporting incidents that may increase the risk of endangerment and/or may be considered harmful or dangerous to an individual or to an agency/clinic site.

### **Definition**

An adverse incident is defined as any condition, event or situation, which in the mind of a reasonable person, jeopardizes or is reasonably considered to be physically or psychologically harmful to consumers, employees, providers or visitors.

## **General Principle**

Incident Reports are confidential communications and are, as a result, privileged information and need to be **identified as such**.

## **Reportable Incidents**

Death of a consumer, provider, or visitor from unnatural causes.  
Physical injury to any consumer or visitor requiring medical attention.  
Suicide.  
Significant injury caused by suicide attempt.  
Homicide.  
Significant injury caused by physical assault/battery by consumer upon another.  
Significant injury to consumer while at agency site.  
Death of consumer by other than natural causes.

The Program Chief shall be responsible for mandated reporting to the SDMH.

## **Adverse Incident/Unusual Occurrence Reporting Procedure**

All adverse incident/unusual occurrences shall be reported by the individual provider or agency to Outpatient Quality Improvement by calling (951) 955-7320.

An Incident Form, Initial Report of Incident (See Attachment #13), shall be written and completed for any adverse incident/unusual occurrence and this shall be written within 24 hours following the Incident. The provider witnessing or discovering the incident shall initiate this form. The clinician will make a brief progress note stating what happened and how it affected the consumer. There shall be no reference to or copy of the Adverse Incident report in the consumer's chart.

Providers/supervisors are to annotate possible license violations on the Department of Mental Health Incident Report Form.

If any other consumers are involved in the incident, they will be identified by number only in the consumer's record.

When more than one staff member is involved, those staff members should participate in completing the necessary forms.

**A copy of the Incident Form shall be mailed to:**

**Riverside County Department of Mental Health (RCDMH)  
Outpatient Quality Improvement (Outpt QI)  
P.O. Box 7549  
Riverside, CA 92513**

**Outpatient QI will evaluate the initial RCDMH report. If determined it is a RCDMH adverse incident, a mandatory DMH Form 408 will be sent to the provider to be completed within 72 hours.**

The provider will forward the original DMH Form 408 to Outpatient QI who will forward the original DMH Form 408 to Risk Management and a duplicate copy to the Medical Director.

### **Definition of an Adverse Incident Review Committee**

A regional/divisional multidisciplinary group of service providers specifically assembled by the appropriate Mental Health Services Manager shall review all documentation and write a report concerning the adverse incident that has been referred to the Committee by the involved providers.

Adverse Incident Review Committees shall rotate members to ensure that there is one or more experienced committee member available at any given time. County employees/providers involved in an incident being investigated shall not be on the Adverse Incident Review Committee during the review of the incident.

Each Region's Committee shall be responsible for the following functions:

Review of Adverse Incidents that occur in a specific region.

Collection and review of all relevant information. Recommendations for appropriate administrative action including licensing review, consultation, education and corrective action when necessary. The Committee may also make recommendations for changes to policy and procedure.

Reporting the Committee findings and recommendations to the appropriate Regional Manager, Department's Program Chief, Medical Director, and Risk Management.

Maintaining summary reports of the Committee's activities, including findings and clinical or administrative recommendations when warranted.

The Committee shall indicate possible license violations upon review of the incident and the provider/supervisor's comments.

The Committee will ensure the confidentiality of the consumer, clinician, and reviewers.

The appropriate Manager, except for possible license violations, shall provide follow-up on the Committee's recommendations.

### **Scope of Authority**

In order to ensure that Adverse Incidents are monitored systematically and that corrective action is implemented in a timely manner, mutual cooperation is required on the part of all individual and agency providers.

The scope of review activities will include county operated and contract providers serving Mental Health funded consumers.

The range of activities of the committees may vary but will extend to all providers within the designated organizational or regional area.

The Outpatient QI Division will be involved and assist the Medical Director and Program Chief with monitoring and oversight of any Adverse Incidents.

# Claims Instructions

## Medi-Cal/RCHC Beneficiaries

For TBS providers it is the provider's responsibility to verify Medi-Cal eligibility each month before service is provided. For CARES authorizations and for adults whom the ACT has referred as Medi-Cal consumers, after the initial month of authorization, it is the provider's **responsibility** to verify Medi-Cal eligibility each month before services are provided. For most providers this will be done using the Automated Eligibility Verification System (AEVS) or the Medi-Cal website via [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) (See Attachment #12 or Attachment #23).

The State Department of Health Services issues a plastic Medi-Cal card to each Medi-Cal recipient. The local DPSS may also issue a paper card for Immediate Need and Minor Consent Program recipients. Possession of either type card **does not** ensure current Medi-Cal or RCHC eligibility, and the procedures noted above must be followed.

In addition to verifying that the consumer is eligible, providers are also responsible for checking Medi-Cal or RCHC eligibility status for:

**County of Responsibility:** For the CARES Unit authorizations the Medi-Cal or RCHC beneficiary should have Riverside County as the county of responsibility that is indicated by a county code of **33**. ACT authorizations can be for any county.

**Other Health Coverage:** Medi-Cal beneficiaries can also have insurance through a private insurance carrier. In these instances, Medi-Cal is the secondary insurer and the standard coordination of benefits rules applies. In all situations, the total reimbursement will not exceed the RCMHP reimbursement rate. The reimbursement rate will be considered payment in full.

The insurance carrier must be billed first and the insurer's Explanation of Benefits (EOB) and/or Remittance Advice must be provided to the Department of Mental Health. Medi-Cal will only pay the balance, less the insurance payment, not to exceed the state maximum allowance (SMA).

If the insurer does not cover mental health benefits, a valid denial letter must be obtained prior to the provision of services. A dated denial letter on the insurance's letterhead must indicate the client's name, date of birth, and the effective date, not to exceed a period of one from the date of the letter and that the services are not a covered benefit (e.g. Mental Health services are not a covered benefit from 1-1-11 through 7-1-11). Provider must retain the letter within the client record in case of audit.

If the insurer does not respond within ninety (90) calendar days, from the initial claim submission date, submit the claim with written documentation showing that the insurer has been billed and a subsequent follow-up claim or letter was sent to the insurer. If the insurer pays the claim at a later date, submit a corrected claim for adjustment. All documents should be retained by the provider within the client record for auditing purposes. Beneficiaries are not Medi-Cal or RCHC eligible if the insurer's denial is due to any reason other than 1) Services are not a covered benefit, or 2) Benefits have been exhausted. Specifically, denials due to the consumer's

failure to use the insurer's provider network (i.e. Kaiser) are invalid and services are not reimbursable by Medi-Cal or RCHC...

**Medi-Cal Share of Cost:** Medi-Cal beneficiaries with a share of cost are not Medi-Cal eligible until their share-of-cost is cleared and paid in full for the month.

Share of cost payments collected by the provider must be posted to the Medi-Cal website (See Attachment #23).

The amount collected by the provider should be posted in block 29, Amount Paid section on the CMS 1500.

**For ACT referrals only:** Verification of Medi-Cal in months after the month of authorization/reauthorization is not necessary, if the ACT did not designate the consumer as Medi-Cal at the time of authorization/reauthorization. Thus, if a consumer becomes eligible for Medi-Cal in months between authorizations, providers will not be held responsible for collecting share of cost. However, providers must still verify eligibility each month and collect share of cost if the consumer was identified as Medi-Cal at the time of authorization/reauthorization.

**For RCHC referrals only:** Verification of eligibility is not applicable and there is no share of cost. Claims processing outlined on pages 3 and 4 remains the same.

**Medicare/Medi-Cal Claims:** Services for clients with Medicare and Medi-Cal coverage are not reimbursable by the RCMH unless the beneficiary's Medicare benefits have been exhausted, or the service is not covered per the Explanation of Benefits (EOB) submitted with the claim. See the "Other Health Care Coverage" section regarding reimbursement for Medi-Cal clients with Medicare Risk and/or Senior HMO coverage.

Only Medicare providers should treat consumers with both Medicare and Medi-Cal benefits. Medicare providers have traditionally been licensed medical doctors and licensed psychologists. Medicare now allows for some licensed clinical social workers to enroll in their program. Services for clients with Medicare and Medi-Cal coverage are reimbursable by Medi-Cal if the rendering provider is not eligible for Medicare program enrollment (i.e. MFTs, unlicensed mental health counselors, etc.). These services may be billed directly to Medi-Cal in most cases...

**HP Enterprise Services  
ATTN: CSU  
P.O. Box 13029  
Sacramento, CA 95813-4029**



## ACT Non-Medi-Cal Consumers

**Insurance Coverage:** Non-Medi-Cal consumer's insurance coverage must be billed before submitting ACT claims for payment and the insurer's Explanation of Benefits (EOB) attached to the CMS Claim Form.

DPSS will only pay the balance, less the insurance payment, up to the contract amount.

The insurer's payment should be posted in block 29, Amount Paid, section of the CMS 1500.

If the insurer does not cover mental health benefits, a valid denial letter must be obtained prior to the provision of services. A dated denial letter on the insurer's letterhead must indicate the client's name, date of birth, the effective dates, not to exceed a period of one year from the date of the letter, and that the services are not a covered benefit, (e.g. Mental Health services are not a covered benefit from 1-1-11 through 7-1-11). Providers must retain the letter within the client record in case of audit.

If the insurer does not respond within ninety (90) calendar days from the initial claim submission date, submit the claim with written documentation showing the insurer has been billed and a subsequent follow-up claim or letter was sent to the insurer. If the insurer pays the claim at a later date, submit a corrected claim for adjustment. All documentation should be retained by the provider within the client record for auditing purposes. Beneficiaries are not Medi-Cal or RCHC eligible if the insurer's denial is due to any reason other than 1) Services are not a covered benefit, or 2) Benefits have been exhausted. Specifically, denials due to consumer's failure to use the insurer's provider network (i.e. Kaiser) are invalid and services are not reimbursable by Medi-Cal or RCHC.

### Valid Claims

Valid claims for Outpatient Specialty Mental Health Services must meet the following criteria:

**Not to exceed** the total numbers of services within the timeframe authorized by the CARES Unit or the ACT.

The provider who was authorized to provide the services must have delivered the services. (There is no reimbursement for services where the consumer failed to show.) The provider cannot bill for more time than was actually spent with the consumer. The provider is to bill with the CPT Code corresponding to the length of time actually spent using the roll-down/cluster codes to the nearest time interval.

**CPT Codes/Cluster Codes:** Providers should only use authorized CPT codes for billing purposes. Some CPT Codes are cluster codes **(the same services with different time increments)**. You may bill for less minutes than authorized in a CPT cluster, **but not for more minutes than authorized**. As an example, if your authorization is for a 60-minute session and the service rendered is a 30-minute session, you would bill using the 30-minute CPT cluster code. **You cannot bill for more time than was actually spent with the consumer even if**

**you have an authorization for a longer time period.** You must roll down to the CPT cluster code that is closest to the timeframe that was actually spent providing services to the consumer.

The service was delivered within the time frame designated, and within the designated frequency specified in the authorization.

The CMS 1500 is the preferred claim form; however, other forms may be used but must include all of the CMS 1500 data elements.

### **The CMS 1500 requires:**

The beneficiary information must be completed (**items 1a, 2, 3, 5, and 12**). Providers can also have the signature on file for Block 12.

The provider completes blocks 21, 24, and 31-33 using **only** authorized codes within an authorized **time** period and frequency.

There **must** be a numeric diagnosis and description from the ICD 9 in block 21.

Block 32 must be filled in with the actual address of the service location where the service is rendered. Block 33 must be filled in with the name, billing address, and telephone number of the provider/agency that was authorized to see the consumer. The address should be the one on file.

**Provider's or authorized biller's written original signature** is required (**no copies or facsimile**) on **all** claim forms in block 31.

**When submitting claims for payment, do not combine two or more months on the same CMS 1500. Each month's dates of service must be billed on a separate CMS 1500 Claim Form.**

**Claim Deadlines:** Claims must be received within **sixty (60) calendar** days (including weekends and holidays) of the date of service being provided on claims without other health coverage. Other Health coverage claims for non-Medi-Cal beneficiaries must be received within **ninety (90) calendar days** (including weekends and holidays) of the service being provided. Other Health Coverage claims for Medi-Cal beneficiaries must be received within fifteen (15) days (including weekends and holidays) of the Explanation of Benefits (EOB) payment/denial date. Claims received after the deadline date will be denied. **If the insurer pays the claim at a later date, submit a corrected claim for adjustment.**

**Riverside County Mental Health Plan Detail Remittance Advice (DRA):** The DRA **will include the name of the consumer, social security number, date of birth, sex, date of service, the CPT code billed, the amount billed, and the amount paid along with an explanation of any reduction or denial of the claim payment.**

**Group Therapy:** Group therapy should be billed as a single service code unit for each consumer being claimed.

**Claims Questions:** If you have questions on a claim, contact the Claims Help Line at (951) 358-7797.

## **Certification of Claims and Program Integrity Form**

The RCDMH is required to certify that contract providers are rendering and claiming for services that are in compliance with specific statutory, regulatory and contractual obligations as stated in their contract. Contract providers are to complete a Certification of Claims and Program Integrity Form (#17) each time a batch of claims is submitted for reimbursement certifying that the claim(s) are in compliance as stated in their individual/agency contract.

Mail all claims and the Certification of Claims and Program Integrity Form to:

Riverside County Mental Health Plan (RCMHP)  
Managed Care Administration Unit/Claims  
9731 Magnolia Avenue  
Riverside, CA 92503  
(951) 358-7797

# Provider Requirements

## Credentialing

All providers must comply with the terms/conditions of their contract with Riverside County Department of Mental Health. As part of their contract, all providers must:

- a) Be credentialed **prior** to providing services and be re credentialed every three years thereafter.
- b) Maintain License/Registration and Malpractice Insurance.
- c) Provide their National Provider Identification (NPI) number.
- d) Contact Provider Relations with any changes to their staff, tax ID#, NPI#, etc.

Failure to maintain credentialing or to comply with the terms of the contract/DMH Policy 160 will result in **non-payment for services during the non compliance period.**

## Medi-Cal Certification

For organizational providers, on-site certification is required every two years. Additional certification reviews may become necessary if:

- The provider makes major staffing changes.
- The provider makes organizational and/or corporate structure changes (example: conversion from non-profit status).
- The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.
- There are significant changes in the physical plant of the provider site (some physical changes could require a new fire clearance).
- There is a change of ownership or location.
- There are complaints regarding the provider.
- There are unusual events, accidents or injury requiring medical treatment for consumers, staff or members of the community.

The RCDMH must be notified in writing at least **sixty (60)** days prior to a change of ownership, or a change of address, for Medi-Cal or certified Fee-For-Service (FFS) programs. Failure to comply may result in a temporary de-certification, delay, or actual loss of Medi-Cal revenue for services provided during the non-certified period. **Providers will not be reimbursed for any services provided during a non-certification period.**

## **Change of Ownership or Location (The Following Applies to Both)**

**Sixty (60)** days prior to the change of ownership or location, the local mental health director or designee must inform the RCDMH Medi-Cal Oversight regional office of the following:

- The current provider name, number, and date of termination, if applicable.
- Name of the new provider, if applicable.
- New address of provider, if applicable.
- Date of ownership or location change.
- Any major staff or program changes.
- A new fire safety inspection and corrections for the new address.

(Involuntary changes of location due to disasters should be reported as soon as possible and are not subject to the sixty (60) day prior notification requirement.)

## **Facility Safety**

All individual, group, and organizational providers will maintain a safe facility in accordance with CCR Title 9, Chapter 11, Section 1810.435 (b)(2). Individual, group, and organizational providers will store and dispense medications in compliance with all applicable state and federal laws and regulations.

## **Hours of Availability**

In accordance with 42 CFR (Code of Federal Regulations), providers serving Medi-Cal or RCHC beneficiaries must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial consumers. If the provider serves only Medi-Cal or RCHC beneficiaries, the hours of service availability must be the same for fee-for-service and managed care consumers.

Outpatient Quality Improvement (Outpt QI) will monitor availability of service hours during site reviews. Problems with availability will be monitored through examination of the Grievance Log.

## **On-Call and Coverage**

All individual, group, and organizational providers will be available to return consumer calls within twenty-four (24) hours. A system must be in place to return consumer crisis calls immediately. The provider's voice mail must include how to access emergency services if the consumer needs assistance prior to the call being returned. This may include referring the consumer to the nearest hospital bed or calling 911.

If the provider of services is out of the office for an extended period of time, a back-up plan for consumer coverage must be in place.

# **Health Insurance Portability and Accountability Act (HIPAA)**

To improve the effectiveness and efficiency of the healthcare system, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. It was enacted to improve the portability and continuity of health care coverage in the group and individual markets, and accomplished these goals by instituting reforms nationwide. The law included Administrative Simplification provisions which are divided into three primary components to address specific standards for privacy, electronic exchange, and security of health information. HIPAA privacy and security rules are applicable to every health plan, health care clearinghouse, and/or health care provider, regardless of size, that transmits or maintains electronic health information, to assure the confidentiality, integrity and security of that data. The County of Riverside defines itself as one covered entity; therefore the Department of Mental Health is a part of that covered entity. Any Riverside County Department of Mental Health contract provider that provides consumer services is required to follow HIPAA Guidelines.

## **PRIVACY RULE**

The HIPAA Privacy Rule establishes a uniform, Federal floor of privacy protections for consumers across the nation. These standards provide patients with access to their medical records and control over how their personal health information is used and disclosed. Protected Health Information (PHI) is defined as individually identifiable demographic information that relates to an individual's past, present or future physical or mental health or condition. This includes information held or transmitted by a covered entity in any form or media, whether electronic, paper, or oral.

The Riverside County Department of Mental Health is committed to protecting the health information of all consumers. All staff members are required to sign an "Oath of Confidentiality". A standard Notice of Privacy Practices (NPP) which describes the County's policies in regards to use, disclosure, and protection of an individual's PHI, is issued to all consumers at their first visit. The NPP is available in English and Spanish. The consumer is to sign the accompanying acknowledgement form to indicate that they have received the organization's NPP, and this acknowledgement is filed in the consumer's chart. If the consumer refuses to sign, such is noted on the acknowledgement form. The NPP outlines the limits within which an individual's health information will be disclosed without an authorization, which includes uses for treatment, payment, and health care operations. A poster containing the same information as the NPP must be posted in the lobby of the office of every health care provider.

As a general rule, aside from uses for treatment, payment, and health care operations, disclosure of PHI is only made with a valid authorization to release information. Reasonable efforts must be made to limit PHI access to those who need the information in order to perform their job duties. Qualified professionals of a covered entity are allowed to disclose PHI to other health care professionals or facilities for the purpose of diagnosis or treatment of the consumer. In such cases, the covered entity must make reasonable efforts to disclose only the minimum information necessary to accomplish the intended purpose of effective diagnosis and treatment, when it is in the consumer's best interest. The Riverside County Department of Mental Health

commits itself to maintaining the confidentiality of Protected Health Information, and implementing the standards established by HIPAA.

Any disclosure made without a valid authorization request must be logged in a “Disclosure Log” maintained in the consumer’s file. Any accidental or potential disclosures should be immediately reported to the program supervisor/manager and the RCDMH Compliance Officer.

## **TRANSACTION AND CODE SET RULE (Electronic Exchange)**

The HIPAA Transaction and Code Set Rule ensures that the health care industry speaks one common “language” when transmitting electronic claims, a remittance advice, status of payment requests, and responses.

Effective May 23, 2007, all service providers must use a National Provider Identifier (NPI) on claims submitted for reimbursement. Both the organization and individual service provider must apply for an NPI through the National Plan and Provider Enumeration Services (NPPES) website <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. The purpose of an NPI is to establish a single identifier that is used nationwide to bill all payor sources for services delivered. It is hoped that the NPI will assist healthcare programs to detect and prevent fraud and/or abuse resulting from duplicate and/or overbillings.

Effective January 1, 2011, all rendering service providers must also include their taxonomy code on all claims submitted reimbursement. When applying for an NPI, the rendering service provider selects a taxonomy code at <http://www.wpc-edi.com/taxonomy> which best identifies their discipline. All staff providing billable mental health or substance abuse services are responsible for obtaining an NPI and taxonomy code, and forwarding it to Riverside County Department of Mental Health at [MentalHealthSupport@rcmhd.org](mailto:MentalHealthSupport@rcmhd.org) so that it can be entered to the billing system and included on the claim.

Organizations and staff are responsible for updating the NPPES website as necessary to reflect any changes to their information such as name, address, license, or work location.

## **SECURITY RULE**

Effective April 20, 2006, the HIPAA Security Rule required covered entities to assess, mitigate, and manage the security of electronic Protected Health Information (PHI) that they receive or maintain. Each covered entity must adopt reasonable and appropriate policies and procedures to address administrative, physical and technical safeguards. Specifically, covered entities must:

- Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit
- Identify and protect against reasonably anticipated threats to the security or integrity of the information

- Protect against reasonably anticipated, impermissible uses or disclosures
- Ensure compliance by their workforce

## **ADVANCE DIRECTIVES**

It is the policy of the Riverside County Department of Mental Health (RCDMH) that all contracted providers provide all adult consumers with an informational brochure concerning their rights under California state law regarding Advance Medical Directives at the first face-to-face contact for services, and thereafter upon request by the consumer. It shall be documented in the chart whether or not a consumer has an Advance Directive in place. In the event a consumer presents a specifically completed, appropriately witnessed, signed and dated Advance Medical Directive (Attachment 38A & 38B), the document shall be placed in the consumer's mental health file.

California law defines an Advance Medical Directive as either an oral or written individual health care instruction or power of attorney for health care. RCDMH contracted providers shall provide the "Your Right to Make Decisions about Medical Treatment" brochure (Attachment 33A & 33B) regarding Advance Medical Directives when they have their first face-to-face contact with an adult consumer and thereafter upon a request from a consumer.

**Questions, comments, or suggestions may be directed to 1-800-413-9990.**



# Medication Guidelines

CHAPTER

12

## Summary of Guidelines

The RCDMH has revised the Medication Guidelines document previously provided. Please go to the website, [www.rcdmh.org](http://www.rcdmh.org) for the most current revision.. These guidelines reflect a synthesis of information and opinions from standard psychiatric textbooks and publications, other published guidelines, and input from RCDMH psychiatrists. The guidelines are meant to be a resource for the provision of care by both RCDMH psychiatrists and Managed Care (contracted) psychiatrists. It is expected the psychiatrist, or other physician, will base his/her treatment plan on the needs of each individual patient and his/her clinical knowledge supported by regular review of relevant literature including this document. For additional copies of the Guidelines please contact the Outpatient QI Division at 951-955-7320.

These guidelines will be used by the Outpatient QI Division when performing quality of care reviews of both RCDMH psychiatrists and Managed Care psychiatrists.

Each patient should participate in the development of his/her treatment plan, which may include the use of medications. Patients should be informed to the fullest extent practical of the anticipated benefits, risks, alternative treatments, and possible immediate and/or long-term effects of specific medications.

## Attachments

### ACT

Attachment 1A:	Assessment/Care Plan: Initial, English (3 pages)
Attachment 1B:	Assessment/Care Plan: Initial, Spanish (3 pages)
Attachment 3:	Discharge Summary (1 page)
Attachment 4:	Medication Declaration Forms (4 Documents) (Website URL - 1 pg) / (Cover Sheet – 1 pg) / (JV220 – 1 pg) / (JV220A – 3 pgs)
Attachment 5:	Referral for Psychological Testing (3 pages)
Attachment 8:	ACT Quarterly Report/Reauthorization Request (3 pages)
Attachment 9A:	ACT Release/Receipt of Information and/or Records, English (1 page)
Attachment 9B:	ACT Release/Receipt of Information and/or Records, Spanish (1 page)
Attachment 10A:	Adult Medical History, English (2 pages)
Attachment 10B:	Adult Medical History, Spanish (2 pages)
Attachment 11A:	Child's Medical, Medication, and Prenatal History, English (2 pages)
Attachment 11B:	Child's Medical, Medication, and Prenatal History, Spanish (2 pages)
Attachment 12:	Automated Eligibility Verification System (AEVS) (7 pages)
Attachment 13:	Initial Report of Incident (1 page)
Attachment 14:	QI Adverse Incident Report (2 pages)
Attachment 15:	CSI Data Collection (2 pages)
Attachment 16:	Provider Referral Request Form (1 page)
Attachment 17:	Certification of Claims and Program Integrity Form (1 page)
Attachment 23:	Eligibility Verification Via Medi-Cal Website (1 page)
Attachment 25:	Medication Guidelines (Separate document on web site)
Attachment 33A:	Your Right to Make Decisions about Medical Treatment (1 pamphlet) (Available on web site)
Attachment 33B:	Your Right to Make Decisions about Medical Treatment, Spanish (1 pamphlet) (Available on web site)
Attachment 37:	Grievance Log

## CARES

Attachment 1A:	Assessment/Care Plan: Initial, English (3 pages)
Attachment 1B:	Assessment/Care Plan: Initial, Spanish (3 pages)
Attachment 2:	Treatment Extension/Change Request (2 pages)
Attachment 3:	Discharge Summary (1 page)
Attachment 4:	Medication Declaration Forms (4 Documents) (Website URL - 1 pg) / (Cover Sheet – 1 pg) / (JV220 – 1 pg) / (JV220A – 3 pgs)
Attachment 5:	Referral for Psychological Testing (3 pages)
Attachment 6A:	Consent to Treat, English (1 page)
Attachment 6B:	Consent to Treat, Spanish (1 page)
Attachment 7A:	Authorization for Treatment of Minors, English (1 page)
Attachment 7B:	Authorization for Treatment of Minors, Spanish (1 page)
Attachment 10A:	Adult Medical History, English (2 pages)
Attachment 10B:	Adult Medical History, Spanish (2 pages)
Attachment 11A:	Child’s Medical, Medication, and Prenatal History, English (2 pages)
Attachment 11B:	Child’s Medical, Medication, and Prenatal History, Spanish (2 pages)
Attachment 12:	Automated Eligibility Verification System (AEVS) (7 pages)
Attachment 13:	Initial Report of Incident (1 page)
Attachment 14	QI Adverse Incident Report (2 pages)
Attachment 15:	CSI Data Collection (2 pages)
Attachment 16:	Provider Referral Request Form (1 page)
Attachment 17:	Certification of Claims and Program Integrity Form (1 page)
Attachment 23:	Eligibility Verification Via Medi-Cal Website (1 page)
Attachment 24:	Psychiatric Treatment Authorization Request (1 page)
Attachment 25:	Medication Guidelines (Separate document on web site)
Attachment 26:	IMD Psychiatrist/Psychologist Treatment Authorization Request (1 page)
Attachment 27	Referral for Services for FFA or Group Home Consumer (1 page)
Attachment 28:	SB785 Forms (2 pages) (Available on Website)
Attachment 29	Informing Materials Order Form (1 page)
Attachment 30A	Riverside County Guide to Medi-Cal Mental Health Services Website URL (English)
Attachment 30B	Riverside County Guide to Medi-Cal Mental Health Services Website URL (Spanish)
Attachment 31A	Notice of Privacy Practice (HIPAA) (English) (5 pages)
Attachment 31B	Notice of Privacy Practice (HIPAA) (Spanish) (5 pages)
Attachment 32A	Grievance/Appeal Procedures/Form (English) (6 pages)
Attachment 32B	Grievance/Appeal Procedures/Form (Spanish) (6 pages)
Attachment 33A	Your Right to Make Decisions about Medical Treatment (1 pamphlet) (Available on web site)
Attachment 33B	Your Right to Make Decisions about Medical Treatment, Spanish (1 pamphlet) (Available on web site)
Attachment 34A	Riverside County Medi-Cal/RCHC Beneficiaries 1-800 Poster (English)
Attachment 34B	Riverside County Medi-Cal/RCHC Beneficiaries 1-800 Poster (Spanish)
Attachment 35A	Mental Health Patient’s Rights Poster (English)
Attachment 35B	Mental Health Patient’s Rights Poster (Spanish)

Attachment 36A	Consumer Grievance/Appeal Poster (English)
Attachment 36B	Consumer Grievance/Appeal Poster (Spanish)
Attachment 37	Grievance Log
Attachment 38A	Advanced Health Care Directive (English)
Attachment 38B	Advanced Health Care Directive (Spanish)

## **TBS**

Attachment 18:	TBS Referral (2 pages)
Attachment 19	TBS Informed Consent and Consent to Treatment
Attachment 20A:	Consent for TBS, English (1 page)
Attachment 20B:	Consent for TBS, Spanish (1 page)
Attachment 21	TBS Eligibility Criteria
Attachment 22	Procedure for TBS Eligibility Criteria Section B (1 page)
Attachment 23	Eligibility Verification Via Medi-Cal Website (1 page)
Attachment 29	Informing Materials Order Form (1 page)
Attachment 30A	Riverside County Guide to Medi-Cal Mental Health Services Website URL (English)
Attachment 30B	Riverside County Guide to Medi-Cal Mental Health Services Website URL (Spanish)
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Attachment 34B	Riverside County Medi-Cal/RCHC Beneficiaries 1-800 Poster (Spanish)
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Attachment 35B	Mental Health Patient's Rights Poster (Spanish)
Attachment 36A	Consumer Grievance/Appeal Poster (English)
Attachment 36B	Consumer Grievance/Appeal Poster (Spanish)
Attachment 37	Grievance Log

All attachments also available at:

[www.rcdmh.org](http://www.rcdmh.org)

[www.dpss.co.riverside.ca.us/childprotectiveservices](http://www.dpss.co.riverside.ca.us/childprotectiveservices).

[www.dpss.co.riverside.ca.us/AdultServices.aspx](http://www.dpss.co.riverside.ca.us/AdultServices.aspx)

RIVERSIDE COUNTY MENTAL HEALTH PALN  
ASSESSMENT / CARE PLAN: INITIAL

Attachment 1A  
Page 1 of 3

Type of Plan ☐ Medi-Cal/RCHC (CARES) ☐ DPSS (ACT) Initial Assessment Date: \_\_\_\_\_

Provider: \_\_\_\_\_ Provider #: 33 \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provide Fax #: \_\_\_\_\_

Consumer Name: \_\_\_\_\_  
First Last

Consumer DOB: \_\_\_\_\_ Consumer SS#: \_\_\_\_\_ Gender: ☐ M ☐ F

Medi-Cal Number: \_\_\_\_\_

Consumer's Primary Language: \_\_\_\_\_ Consumer's Ethnicity: \_\_\_\_\_

Type of Living Situation: ☐ Group Home ☐ Bio Parents ☐ Foster Home ☐ FFA (Private Foster Home)  
☐ Relative Placement (Minors) ☐ Shelter Home ☐ Board & Care ☐ IMD  
☐ SNF ☐ Independent Living ☐ Other \_\_\_\_\_

Name of Residential Facility (if Applicable): \_\_\_\_\_

Date of Placement: \_\_\_\_\_

Consumer's Current Address: \_\_\_\_\_

Consumer's Phone Number(s): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Axis I: \_\_\_\_\_

Secondary: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

(Specific Psychosocial Stressors)

Axis V: \_\_\_\_\_ / \_\_\_\_\_  
Current Highest in Past Year

Presenting Problems/Clinical Symptomology: \_\_\_\_\_

**Risk Assessment**

Suicide Ideation: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Suicide Intent: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Homicidal Ideation: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Homicidal Intent: ☐ None ☐ Mild ☐ Moderate ☐ Severe

If any at present, describe type and frequency of ideation, plan, and means: \_\_\_\_\_

RIVERSIDE COUNTY MENTAL HEALTH PALN  
ASSESSMENT / CARE PLAN: INITIAL

Attachment 1A  
Page 2 of 3

CONSUMER NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

Recommendations (Reasons for continued treatment/expected duration of treatment):

Current Medication(s) and Dosage(s): \_\_\_\_\_

Prescribing MD: \_\_\_\_\_

History of Mental Illness in Family: ☐ No ☐ Yes If yes, describe \_\_\_\_\_

Prior Psychiatric Hospitalization(s)? ☐ No ☐ Yes If yes, where, when, and why: \_\_\_\_\_

Mental Status

Appearance	<input type="checkbox"/> Clean	<input type="checkbox"/> Well Groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Bizarre		
Orientation	<input type="checkbox"/> Oriented	<input type="checkbox"/> Disoriented	<input type="checkbox"/> Time	<input type="checkbox"/> Place	<input type="checkbox"/> Person	<input type="checkbox"/> Situation
Mood	<input type="checkbox"/> Normal	<input type="checkbox"/> Anxious	<input type="checkbox"/> Depressed	<input type="checkbox"/> Angry	<input type="checkbox"/> Sad	<input type="checkbox"/> Euphoric
Affect	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Flat	<input type="checkbox"/> Labile	<input type="checkbox"/> Blunted	<input type="checkbox"/> Depressed
Intelligence	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average	<input type="checkbox"/> Below Average			
Memory	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> short Term	<input type="checkbox"/> Long Term		
Attention	<input type="checkbox"/> WNL	<input type="checkbox"/> Short	<input type="checkbox"/> Impaired	<input type="checkbox"/> Preservative		
Psychomotor	<input type="checkbox"/> WNL	<input type="checkbox"/> Agitated	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Retarded	<input type="checkbox"/> Catatonic	
Judgment	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Limited	<input type="checkbox"/> Poor		
Insight	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Limited	<input type="checkbox"/> Poor		
Speech	<input type="checkbox"/> WNL	<input type="checkbox"/> Pressured	<input type="checkbox"/> Minimal	<input type="checkbox"/> Rambling	<input type="checkbox"/> Circumstantial	
Thought	<input type="checkbox"/> WNL	<input type="checkbox"/> Concrete	<input type="checkbox"/> Disorganized	<input type="checkbox"/> Ruminative	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Loose <input type="checkbox"/> Tangential
Delusions	<input type="checkbox"/> Somatic	<input type="checkbox"/> Jealous	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Persecutory	<input type="checkbox"/> Erotic	
Hallucinations	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual	<input type="checkbox"/> Tactile	<input type="checkbox"/> Olfactory	<input type="checkbox"/> Command	

Occupation: \_\_\_\_\_

School: Education Level: \_\_\_\_\_ Functioning / Grades: \_\_\_\_\_

Drug / Alcohol Use: ☐ Present ☐ Past Duration of current Remission: \_\_\_\_\_

Describe (Type, Amount, Frequency): \_\_\_\_\_

Drug Rehabilitation Treatment: \_\_\_\_\_

Dysfunction Rating: ☐ None ☐ Mild ☐ Moderate ☐ Severe

RIVERSIDE COUNTY MENTAL HEALTH PALN  
ASSESSMENT / CARE PLAN: INITIAL

Attachment 1A  
Page 3 of 3

CONSUMER NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

**MEDICAL NECESSITY:** Describe specifically how symptoms impair a specific area of functioning; ie: work, school, health/safety, social. (For children there must be a reasonable probability/risk of significant deterioration in an important area of life functioning).  
**USE CURRENT DSM CRITERIA WHEN POSSIBLE:**

**GOALS:** Must be related to the specific impairment(s) listed above. Must be measurable/observable, and must include current frequency of the behavior, and the desired frequency.

Behavior Outcome/Goal # 1: \_\_\_\_\_

Target Date to Meet Goal #1: \_\_\_\_\_

Behavior Outcome/Goal # 2: \_\_\_\_\_

Target Date to Meet Goal #2: \_\_\_\_\_

Provider Intervention \_\_\_\_\_

Consumer Will: \_\_\_\_\_

**PROPOSED TREATMENT:** \*\* For providers requesting authorization through CARES only.

Refer for Psychiatric Services: ☐ Yes ☐ No If yes need to complete a "Provider Referral Request Form"

Individual Therapy: \_\_\_\_\_ session(s) per ☐ wk / ☐ month / ☐ qtr for \_\_\_\_\_ ☐ wks/☐ months (☐ 15/ ☐ 30 / ☐ 60 / ☐ 90 mins)

Group Psychotherapy: \_\_\_\_\_ session(s) per ☐ week / ☐ month \_\_\_\_\_ ☐ weeks / ☐ months

Family Therapy: \_\_\_\_\_ session(s) per ☐ wk / ☐ month / ☐ qtr for \_\_\_\_\_ ☐ weeks / ☐ months (☐ 30 / ☐ 60 minutes)

Family Collateral: \_\_\_\_\_ session(s) per ☐ wk / ☐ month / ☐ qtr for \_\_\_\_\_ ☐ weeks / ☐ months (☐ 30 / ☐ 60 minutes)

With: \_\_\_\_\_ Purpose: \_\_\_\_\_

Non Family Collateral: \_\_\_\_\_ session(s) per ☐ wk / ☐ month / ☐ qtr for \_\_\_\_\_ ☐ weeks / ☐ months (☐ 30 / ☐ 60 minutes)

With: \_\_\_\_\_ Purpose: \_\_\_\_\_

Outpatient Consultation with: \_\_\_\_\_

Purpose: \_\_\_\_\_

Consumer requested a copy of Care Plan? ☐ Yes ☐ No Consumer received copy of Care Plan? ☐ Yes ☐ No

Interpretation Services Offered? ☐ Yes ☐ No Date: \_\_\_\_\_ Date

Consumer's Response to Interpretation Services: \_\_\_\_\_

Contractor's Signature and License

Date

Clinical Supervisor's Signature and License

Date

Consumer's Signature

Date

Parent/Guardian's Signature

Date

*Consumer Received Riverside County's Informing Material*

Send Form to Appropriate Unit  
Community Access, Referral, Evaluation, & Support (CARES) - P. O. Box 7549, Riverside, CA 92513, Fax: (951) 358-5352  
Assessment and Consultation Team (ACT), P.O. Box 7549, Riverside, CA 92513, Fax: (951) 687-5819  
**Confidential patient information. See California Welfare and Institutions Code Section 5328**



**PLAN DE SALUD MENTAL DEL CONDADO DE RIVERSIDE**  
**EVALUACIÓN / PLAN DE TRATAMIENTO: INICIALE**

Anexo 1B  
Página 1 de 3

Tipo de Plan: ☐ Medi-Cal/RCHA (CARES) ☐ DPSS (ACT) ( Decreto) Fecha: \_\_\_\_\_

Proveedor: \_\_\_\_\_

# del Proveedor: 33 \_\_\_\_\_

Teléfono del Proveedor: \_\_\_\_\_ # de Fax del Proveedor: \_\_\_\_\_

[Para los Consumidores del Quiro De Evaluación Y Consulta (ACT)] DPSS Trabajador Social: \_\_\_\_\_

Clínico del ACT: \_\_\_\_\_

Nombre del Consumidor: \_\_\_\_\_

Primer Nombre

Afellido

Fecha de Nacimiento del Consumidor: \_\_\_\_\_ Numero de Seguro Social: \_\_\_\_\_

Género: ☐ M ☐ F

Idioma Natal del Consumidor: \_\_\_\_\_ Grupo Étnico del Consumidor: \_\_\_\_\_

Vivienda: ☐ Hogar en Grupo (para menores) ☐ Padres Biológicos ☐ Hogar de Crianza ☐ FFA (Hogar de Crianza Privado)

☐ Ubicación relativa (para un menor) ☐ Casa de Refugio (para menores) ☐ Instalación de hospedamiento y tratamiento

☐ IMD ☐ SNF ☐ Otra Forma de Vivir Independiente:

Nombre de la Instalación Residencial (si aplica): \_\_\_\_\_ Fecha de colocación: \_\_\_\_\_

Domicilio Actual del Consumidor: \_\_\_\_\_ Teléfono

del consumidor #: \_\_\_\_\_ Médico de Personal: \_\_\_\_\_

Fecha del último examen físico: \_\_\_\_\_

Diagnóstico:

Eje I: \_\_\_\_\_

Eje II: \_\_\_\_\_

Eje III: \_\_\_\_\_

Eje IV: \_\_\_\_\_

Motivos de Tensión Mental Psicosociales Específicos

Eje V: \_\_\_\_\_/\_\_\_\_\_

Actuales

más serios del último año

**Problemas presentados/ Sintomatología Clínica:** \_\_\_\_\_

**Evaluación de riesgo:**

Ideas Suicidas ☐ Ninguna ☐ leves ☐ Moderadas ☐ Severas

Intenciones Suicidas ☐ Ninguna ☐ leves ☐ Moderadas ☐ Severas

Ideas Homicidas ☐ Ninguna ☐ Leves ☐ Moderadas ☐ Severas

Intenciones Homicidas ☐ Ninguna ☐ Leves ☐ Moderadas ☐ Severas

Si existen algún riesgo actualmente, describa el tipo la frecuencia de las ideas, el plan, y los medios: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Informacion Confidencial del Paciente. Vea el bienestar de California; Código 5328 de las instituciones

February 2012

Mande el formulario a la unidad de autorización apropiada:

(Equipo de Acceso Central) Community Access, Referral, Evaluation, And Support\* PO Box 7549\* Riverside\* CA 92513\* FAX (951) 358-5352

(Equipo de Evaluación y Consulta) Assessment and Consultation Team \* PO Box 7549\* Riverside\* CA 92513\* FAX (951) 687-5819

## EVALUACIÓN / PLAN DE TRATAMIENTO: INICIALES

**NOMBRE DEL CONSUMIDOR:** \_\_\_\_\_ **# DE SEGURO SOCIAL:** \_\_\_\_\_

Recomendaciones: (Motivos por los cuales debe continuar el tratamiento / duración esperada del tratamiento.)

**Medicamento(s) Actuales y Dosis:** \_\_\_\_\_

**Médico que las receto:** \_\_\_\_\_

¿Antecedentes de Enfermedades Mentales en la Familia? ☐ No ☐ Sí Si la respuesta es afirmativa, descríbalos

¿Previas Hospitalizaciones Psiquiátricas(s)? ☐ No ☐ Sí Si la respuesta es afirmativa, diga dónde, cuándo, y por qué

Previo Tratamiento de Salud Mental como Paciente Externo? ☐ No ☐ Sí Si la respuesta es afirmativa díganos con quién, cuándo, y por qué

### ESTADO MENTAL

<b>Apariencia</b>	<input type="checkbox"/> Limpio(a)	<input type="checkbox"/> Bien Cuidado(a)	<input type="checkbox"/> Mal Cuidado(a)	<input type="checkbox"/> Extraño(a)
<b>Orientación</b>	<input type="checkbox"/> Orientado(a)	<input type="checkbox"/> Desorientado	<input type="checkbox"/> Hora	<input type="checkbox"/> Lugar <input type="checkbox"/> Persona <input type="checkbox"/> Situación
<b>Ánimo</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Ansioso(a)	<input type="checkbox"/> Deprimido(a)	<input type="checkbox"/> Enojado(a) <input type="checkbox"/> Triste <input type="checkbox"/> Eufórico(a)
<b>Afecto</b>	<input type="checkbox"/> Apropiado	<input type="checkbox"/> Inapropiado	<input type="checkbox"/> Insípido	<input type="checkbox"/> Inestable <input type="checkbox"/> Rudo <input type="checkbox"/> Deprimido
<b>Inteligencia</b>	<input type="checkbox"/> Promedio	<input type="checkbox"/> Superior a lo promedio	<input type="checkbox"/> Inferior a lo promedio	
<b>Memoria</b>	<input type="checkbox"/> Intacta	<input type="checkbox"/> Perjudicada	<input type="checkbox"/> Termina Corto	<input type="checkbox"/> Termina Largo
<b>Atención</b>	<input type="checkbox"/> Dentro de los Límites Normales	<input type="checkbox"/> Corta	<input type="checkbox"/> Perjudicada	<input type="checkbox"/> Preservativa
<b>Psicomotor</b>	<input type="checkbox"/> Dentro de los Límites Normales	<input type="checkbox"/> Agitado	<input type="checkbox"/> Letárgico	<input type="checkbox"/> Retardado <input type="checkbox"/> Cata tónico
<b>Juicio</b>	<input type="checkbox"/> Bueno	<input type="checkbox"/> Más o menos bueno	<input type="checkbox"/> Limitado	<input type="checkbox"/> Malo
<b>Discernimiento</b>	<input type="checkbox"/> Bueno	<input type="checkbox"/> Más o menos bueno	<input type="checkbox"/> Limitado	<input type="checkbox"/> malo
<b>Habla</b>	<input type="checkbox"/> Dentro de los límites normales	<input type="checkbox"/> Oprimida	<input type="checkbox"/> Mínima	<input type="checkbox"/> Vagante <input type="checkbox"/> Circunstancial
<b>Pensamiento</b>	<input type="checkbox"/> Dentro de los límites normales	<input type="checkbox"/> Concreto	<input type="checkbox"/> Desorganizado	<input type="checkbox"/> Meditador <input type="checkbox"/> Paranoide <input type="checkbox"/> Suelto <input type="checkbox"/> Impertinente
<b>Conceptos Falsos</b>	<input type="checkbox"/> Somáticos	<input type="checkbox"/> Envidiosos	<input type="checkbox"/> Grandiosos	<input type="checkbox"/> Persecutorios <input type="checkbox"/> Eróticos
<b>Alucinaciones</b>	<input type="checkbox"/> Auditivas	<input type="checkbox"/> Visuales	<input type="checkbox"/> Táctiles	<input type="checkbox"/> Olfatorias <input type="checkbox"/> Ordenes

**Comentarios Adicionales:** \_\_\_\_\_

**Oficio:** \_\_\_\_\_

**Escuela: Nivel Educativo:** \_\_\_\_\_ **Funcionamiento/Grado:** \_\_\_\_\_

**Uso de Drogas/Alcohol:** ☐ Actualmente ☐ Anteriormente Duración de la Remisión actual: \_\_\_\_\_

**Descríbalo (Tipo, Cantidad, Frecuencia):** \_\_\_\_\_

**Tratamiento de Rehabilitación contra las Drogas:** \_\_\_\_\_

**Avalúo de disfunción** ☐ Ninguna ☐ Leve ☐ Moderada ☐ Severa

## EVALUACIÓN / PLAN DE TRATAMIENTO: INICIALES

NOMBRE DEL CONSUMIDOR: \_\_\_\_\_ # DE SEGURO SOCIAL: \_\_\_\_\_

Describa específicamente como los síntomas perjudican un área específica del funcionamiento (Ejemplos; trabajo, escuela, salud/seguridad, social): \_\_\_\_\_

**METAS:** Tienen que poderse medir/ser observables y deben estar directamente relacionadas al área del funcionamiento cotidiano que esta siendo perjudicado. Esta es la misma área perjudicada que le permite al consumidor reunir las necesidades de la parte B de Medical. Incluya la frecuencia actual y meta.**Efectos en el comportamiento/meta 1:** \_\_\_\_\_

Fecha meta para lograr las mismas 1: \_\_\_\_\_

**Efectos en el comportamiento/meta 2:** \_\_\_\_\_

Fecha meta para lograr la misma 2: \_\_\_\_\_

**Intervención del Proveedor:** \_\_\_\_\_**El consumidor hará lo siguiente:** \_\_\_\_\_**TRATAMIENTO PROPUESTO: \*\*Para los proveedores solicitando autorización solamente a través de CAT.****Evaluación Psiquiátrica:** \_\_\_\_\_ sesión(s) por ☐ semana/☐ mes/☐ cuarto de \_\_\_\_\_ ☐ semanas/☐ meses (☐15/☐30/☐60 minutos)**Terapia Individual:** \_\_\_\_\_ sesión(s) por ☐ semanas/☐ mes/☐ cuarto por \_\_\_\_\_ ☐ semanas/☐ meses (☐15/☐30/☐60/☐90 minutos)**Psicoterapia en grupo:** \_\_\_\_\_ sesión(s) por ☐ semana/☐ mes ☐ por \_\_\_\_\_ ☐ semanas/☐ meses**Terapia Familiar:** \_\_\_\_\_ sesión(s) por ☐ semana/☐ mes/☐ cuarto por \_\_\_\_\_ ☐ semanas/☐ meses (☐30/☐60 minutos)**Acciones Paralelas Familiares:** \_\_\_\_\_ sesión(s) por ☐ semana/☐ mes/☐ cuarto por \_\_\_\_\_ ☐ semanas/☐ meses (☐30/☐60 minutos)**Con:** \_\_\_\_\_**El Propósito de:** \_\_\_\_\_**Colateral no familiar:** \_\_\_\_\_ sesión(s) por ☐ semana/☐ mes/☐ cuarto por \_\_\_\_\_ ☐ semanas/☐ meses (☐30/☐60 minutos)**Con:** \_\_\_\_\_**El Propósito de:** \_\_\_\_\_**Consulta como paciente externo con:** \_\_\_\_\_ (☐25/☐60 minutos)**El Propósito de:** \_\_\_\_\_¿Solicito el consumidor una copia del Plan de Tratamiento? ☐ Sí ☐ No \_\_\_\_\_ ¿Recibió el consumidor una FechaCopia del Plan de Tratamiento? ☐ Sí ☐ No \_\_\_\_\_ FechaSe ofrecieron servicios de interpretación? ☐ Sí ☐ No \_\_\_\_\_ Fecha**Respuesta del consumidor acerca de los Servicios de Interpretación:** \_\_\_\_\_

Firma del contratista y título

Fecha

Supervisor Clínico y licencia

Fecha

Firma del consumidor

Fecha

Firma del Padre/Tutor

Fecha

El Consumidor Recibió Información escrita del Condado de Riverside \_\_\_\_\_

Información Confidencial del Paciente. Vea el bienestar de California; Código 5328 de las instituciones

**RIVERSIDE MENTAL HEALTH PLAN  
CONSUMER ACCESS, REFERRAL, EVALUATION, & SUPPORT (CARES)  
TREATMENT EXTENSION/CHANGE REQUEST**

Type of Plan: ☐ Medi-Cal/RCHC ☐ Minor Consent Medi-Cal Date: \_\_\_\_\_

This is a request for a(n): ☐ EXTENSION ☐ CHANGE

Provider: \_\_\_\_\_ Provider #: 33 \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider FAX #: \_\_\_\_\_

Consumer Name: \_\_\_\_\_ Consumer Date of Birth: \_\_\_\_\_

Consumer SS#: \_\_\_\_\_ Medi-Cal #: \_\_\_\_\_

Type of Living Situation: ☐ Group Home (for minors) ☐ Bio-parents ☐ Foster ☐ Relative Placement  
☐ FFA (private foster family home for minors) ☐ Shelter Home (for minors)  
☐ Independent Living Arrangement ☐ IMD ☐ SNF ☐ Board/Care

Name of Residential Facility (if applicable): \_\_\_\_\_

Date of Placement: \_\_\_\_\_

Consumer's Current Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Diagnosis:**

Axis I: \_\_\_\_\_  
\_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Specific Psychosocial Stressors

Axis V: \_\_\_\_\_ / \_\_\_\_\_  
Current Highest in Past Year

Current Medication(s) and Dosage(s): \_\_\_\_\_

Prescribed By: \_\_\_\_\_

**Risk Assessment:**

Suicide Ideation ☐ None ☐ Mild ☐ Moderate ☐ Severe

Suicide Intent: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Homicidal Ideation: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Homicidal Intent: ☐ None ☐ Mild ☐ Moderate ☐ Severe

If any present, describe type and frequency of ideation, plan, and means: \_\_\_\_\_

Date treatment started: \_\_\_\_\_ Total # of sessions provider has completed with this consumer: \_\_\_\_\_

Progress on Goals: Describe the consumer's progress in meeting the previous goals (as stated on last Auth Request):

Goal (1): \_\_\_\_\_

Goal (2): \_\_\_\_\_

## TREATMENT EXTENSION/CHANGE REQUEST

For Requests to Change Authorization: Describe Change Requested (service type/frequency, etc) and Rationale:

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**Current Goals:** Must be observable/measurable behaviors and focus specifically on the area of impairment (work, school, health/safety, social) that enables this consumer to meet Medical Necessity Part B. Must include a baseline and frequency.

**Behavioral Outcome/Goal:** \_\_\_\_\_

**Behavioral Outcome/Goal:** \_\_\_\_\_

**Target Date:** \_\_\_\_\_

**Current Dysfunction rating:** ☐None ☐Mild ☐Moderate ☐Severe

**Describe how symptoms impair functioning:** \_\_\_\_\_

**Method For Achieving Goal(s) and Consumer's Responsibilities:**

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**PROPOSED TREATMENT:** \*\*For providers requesting authorization through CAT only.

**Refer for Psychiatric Treatment:** ☐ Yes ☐ No If yes, need to complete a "Provider Referral Request Form"

**Individual Therapy:** \_\_\_\_\_ session(s) per ☐week/☐month/☐quarter for \_\_\_\_\_ ☐weeks/☐months (☐15/☐30/  
☐60/☐90 min)

**Group Psychotherapy:** \_\_\_\_\_ session(s) per ☐week/☐month for \_\_\_\_\_ ☐weeks/☐months

**Family Therapy:** \_\_\_\_\_ session(s) per ☐week/☐month/☐quarter for \_\_\_\_\_ ☐weeks/☐months (☐30/☐60 min)

**Family Collateral:** \_\_\_\_\_ session(s) per ☐week/☐month/☐quarter for \_\_\_\_\_ ☐weeks/☐months (☐30/☐60 min)

**With:** \_\_\_\_\_

**Purpose:** \_\_\_\_\_

**Non-Family Collateral:** \_\_\_\_\_ session(s) per ☐week/☐month/☐quarter for \_\_\_\_\_ ☐weeks/☐months (☐30/☐60 minutes)

**With:** \_\_\_\_\_

**Purpose:** \_\_\_\_\_

**Outpatient Consultation with:** \_\_\_\_\_ (☐25/☐60 minutes)

**Purpose:** \_\_\_\_\_

\_\_\_\_\_  
Contractor's Signature and Discipline

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contractor's Printed Name and Discipline

\_\_\_\_\_  
Consumer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

Mail form to: Community Access, Referral, Evaluation, & Support (CARES)\* PO Box 7549\*Riverside CA 92513 or Fax 951 358-5352

**DISCHARGE SUMMARY**☐ Group Home Child☐ C.A.R.E.S.☐ A.C.T.

Consumer Name

DOB

Discharge Date

Social Security Number

Medi-Cal ID Number

Reason for Discharge:

Type of treatment received, summary of treatment, consumer's response to treatment:

Family Involvement:

Discharge medications / response and significant physical conditions:

Follow up recommendations (include services needed, consumer's agreement with recommendation, and final disposition):

**Discharge Diagnosis**

Axis I

Axis I

Secondary

Axis II

Axis III

Axis IV

Specific Psychological Stressors

Axis V

Current

Highest in Past  
Year

Provider's Signature &amp; Title:

Provider's Name (printed):

Agency Provider Represents:

DPSS Social Worker:

Group Home Name:

Confidential Patient Information – See California Welfare &amp; Institutions Code 5328

## Attachment 4

JV 220; JV 220a

Can be found on the following website:

<http://www.courtinfo.ca.gov/selfhelp/family/allforms.htm>



# RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

*Jerry A. Wengerd, Director*

Reply to:

Outpatient Quality Improvement  
P.O. Box 7549  
Riverside, CA 92513  
(951) 955-7320  
Fax (951) 955-7203

**This fax cover sheet must be completed and used when submitting a Medication Declaration.**

Date: \_\_\_\_\_

To: Quality Improvement Outpatient

Fax # (951) 955-7203

From: \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

Client Name: \_\_\_\_\_

Social Security # of client \_\_\_\_\_

Page 1 of \_\_\_\_\_ pages

## PROPOSED TREATMENT AND FOLLOW UP SERVICES

Referral Source: ☐ ACT ☐ CAT ☐ TRACT

Psychiatric Evaluation \_\_\_\_\_ Session(s) per week/month for \_\_\_\_\_ weeks/months (15, 30, 60 min.)

Collateral Visit \_\_\_\_\_ Session(s) per week/month for \_\_\_\_\_ weeks/months (30, 60 min.)

Collateral Sessions with: \_\_\_\_\_

**CAUTION:** The information contained in this facsimile message is confidential and intended solely for the use of the individual or entity named above. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, copying, or unauthorized use of this communication is strictly prohibited. If you have received this communication in error, please immediately notify the sender by telephone and return the facsimile message to the sender at the above address via the United States Postal Service. Thank you.



**Application Regarding  
Psychotropic Medication**

Attach a completed and signed JV-220(A), *Prescribing Physician's Statement—Attachment*, with all its attachments, must be attached to this form before it is filed with the court. Read JV-219-INFO, *Information About Psychotropic Medication Forms*, for more information about the required forms and the application process.

**1** Information about where the child lives:

- a. The child lives ☐ with a relative ☐ in a foster home  
☐ with a nonrelative extended family member  
☐ in a regular group home ☐ in a level 12–14 group home  
☐ at a juvenile camp ☐ at a juvenile ranch  
☐ other (specify): \_\_\_\_\_

b. If applicable, name of facility where child lives: \_\_\_\_\_

c. Contact information for responsible adult where child lives:

(1) Name: \_\_\_\_\_

(2) Phone: \_\_\_\_\_

**2** Information about the child's current location:

a. ☐ The child remains at the location identified in **1**.

b. ☐ The child is currently staying in:

(1) ☐ a psychiatric hospital (name): \_\_\_\_\_

(2) ☐ a juvenile hall (name): \_\_\_\_\_

(3) ☐ other (specify): \_\_\_\_\_

**3** Child's ☐ social worker ☐ probation officer

a. Name: \_\_\_\_\_

b. Address: \_\_\_\_\_

c. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**4** Number of pages attached: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Type or print name of person completing this form

\_\_\_\_\_  
Signature

- ☐ Child welfare services staff (sign above)  
☐ Probation department staff (sign above)  
☐ Medical office staff (sign above)  
☐ Caregiver (sign above)  
☐ Prescribing physician (sign on page 3 of JV-220(A))

Clerk stamps date here when form is filed.

Fill in court name and street address:

Superior Court of California, County of \_\_\_\_\_

Fill in child's name and date of birth:

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Clerk fills in case number when form is filed.

Case Number: \_\_\_\_\_

This form must be completed and signed by the prescribing physician. Read JV-219-INFO, *Information About Psychotropic Medication Forms*, for more information about the required forms and the application process.

- ① Information about the child (*name*): \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_  
Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_
- ② Type of request:  
a. ☐ An initial request to administer psychotropic medication to this child  
b. ☐ A request to continue psychotropic medication the child is currently taking
- ③ ☐ This application is made during an emergency situation. The emergency circumstances requiring the temporary administration of psychotropic medication pending the court's decision on this application are:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- ④ Prescribing physician:  
a. Name: \_\_\_\_\_ License number: \_\_\_\_\_  
b. Address: \_\_\_\_\_  
c. Phone numbers: \_\_\_\_\_  
d. Medical specialty of prescribing physician:  
☐ Child/adolescent psychiatry ☐ General psychiatry ☐ Family practice/GP ☐ Pediatrics  
☐ Other (*specify*): \_\_\_\_\_
- ⑤ This request is based on a face-to-face clinical evaluation of the child by:  
a. ☐ the prescribing physician on (*date*): \_\_\_\_\_  
b. ☐ other (*provide name, professional status, and date of evaluation*): \_\_\_\_\_  
\_\_\_\_\_
- ⑥ Information about child provided to the prescribing physician by (*check all that apply*):  
☐ child ☐ caregiver ☐ teacher ☐ social worker ☐ probation officer ☐ parent  
☐ records (*specify*): \_\_\_\_\_  
☐ other (*specify*): \_\_\_\_\_
- ⑦ Describe the child's symptoms, including duration as well as the child's response to any current psychotropic medication. If the child is not currently taking psychotropic medication, describe treatment alternatives to the proposed administration of psychotropic medication that have been tried with the child in the last six months. If no alternatives have been tried, explain the reasons for not doing so.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Case Number: \_\_\_\_\_

Child's name: \_\_\_\_\_

- ⑧ Diagnoses from *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (provide full Axis I and Axis II diagnoses; inclusion of numeric codes is optional):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ⑨ Therapeutic services, other than medication, in which the child will participate during the next six months (check all that apply; include frequency for group therapy and individual therapy):

a. ☐ Group therapy: \_\_\_\_\_ b. ☐ Individual therapy: \_\_\_\_\_  
c. ☐ Milieu therapy (explain): \_\_\_\_\_  
d. ☐ Other modality (explain): \_\_\_\_\_

- ⑩ a. Relevant medical history (describe, specifying significant medical conditions, all current nonpsychotropic medications, date of last physical examination, and any recent abnormal laboratory results):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- b. Relevant laboratory tests performed or ordered (optional information; provide if required by local court rule):

☐ kidney function ☐ liver function ☐ thyroid function ☐ UA ☐ glucose ☐ lipid panel  
☐ CBC ☐ EKG ☐ pregnancy ☐ medication blood levels (specify): \_\_\_\_\_  
☐ other (specify): \_\_\_\_\_

- ⑪ **Mandatory Information Attached:** Significant side effects, warnings/contraindications, drug interactions (including those with continuing psychotropic medication and all nonpsychotropic medication currently taken by the child), and withdrawal symptoms for each recommended medication are included in the attached material.

- ⑫ a. ☐ The child was told in an age-appropriate manner about the recommended medications, the anticipated benefits, the possible side effects and that a request to the court for permission to begin and/or continue the medication will be made and that he or she may oppose the request. The child's response was ☐ agreeable ☐ other (explain): \_\_\_\_\_

- b. ☐ The child has not been informed of this request, the recommended medications, their anticipated benefits, and their possible adverse reactions because:

(1) ☐ the child is too young.  
(2) ☐ the child lacks the capacity to provide a response (explain): \_\_\_\_\_  
(3) ☐ other (explain): \_\_\_\_\_

- ⑬ The child's present caregiver was informed of this request, the recommended medications, the anticipated benefits, and the possible adverse reactions. The caregiver's response was ☐ agreeable ☐ other (explain): \_\_\_\_\_

- ⑭ Additional information regarding medication treatment plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Case Number: \_\_\_\_\_

Child's name: \_\_\_\_\_

- 15 List all psychotropic medications currently administered that you propose to continue and all psychotropic medications you propose to begin administering. Mark each psychotropic medication as New (N) or Continuing (C). Administration schedule is optional information; provide if required by local court rule.

Medication name (generic or brand) and symptoms targeted by each medication's anticipated benefit to child	C or N	Maximum total mg/day	Treatment duration*	Administration schedule (optional) • Initial and target schedule for new medication • Current schedule for continuing medication • Provide mg/dose and # of doses/day • If PRN, provide conditions and parameters for use
Med:				
Targets:				
Med:				
Targets:				
Med:				
Targets:				
Med:				
Targets:				
Med:				
Targets:				

\*Authorization to administer the medication is limited to this time frame or six months from the date the order is issued, whichever occurs first.

- 16 List all psychotropic medications currently administered that will be stopped if this application is granted.

Medication name (generic or brand)	Reason for stopping

- 17 List the psychotropic medications that you know were taken by the child in the past and the reason or reasons these were stopped if the reasons are known to you.

Medication name (generic or brand)	Reason for stopping

Date: \_\_\_\_\_

Type or print name of prescribing physician

Signature of prescribing physician

Attachment 5  
Page 1 of 3

☐ MEDI-CAL (CARES)                      ☐ DPSS (ACT)                      ☐ GROUP HOME (CARES)

Diagnosis:

Axis I: \_\_\_\_\_

Secondary: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

(Specific Psychosocial Stressors)

Axis V: \_\_\_\_\_ / \_\_\_\_\_

Current Highest in Past Year

Riverside County Mental Health Plan  
REFERRAL FOR PSYCHOLOGICAL TESTING

Attachment 5  
Page 2 of 3

CONSUMER NAME: \_\_\_\_\_

SS#: \_\_\_\_\_

Nature and progress of treatment to date (including # of sessions with consumer)

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History of institutional placements (Psychiatric Hospitals, Group Homes, Shelter Homes, IMD):

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Psychological testing in last two years (Date, Types of Tests, Referral Question):

\*\* Copies of Psychological Tests are Requested if Available

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Specific Questions to be Answered by Psychological Testing:

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Riverside County Mental Health Plan  
REFERRAL FOR PSYCHOLOGICAL TESTING

Attachment 5  
Page 3 of 3

CONSUMER NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

Other methods that have been tried to answer these questions and why haven't they sufficed:

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How will result of testing specifically be used to impact treatment? Give examples:

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Name of Psychologist Recommended to Perform Testing (Optional):

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\_\_\_\_\_  
Referent's Signature & Title

\_\_\_\_\_  
License #

\_\_\_\_\_  
Referent's Printed Name & Title

Where To Send Form:

For Medi-Cal and Group Home Consumers - Fax form to Community Access, Referral, Evaluation & Support (CARES) at (951) 358-5352 or Mail to CARES \* P O Box 7549 \* Riverside, CA 92513

For DPSS Consumers of ACT - Fax completed form to (951) 687-5819 or  
Mail to ACT \* P O Box 7549 \* Riverside, CA 92513

Riverside County Department of Mental Health  
**CONSENT TO TREATMENT**

I, \_\_\_\_\_, consent and agree voluntarily to receive psychological services from Riverside County Department of Mental Health. These services may include, but are not limited to, diagnostic assessments; psychological testing; crisis intervention; individual, group, and/or family therapy; and consultations and referrals to other behavioral health professionals.

I understand that by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operations purposes, only.

I understand that I have the right to terminate treatment at any time. I also understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I understand that I am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

\_\_\_\_\_  
Consumer or Legal Representative's Signature

\_\_\_\_\_  
Date



**Departamento de Salud Mental Del Condado De Riverside**

**CONSENTIMIENTO PARA RECIBIR TRATAMIENTO**

Yo, \_\_\_\_\_ voluntariamente, doy mi consentimiento y estoy de acuerdo en recibir servicios psicológicos del Departamento de Salud Mental del Condado de Riverside. Estos servicios pueden incluir, pero no se limitan a; evaluación de diagnóstico, pruebas psicológicas, intervención en crisis, terapia individual, en grupo y/o con la familia; consultas y referencias a otros profesionales médicos especialistas en el comportamiento.

Entiendo que al dar mi consentimiento a que se me dé tratamiento, es posible que cierta información médica personal puede intercambiarse, solamente para los siguientes propósitos; ser tratado(a), para obtener pago, y para la administración de tratamiento médico.

Entiendo que tengo el derecho de finalizar mi tratamiento en cualquier momento dado. Además, comprendo que tengo el derecho de rehusarme a implementar cualquier recomendación, intervención psicológica, o procedimiento relativo al tratamiento.

Entiendo que se espera que el tratamiento me ayude, sin embargo no existe ninguna garantía implícita ni expresa de que el mismo me sea beneficioso.

\_\_\_\_\_  
Firma del Consumidor o el Representante Legal

\_\_\_\_\_  
Fecha

Riverside County Department of Mental Health  
**Child Consent for Treatment**

I authorize \_\_\_\_\_ to participate in treatment provided by the Riverside County Department of Mental Health. This authorization requests and authorizes any necessary psychological and/or psychiatric evaluation and treatment. My signature below indicates that I agree and give consent to the above services. I also understand that parental participation in one or more of the following may be requested:

Assessment  
Individual Counseling  
Family Counseling  
Parenting Skills Training or  
Group Counseling

I understand that by authorizing treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operations purposes, only.

Signature \_\_\_\_\_  
( Circle one)                      Parent                      Legal Guardian

Date \_\_\_\_\_

Print Name: \_\_\_\_\_

Witnessed: \_\_\_\_\_

Date: \_\_\_\_\_

# County of Riverside Departamento de Salud Mental

Yo, autorizo \_\_\_\_\_ que participe en el tratamiento proveído por el Departamento de Salud Mental del Condado de Riverside. Esta autorización solicita y autoriza cualquier evaluación y tratamiento psicológico y/o psiquiátrico necesarios. Mi firma abajo indica que estoy de acuerdo y doy consentimiento a los servicios antes mencionados. Además, entiendo que la participación de los padres en una o más de lo siguiente puede solicitarse:

Evaluación  
Asesoramiento/Consejería Individual  
Asesoramiento/Consejería Familiar  
Capacitación de habilidades de los padres o  
Asesoramiento/Consejería en Grupo

Entiendo que autorizando el tratamiento, es posible que la información médica personal se comparta de manera limitada para el mismo tratamiento, para el pago, y para el propósito de operaciones de tratamiento médico solamente.

Firma \_\_\_\_\_  
Circule uno:                      Padre de familia      Tutor Legal

Fecha \_\_\_\_\_

Nombre en letra de molde: \_\_\_\_\_

Testigo: \_\_\_\_\_

Fecha \_\_\_\_\_

**Riverside County Department of Mental Health  
Assessment & Consultation Team  
Quarterly Progress Report/Reauthorization Request**

Consumer's Name: \_\_\_\_\_ Date of Report: \_\_\_\_\_

Consumer ID # (see client ID # on authorization): \_\_\_\_\_

Therapist Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

Agency Name: \_\_\_\_\_

M.H. (ACT) Clinician: \_\_\_\_\_ Ph#: \_\_\_\_\_

Social Worker's Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

First Date of Service: \_\_\_\_\_ Quarterly Report: ☐ 1<sup>st</sup> ☐ 2<sup>nd</sup> ☐ 3<sup>rd</sup> ☐ 4<sup>th</sup>

**Reason for Initial Referral:**

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**Services Provided:** (Type: i.e.: Individual, Family, and dates of sessions attended)

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**Diagnosis:** (Use CURRENT DSM Codes and Descriptions: Treatment, goals, objectives, etc must be consistent with the current diagnosis) Complete all 5 Axes and designate "primary" diagnosis.

Axis I \_\_\_\_\_

\_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Axis V \_\_\_\_\_ / \_\_\_\_\_

Current

Highest past year

**Treatment Issues Addressed/ Assessment as related to DSM Diagnosis:**

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**Progress on Goals:** Describe the consumer's progress in meeting the previous goals (identified on the Assessment & Care Plan or the last Quarterly Report):

**Goal #1:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Goal #2:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommendations/justification for ongoing services:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Goals for this Quarter:** [must be observable/measurable & specifically focus on areas of impairment (family unit, health/safety, school, social, work) that enables this consumer to meet Medical Necessity.] Must include baseline and frequency. Children need only be "at risk" of impairment in the aforementioned areas.

Also include description of the method for achieving goal(s) and the consumer's responsibility.

**Goal #1:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Target Completion Date: \_\_\_\_\_

**Goal #2:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Target Completion Date: \_\_\_\_\_

Describe how symptoms currently impair functioning: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CONSUMER'S NAME \_\_\_\_\_

**PROPOSED TREATMENT:**

**Total Number of Sessions Used to Date:** \_\_\_\_\_

**Psychiatric Evaluation** \_\_\_\_\_ session(s) per ☐ week / ☐ month / ☐ quarter for \_\_\_\_\_ ☐ weeks / ☐ months (☐15 / ☐30 mins)

**Individual Therapy:** \_\_\_\_\_ session(s) per ☐ week / ☐ month / ☐ quarter for \_\_\_\_\_ ☐ weeks / ☐ months (☐60 mins)

**Group Psychotherapy:** \_\_\_\_\_ session(s) per ☐ week / ☐ month \_\_\_\_\_ ☐ weeks / ☐ months

**Family Therapy:** \_\_\_\_\_ session(s) per ☐ week / ☐ month / ☐ quarter for \_\_\_\_\_ ☐ weeks / ☐ months (☐30 mins)

Name of Participant(s) & Relationship to Consumer:

_____	Purpose: _____
_____	Purpose: _____
_____	Purpose: _____
_____	Purpose: _____

**Collateral:** \_\_\_\_\_ session(s) per ☐ week ☐/month / ☐ quarter for \_\_\_\_\_ ☐ weeks/ ☐ months (30 mins)

Name of Participant(s) & Relationship to Consumer:

_____	Purpose: _____
_____	Purpose: _____

\_\_\_\_\_  
**Treating Therapist/Intern Signature w/license # or Intern designation**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Clinical Supervisor's Signature and License**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Consumer's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/ Guardian's Signature (if minor)\*\***

\_\_\_\_\_  
**Date**

\*\*(If "dependent" Court Minute Order can be substituted for parent/guardian signature--no foster parent, social worker or group home staff may sign for a minor in their care)

**FAX COMPLETED REPORT TO: Assessment & Consultation Team (ACT) (951) 687-5819**

**Riverside County Department of Mental Health**  
**Assessment and Consultation Team (ACT)**  
**Authorization Requesting Release/Receipt of Information and/or Records**  
**(Confidential Patient Information – W & I Code Sec. 5328)**

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

The Department of Public Social Services has arranged and is partially funding treatment services for you as a part of a service plan through the Juvenile Court. As a part of this process, there is a need to share information between your clinician/provider, the Riverside County Department of Mental Health and the Riverside County Department of Public Social Services. This release of information allows for this exchange of information. If you do not wish to sign this authorization, you may still receive confidential services through your own resources. If desired, discuss possible treatment resources with your clinician and, if you wish, with your DPSS social worker.

I, the undersigned, hereby authorize the following to release and exchange information. Please be advised that this authorization allows disclosure as described above and the Riverside County Department of Mental Health cannot be held liable for how this information is used by the person/agency to whom the disclosure is made to and their safeguard practices.

Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Riverside County Department of Mental Health Assessment & Consultation Team  
 Riverside County Department of Public Social Services

Information may be released with the knowledge that such contact discloses the fact that mental health and/or chemical dependency services have been/are being provided.

This disclosure may include any of the following:

Assessment & Diagnosis  
 Consumer Care Plan and Discharge Summary  
 Psychological Testing  
 Medical, Neurological, Lab Tests, Medications  
 Progress Reports

This authorization becomes effective \_\_\_\_\_. This authorization may be revoked by the undersigned at any time, except to the extent that information has already been released. If not revoked, it shall terminate one year from the date of authorization. You have the right to have a copy of this Authorization upon request.

Date: \_\_\_\_\_ Consumer Signature: \_\_\_\_\_

☐ Authorization Revoked: \_\_\_\_\_ Consumer Signature: \_\_\_\_\_

☐ I refuse all release of information.

Date: \_\_\_\_\_ Consumer Signature: \_\_\_\_\_

**Autorización de Divulgación, Comprobante de Información y/o Archivos**  
**(Información Confidencial del Paciente – Código del Bienestar e Instituciones, la sección 5328)**

Nombre del Paciente: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_

El Departamento de Servicios Sociales Públicos ha hecho arreglos y está aportando fondos para los servicios de tratamiento para usted, como parte de un plan de servicio a través del Tribunal Juvenil. Como parte de este proceso, es necesario compartir información entre su clínico médico / prestador de servicios, El Departamento de Salud Mental del Condado de Riverside y el Departamento de Servicios Sociales. La siguiente autorización para divulgar información permite que este intercambio de información tome lugar. Si no desea firmar este acuerdo, de cualquier manera puede recibir servicios confidenciales a través de sus propios recursos. Si lo desea, puede tratar los recursos de tratamiento potenciales con su clínico médico y, si quiere, con el trabajador social del Departamento de Servicios Sociales Públicos.

Yo, el infrascrito, por la presente autorizo lo siguiente para que se divulgue e intercambie mi información.

Prestador de servicios: \_\_\_\_\_ # de teléfono: \_\_\_\_\_

El Equipo de Consultas y evaluaciones del Departamento de Salud Mental del Condado de Riverside  
 Departamento de Servicios Sociales Públicos del Condado de Riverside

La información puede divulgarse a sabiendas de que dicho contacto divulga el hecho de que se han o están prestados servicios relacionados a la salud mental y/o la dependencia química.

Esta divulgación puede incluir cualquiera de lo siguiente:

Evaluación y diagnóstico

Plan de tratamiento del cliente y el resumen de alta

Pruebas psicológicas

Pruebas médicas, neurológicas, de laboratorio y medicamentos

Informes de progreso

Este consentimiento toma vigencia \_\_\_\_\_. Este consentimiento puede ser revocado por el infrascrito en cualquier momento dado, salvo si la información ya se divulgó. Si no se ha revocado, la autorización caduca un año de la fecha que se dio la autorización. A su petición, usted tiene el derecho de que se le provee una copia de esta autorización.

Fecha: \_\_\_\_\_ Firma del Cliente: \_\_\_\_\_

☐ El consentimiento se revoca: \_\_\_\_\_ Firma del Cliente: \_\_\_\_\_

☐ Me rehúso a dar mi autorización.

Fecha: \_\_\_\_\_ Firma del Cliente: \_\_\_\_\_





Consumer Name: \_\_\_\_\_

**Part II – HISTORY TAKING FOR STAFF USE ONLY** (Use Additional Sheets if Necessary)1. SIGNIFICANT PAST ILLNESS, ACCIDENTS, HOSPITALIZATION, and MEDICAL PROBLEMS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. SIGNIFICANT FAMILY HEALTH HISTORY AND PROBLEMS: \_\_\_\_\_

3. SIGNIFICANT CURRENT MEDICAL PROBLEMS: \_\_\_\_\_

4. CURRENT PSYCHOTROPIC MEDICATION:

<u>Name</u>	<u>Strength /Dose</u>	<u>Duration of Use</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. PAST PSYCHOTROPIC MEDICATION:

<u>Name</u>	<u>Strength /Dose</u>	<u>Duration of Use</u>	<u>Adverse Reactions? (Yes/No)</u>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. OTHER CURRENT MEDICATIONS (Includes Prescription and Non-Prescriptive Drugs):

<u>Name</u>	<u>Strength /Dose</u>	<u>Indication</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. CURRENT USE OF ALCOHOL AND/OR STREET DRUGS:

<u>Name</u>	<u>Frequency/Amount</u>
_____	_____
_____	_____

8. PAST USE OF ALCOHOL AND/OR STREET DRUGS:

<u>Name</u>	<u>Frequency/Amount</u>
_____	_____
_____	_____

IF ENTRIES ARE MADE TO EITHER QUESTION 7 OR QUESTION 8, PLEASE COMPLETE DRUG/ALCOHOL ASSESSMENT.

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Clinician Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewing Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewing Physician Printed Name \_\_\_\_\_

**DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE RIVERSIDE**  
**RESUMEN HISTORIAL MÉDICO PARA ADULTOS**

Anexo 10B  
Página 1 de 2

**Parte I – DEBE SER LLENADA POR EL PACIENTE O EL INFORMANTE DEL PACIENTE**  
**(Favor de escribir en letra de molde)**

Nombre del Paciente: \_\_\_\_\_  
(Primero) (Segundo) Apellido) (Apellido Materno)

Nombre del Informante si no fue el Paciente/Parentesco: \_\_\_\_\_

Médico Actual: \_\_\_\_\_  
(Nombre) (Domicilio/Ciudad)

Fecha del último examen físico: \_\_\_\_\_ Tiene alergias? ☐ Sí ☐ No

**POR FAVOR MARQUE TODO LOS SIGUIENTE QUE HA TENIDO EN EL PASADO:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Problemas del corazón                                     | <input type="checkbox"/> Uso de Drogas                       | <input type="checkbox"/> Problemas del hígado                    |
| <input type="checkbox"/> Insuficiencia Respiratoria                                | <input type="checkbox"/> Cáncer/Enfermedades de la Inmunidad | <input type="checkbox"/> Hepatitis/Ictericia                     |
| <input type="checkbox"/> Dolor/Presión en el pecho                                 | <input type="checkbox"/> Dolor de cabeza frecuente/fuerte    | <input type="checkbox"/> Diabetes                                |
| <input type="checkbox"/> Alta presión arterial                                     | <input type="checkbox"/> Lesión de la cabeza                 | <input type="checkbox"/> Tuberculosis (TB)                       |
| <input type="checkbox"/> Problemas estomacales                                     | <input type="checkbox"/> Apoplejía                           | <input type="checkbox"/> Enfermedades sexualmente transmisibles  |
| <input type="checkbox"/> Uso de Alcohol  | <input type="checkbox"/> Epilepsia/Convulsiones              | <input type="checkbox"/> Asma/Fiebre del heno/Ronchas/Sarpullido |
| <input type="checkbox"/> Mareos /Desmayos  | <input type="checkbox"/> Problemas de los riñones            | <input type="checkbox"/> Orinarse/Ensuciarse en la cama          |
| <input type="checkbox"/> Convulsiones  | <input type="checkbox"/> Problemas de la Tiroides            | <input type="checkbox"/> Sangrado inusual                        |
| <input type="checkbox"/> PMS (Síndrome previo a la menstruación) /Terapia hormonal |  | <input type="checkbox"/> Embarazo                                |

**OTRAS ENFERMEDADES SERIAS Y O PRUEBAS MÉDICAS:** \_\_\_\_\_

**SUSTANCIAS A LAS QUE USTED ES ALÉRGICO(A):** \_\_\_\_\_

**DESCRIPCIÓN DE LOS SÍNTOMAS CAUSADOS POR LA ALERGIA/NATURALESA DE LA REACCIÓN:** \_\_\_\_\_

**DENTRO DEL ÚLTIMO AÑO, USTED HA TOMADO MEDICAMENTOS RECETADOS U OTROS MEDICAMENTOS PARA:**

<input type="checkbox"/> ¿Disturbios del sueño?	Nombre: _____	¿Actualmente usando?	<input type="checkbox"/> Sí	<input type="checkbox"/> No
<input type="checkbox"/> ¿Nutrición/¿Problemas del peso?	Nombre: _____	¿Actualmente usando?	<input type="checkbox"/> Sí	<input type="checkbox"/> No
<input type="checkbox"/> ¿Nervios/Ansiedad/Depresión?	Nombre: _____	¿Actualmente usando?	<input type="checkbox"/> Sí	<input type="checkbox"/> No
<input type="checkbox"/> ¿Dolor? Nombre	Nombre: _____	¿Actualmente usando?	<input type="checkbox"/> Sí	<input type="checkbox"/> No
<input type="checkbox"/> ¿Recreación/Relajamiento?	Nombre: _____	¿Actualmente usando?	<input type="checkbox"/> Sí	<input type="checkbox"/> No

¿Está tomando, o ha tomado Antabuse? ☐ Sí ☐ No

Firma del Consumidor: \_\_\_\_\_ Fecha: \_\_\_\_\_

Confidential Patient Information. Se California Welfare & Institutions Code Section 5328

**DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE RIVERSIDE  
RESUMEN HISTORIAL MÉDICO PARA ADULTOS**

**Parte II – HISTORIAL TOMADO PARA EL USO DE EMPLEADOS SOLAMENTE (Use una hoja adicional si es necesario.)**

1. ENFERMEDADES, ACCIDENTS, HOSPITALIZACIONES, Y PROBLEMAS MÉDICOS QUE SIGNIFICANTES PADECIO EN EL PASADO: \_\_\_\_\_

2. ANTECEDENTES MÉDICOS FAMILIARES Y PROBLEMAS SIGNIFICANTES: \_\_\_\_\_

3. PROBLEMAS MÉDICOS ACTUALES SIGNIFICANTES: \_\_\_\_\_

4. MEDICAMENTOS PSICOTRÓFICOS ACTUALES:

<u>Nombre</u>	<u>Miligramos/Dosis</u>	<u>Duración del uso</u>
---------------	-------------------------	-------------------------

\_\_\_\_\_

\_\_\_\_\_

5. MEDICAMENTOS PSICOTRÓFICOS DEL PASADO:

<u>Nombre</u>	<u>Miligramos/Dosis</u>	<u>Duración del uso</u>	<u>Reacciones adversa (Sí o No)</u>
---------------	-------------------------	-------------------------	-------------------------------------

\_\_\_\_\_

\_\_\_\_\_

6. OTROS MEDICAMENTOS ACTUALES (Incluyendo medicamentos recetados y sin receta):

<u>Nombre</u>	<u>Miligramos/Dosis</u>	<u>Duración del uso</u>
---------------	-------------------------	-------------------------

\_\_\_\_\_

\_\_\_\_\_

7. USO ACTUAL DE ALCOHOL Y/O DROGAS ILICITAS:

<u>Nombre</u>	<u>Frecuencia/Cantidad</u>
---------------	----------------------------

\_\_\_\_\_

\_\_\_\_\_

8. USO DE ALCOHOL Y/O DROGAS ILICITAS EN EL PASADO:

<u>Nombre</u>	<u>Frecuencia/Cantidad</u>
---------------	----------------------------

\_\_\_\_\_

\_\_\_\_\_

**SI RESPONDE A CUALQUIERA DE LAS PREGUNTAS 7 ó 8, FAVOR DE LLENAR LA EVALUACIÓN DE DOGRAS/ALCOHOL.**

COMENTARIOS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Firma del Clínico

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Médico de Revisión

\_\_\_\_\_  
Date (Fecha)

Riverside County Department of Mental Health  
**CHILD'S MEDICAL, MEDICATION, AND PRENATAL HISTORY**

**CHILD'S NAME:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**AGE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

In order to provide the best mental health care, it is necessary to know some things about your child's physical condition. Please answer the following questions as best you can. Someone will assist you if necessary.

**MEDICAL:**

HAS YOUR CHILD EVER HAD: (Please write in "yes" or "no" next to each question)

**Ear, nose, and throat problems?** \_\_\_\_\_ Frequent colds? \_\_\_\_\_ Frequent earaches? \_\_\_\_\_

Other? \_\_\_\_\_

**Eye problems?** \_\_\_\_\_ Infections? \_\_\_\_\_ Wears glasses? \_\_\_\_\_ Other? \_\_\_\_\_

**Stomach or intestinal problems?** \_\_\_\_\_ Frequent stomachaches? \_\_\_\_\_ Vomiting? \_\_\_\_\_ Diarrhea? \_\_\_\_\_

Soiling? \_\_\_\_\_

**Lung problems?** \_\_\_\_\_ Cough? \_\_\_\_\_ Asthma? \_\_\_\_\_ Pneumonia? \_\_\_\_\_

**High fevers?** \_\_\_\_\_ Convulsions? \_\_\_\_\_

**Heart problems?** "Blue Baby"? \_\_\_\_\_ Other? \_\_\_\_\_

**Urinary problems?** Bladder infection? \_\_\_\_\_ Persistent wetting? \_\_\_\_\_

Other? \_\_\_\_\_

**Allergies?** \_\_\_\_\_ Sneezing, always runny nose? \_\_\_\_\_ Itching? \_\_\_\_\_ Food or medication sensitivity? \_\_\_\_\_

Other? \_\_\_\_\_

**Surgery?** \_\_\_\_\_

Injury? (Including head injury) \_\_\_\_\_ Near drowning? \_\_\_\_\_ Poisoning? \_\_\_\_\_

Other? \_\_\_\_\_

Is child under a doctor's care regularly (except for routine physical, immunization, occasional illness)? \_\_\_\_\_

Does your child need to see a doctor for physical problems? \_\_\_\_\_

Please give a short explanation of questions answered "yes."

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## Riverside County Department of Mental Health

**CHILD'S MEDICAL, MEDICATION, AND PRENATAL HISTORY**

Child's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

**MEDICATION** Please write answers to each of the following questions:

What prescription medication is child currently taking? (Include dose and frequency) \_\_\_\_\_

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What non-prescription medication is child currently taking? \_\_\_\_\_

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What medications has the child taken in the past six months? \_\_\_\_\_

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Has any medication produced allergic or other adverse symptoms? If so, name medication and describe symptoms. \_\_\_\_\_

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Give brief child and family history of drug and/or alcohol use. \_\_\_\_\_

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**PRENATAL****DURING PREGNANCY WITH THIS CHILD:**

Prenatal care starting at what month? \_\_\_\_\_ Any bleeding? \_\_\_\_\_ High blood pressure? \_\_\_\_\_ Anemia? \_\_\_\_\_

Nutrition? Adequate? \_\_\_\_\_ Inadequate? \_\_\_\_\_

Smoking? \_\_\_\_\_ If yes, how much? \_\_\_\_\_ Drinking? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Drugs – Prescribed? \_\_\_\_\_ Name? \_\_\_\_\_

Non-Prescribed? \_\_\_\_\_ Name? \_\_\_\_\_

Delivery: At what month of pregnancy? \_\_\_\_\_ Was labor induced? \_\_\_\_\_ Duration in hours? \_\_\_\_\_

Condition of infant immediately after birth, and during first month. \_\_\_\_\_

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Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name/Discipline: \_\_\_\_\_

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**CONFIDENCIAL**  
**DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE RIVERSIDE**  
**HISTORIAL MÉDICO, DE MEDICAMENTOS, Y PRENATAL DEL MENOR**

Anexo 11B  
Página 1 de 2

**NOMBRE DEL MENOR:** \_\_\_\_\_ **# DEL COSUMIDOR:** \_\_\_\_\_

**EDAD:** \_\_\_\_\_ **FECHA DE NACIMIENTO:** \_\_\_\_\_ **FECHA:** \_\_\_\_\_

Para proveer el mejor tratamiento de salud mental, es necesario saber ciertas cosas acerca de la condición física de su hijo(a). Por favor responda las siguientes preguntas lo mejor que pueda. Si es necesario alguien le ayudará.

**MÉDICO:**

**SU HIJO(A) ALGUNA VES TUBO:** (Por favor escriba “sí” o “no” al lado de cada pregunta)

**¿Problemas de los oídos, nariz, o la garganta?** \_\_\_\_\_

¿Resfriados frecuentes? \_\_\_\_\_ ¿ Dolor de Oído frecuente? \_\_\_\_\_ ¿ Otra cosa? \_\_\_\_\_

**¿Problemas de los ojos?**

¿Infecciones? \_\_\_\_\_ ¿Usa lentes? \_\_\_\_\_ Otra cosa? \_\_\_\_\_

**¿Problemas estomacales o intestinales?** \_\_\_\_\_

¿Dolor de estomago frecuente? \_\_\_\_\_ ¿Vómito? \_\_\_\_\_ ¿Diarrea? \_\_\_\_\_ ¿Orinando o ensuciándose en la cama? \_\_\_\_\_

**¿Problemas de los pulmones?**

¿Tos? \_\_\_\_\_ ¿Asma? \_\_\_\_\_ ¿Pulmonía? \_\_\_\_\_

**¿Fiebre alta?**

¿Convulsiones? \_\_\_\_\_

**¿Problemas del corazón?**

¿"Lividez de la piel de nacimiento"? \_\_\_\_\_ ¿Otra cosa? \_\_\_\_\_

**¿Problemas Urinarios?**

¿Infecciones de la vejiga? \_\_\_\_\_ ¿Orina persistente? \_\_\_\_\_ Otra cosa? \_\_\_\_\_

**¿Alergias?** \_\_\_\_\_

¿Estornudos, nariz supurante? \_\_\_\_\_ ¿Comezón? \_\_\_\_\_ ¿Sesibilidad a medicamentos o alimentos? \_\_\_\_\_  
¿Otra cosa? \_\_\_\_\_

**Otras cosas - ¿Cirugías?** \_\_\_\_\_

¿Lesiones? (Incluyendo lesiones de la cabeza) \_\_\_\_\_ ¿Casi ahogarse? \_\_\_\_\_ ¿Envenenamiento? \_\_\_\_\_  
¿Otra cosa? \_\_\_\_\_

¿Está el menor de edad bajo el tratamiento regular de un médico(excepto los exámenes físicos rutinarios, vacunas, y enfermedades ocasionales)? \_\_\_\_\_

¿Su hijo(a) tiene que ver a un médico por problemas físicos? \_\_\_\_\_

Por favor dé una explicación corta acerca de las preguntas a las que respondió “sí.”

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## MEDICAMENTO

Por favor escriba respuestas a cada una de las siguientes preguntas:

¿Qué medicamento recetado está tomando actualmente su menor de edad? (incluyendo la dosis y la frecuencia) \_\_\_\_\_

\_\_\_\_\_

¿Qué medicamento sin receta está tomando actualmente su hijo(a)? \_\_\_\_\_

\_\_\_\_\_

¿Qué medicamentos ha tomado su hijo(a) en los últimos seis meses? \_\_\_\_\_

\_\_\_\_\_

¿Algún medicamento a causado algún síntoma alérgico o adverso? Si la respuesta es afirmativa, denos el nombre del medicamento y describa los síntomas. \_\_\_\_\_

\_\_\_\_\_

¿Qué medicamentos han sido más eficaces en el tratamiento de los síntomas psiquiátricos de su hijo(a)? \_\_\_\_\_

\_\_\_\_\_

Dé un historial breve acerca del uso de drogas y/o alcohol de su hijo(a) y de la familia. \_\_\_\_\_

\_\_\_\_\_

## PRENATAL

DURANTE EL EMBARAZO CON ESTE(A) HIJO(A):

¿En qué mes comenzó el cuidado prenatal? \_\_\_\_\_

¿Hubo sangrado? \_\_\_\_\_ ¿Alta presión arterial? \_\_\_\_\_ ¿Anemia? \_\_\_\_\_

¿Nutrición? ¿Adecuada? \_\_\_\_\_ ¿Inadecuada? \_\_\_\_\_

¿Fuma? \_\_\_\_\_ Si fuma, ¿cuánto? \_\_\_\_\_

¿Toma? \_\_\_\_\_ Si toma, ¿cuánto? \_\_\_\_\_

Medicamentos - ¿Recetados? \_\_\_\_\_ ¿Nombre? \_\_\_\_\_

¿No recetados? \_\_\_\_\_ ¿Nombre? \_\_\_\_\_

Parto: ¿En qué mes del embarazo? \_\_\_\_\_

¿Le provocaron el parto? \_\_\_\_\_ ¿Duración en horas? \_\_\_\_\_

La condición del infante, inmediatamente después del parto, y durante el primer mes. \_\_\_\_\_

\_\_\_\_\_

Firma del Padre/Tutor

Revisado por: \_\_\_\_\_ M.D. Fecha: \_\_\_\_\_

\_\_\_\_\_



## AEVS: GENERAL INSTRUCTIONS

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows you the ability – through a touch-tone telephone – to access recipient eligibility, clear Share of Cost liability and/or reserve a Medi-Service.

Recipient eligibility verification information is available for Medi-Cal, County Medical Services Program (CMSP) and Family PACT. Recipient eligibility for the Child Health and Disability Prevention (CHDP) program, the California Children Services (CCS) program or the Genetically Handicapped Persons Program (GHPP) is not available.

There is no enrollment requirement to participate in AEVS. Providers must use a valid Provider Identification Number (PIN) to access AEVS. The PIN is issued when providers enroll with Medi-Cal. If the PIN is unknown, providers should complete and return the *Provider Identification Number (PIN) Reissue Request* Form at the end of the *Provider Telecommunications Network (PTN)* section in this manual.

### For questions about...      Call...

Operation of AEVS	POS Help Desk (800) 427-1295
Medi-Cal Policy	Provider Support Center (PSC) (800) 541-5555
Family PACT	Health Access Programs (HAP) (800) 257-6900

## GENERAL INFORMATION

### Edit Conditions

Use of AEVS does not guarantee that the claim will be paid. All existing edit conditions – such as service restrictions, SOC certification, provider eligibility or prior authorization requirements – must still be satisfied.

### Transactions Available

AEVS verifies a recipient's eligibility for the current and/or prior 12 months; provides information on SOC, Other Health Coverage, and Prepaid Health Plan (PHP) status; identifies any service restrictions placed on that recipient; clears SOC liability; and allows podiatrists and certain allied health providers to reserve Medi-Services.

### BIC Card

When a recipient presents a plastic Medi-Cal Benefits Identification Card (BIC), recipient eligibility must be verified. BICs are not a guarantee of Medi-Cal, CMSP or Family PACT eligibility because they are a permanent form of identification and recipients retain the cards even if they are not eligible for Medi-Cal, CMSP or Family PACT during the current month.

### HAP Card

A Health Access Programs (HAP) card is issued and activated by the provider after the consumer has completed and signed a *Health Access Programs State-Only Family Planning Program Consumer Eligibility Certification* Form. HAP cards are not a guarantee of Family PACT eligibility because they are a permanent form of identification and consumers retain the cards even if they are not eligible for Family PACT during the current month.

# AEVS: GENERAL INSTRUCTIONS

**Eligibility Verification** AEVS accesses the most current recipient information for a specific month of **Confirmation of (EVC) Number** eligibility. AEVS returns a 10-character EVC number after eligibility is confirmed. It is recommended to enter in the EVC number in the remarks area of the claim. However, the EVC number is not required information for claim processing.

**Note:** An Eligibility Verification Confirmation (EVC) number is only valid for the provider who submitted the inquiry.

## Unmet Share of Cost

If the recipient has an unmet SOC, no EVC number is given unless the recipient is dually eligible (eligible for services under more than one aid code). For a dually eligible recipient, who is eligible for certain services with no SOC and the remaining services with a SOC, the aid code and corresponding eligibility message and an EVC number are given in the eligibility response for the non-SOC aid code only. An SOC message is then given for the SOC aid code.

**Important:** To avoid having a claim deny for recipient eligibility, the claim must be submitted with the same provider number, recipient ID and date of service used for the AEVS inquiry.

## ACCESSING TELEPHONE AEVS

### Introduction

Before you access telephone AEVS, you should have the required information ready to enter using your touch-tone telephone when prompted by AEVS.

### Time Limit

Telephone AEVS allows you a specified amount of time following each prompt to enter information using your touch-tone telephone. If you fail to respond to a prompt within five seconds, AEVS will remind you up to three times. If you have not entered any information after the third reminder, you will “time out” and AEVS will terminate the call with the following message:

*“We’re sorry, we are unable to complete your call. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. If you have any questions concerning AEVS, please contact the POS Help Desk at (800) 427-1295. Denti-Cal providers should call (800) 423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye.”*

### Error Limits

When entering required information using your touch-tone telephone, AEVS will allow you three opportunities to correctly enter the information. Upon your first and second error, AEVS will prompt you to re-enter the information correctly. After the third error, AEVS will terminate your call with the following message:

# AEVS: GENERAL INSTRUCTIONS

*“We’re sorry, we are unable to complete your call. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. If you have any questions concerning AEVS, please contact the POS Help Desk at (800) 427-1295. Denti-Cal providers should call (800) 423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye.”*

## Documenting Eligibility

Following receipt of AEVS eligibility information, note the information. For future reference when completing your claim forms.

## Information

Be prepared to write down the eligibility information for each inquiry as it is given to you over the telephone. AEVS will give an Eligibility Verification Confirmation (EVC) number for each inquiry that receives an eligible response.

Providers verifying eligibility information for Medi-Cal recipients may want to use the *AEVS Response Log* to track AEVS transactions. This form is located at the end of the *AEVS: Transactions* section in this manual.

The EVC number should be noted in your patient’s records for future reference. AEVS will provide you with the option to repeat eligibility information and the verification code as needed to ensure that you record the information accurately.

## Hours of Operation

Telephone AEVS are available by using a touch-tone telephone between 2 a.m. and midnight, seven days a week. If you attempt to access telephone AEVS during non-operational hours, you will receive the following message:

*“The Medi-Cal Automated Eligibility Verification System is available between 2 a.m. and midnight. Please call back during these hours of operation. Thank you for calling the Automated Eligibility Verification System. Good-bye.”*

In the unlikely event that telephone AEVS is unavailable during normal hours of operation, you will receive the following message when you attempt to verify eligibility for Medi-Cal or County Medical Services Program (CMSP) recipients:

**“The Medi-Cal Automated Eligibility Verification System is currently unavailable. Please call back later. Thank you for calling the Medi-Cal Automated Eligibility Verification System. Good-bye.”**

If AEVS is not available when you attempt to access Family PACT transactions, you will receive the following message:

# AEVS: GENERAL INSTRUCTIONS

*“The State-Only Family Planning system is currently unavailable. Please report your problem to the POS Help Desk at (800) 427-1295.”*

## **Inquiry Limitations**

To ensure optimal availability of telephone AEVS; providers are limited to a maximum of 10 inquiries for each telephone call. An inquiry is any request that is sent to the Medi-Cal eligibility verification system. For example, if verification is requested for a single recipient for the current month and three previous months, that is considered four inquiries. If the Medi-Cal eligibility verification system tells you that you have made an error and you resubmit the transaction, that is considered two inquiries. An inquiry for eligibility for one recipient and a Share of Cost clearance for another recipient is considered two inquiries. Any combinations of inquiries, to a maximum of 10, are allowed per telephone call.

## **“Bypass” Procedures**

After you have become accustomed to the system and the prompt messages; you may choose to “bypass” listening to the entire prompt. To use the “bypass” feature, enter the appropriate data after the beginning of each prompt.

## **Star Key (\*)**

The star key (\*) has a variety of functions:

### **Repeat Previous Prompt**

[\* #] Pressing the star key followed by the pound sign key [\* #] will cause AEVS to repeat the previous prompt.

### **Deleting Entered Data**

[\* \*] To delete all entered data in a current field, press two successive star keys, and then enter the correct data.

For example, if you intended to enter “12345” but accidentally keyed “12567”, the mistake can be corrected by entering [\* \*] followed by the correct data. The sequence of keystrokes would be:

12567\* \*12345 #

By pressing [#] you end the data entry. When AEVS receives the input, it discards all data in the field preceding the double star and takes the data following the double star as the intended input. The final input to AEVS would be “12345”.

## **Return To Main Menu**

[\* 99 #] Pressing the star key, followed by “99”, followed by the pound sign key [\* 99 #] will return you to the main menu and you will hear the following:

*“To perform an Eligibility Verification, press 1. To perform a Share of Cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a State-*

# AEVS: GENERAL INSTRUCTIONS

*Only Family Planning program transaction, press 4. To end this call, press 5."*

## Help Prompt

[\* 4 #] Pressing the star key, followed by "4", followed by the pound sign key [\* 4 #] will cause AEVS to speak the following message:

*"Special touch-tone features exist for this application. To repeat the previous prompt, press star pound [\* #]. To void data entered, press star star [\* \*] and re-enter the correct data. To go to the main menu, press star nine nine pound [\* 99 #]. Press star four pound [\* 4 #] to hear this help message any time during your call."*

## ENTERING ALPHABETIC DATA

### Introduction

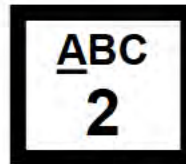
To enter alphabetic data (letters A, B, C, etc.), press the star key (\*) followed by a two-digit code representing the letter. This function is used when entering some Medi-Cal identification numbers or procedure codes with alphabetic characters.

### Two-Digit Code

The first digit of the code for all letters (except "Q" and "Z") is the keycap on which the letters appear. The second digit of the code identifies the letter's corresponding position on the appropriate keycap.

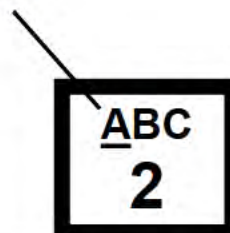
To enter the first digit of the code, press the keycap on which the letter appears. To enter the second digit of the code for the letter, find the position of the letter on the keycap (first, second or third position) and press the corresponding keycap representing the position ([1], [2] or [3]).

For example, to enter the two-digit code for the letter "A," first press the star key (\*), then press [2] keycap to identify "A":



Then press the [1] keycap to identify the first position:

first position



Press



# AEVS: GENERAL INSTRUCTIONS

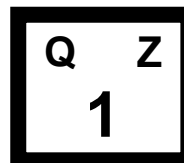
## Alphabetic Codes

### “Q” and “Z”

Therefore, the two-digit code for the letter “A” is **\* 21**.

Since the letters “Q” and “Z” do not appear on any keycap of the touch-tone keypad, these two letters are treated as though “they are the first two letters on keycap [1].

Press



for characters Q and Z

To enter “Q,” press (\*) plus [1] to identify the letter “Q” and [1] to show that “Q” is in the first corresponding position on the keycap. Therefore, the two-digit code for the letter “Q” is **\* 11**.

To enter “Z,” press (\*) plus [1] to identify the letter “Z” and [2] to show that “Z” is in the second corresponding position on the keycap. Therefore, the two-digit code for the letter “Z” is **\* 12**.

## 14-digit Medi-Cal ID

To enter the 14-digit Medi-Cal Identification Number “443**C**5213910234” you would identify the letter “C” by entering the following two-digit code (including the required star):

**C = \* 23**

Therefore, the touch-tone entry for “443**C**5213910234” would be “443\***23**5213910234”.

## 9-digit ID Number

To enter the 9-digit ID Number “444-55-611**P**” you would identify the letter “P” by entering the following two-digit code (including the required star):

**P = \* 71**

Therefore, the touch-tone entry for “444-55-611**P**” would be “44455611\***71**”.

## HCPCS Codes

To enter the HCPCS code “**Z**2345” you would identify the letter “Z” by entering the following two-digit code (including the required star):

**Z = \* 12**

Therefore, the touch-tone entry for “**Z**2345” would be “\***12**2345”.

## List of Alphabetic Codes

The alphabetic code listing for AEVS is as follows:

# AEVS: GENERAL INSTRUCTIONS

<u>LETTER</u>	<u>2-DIGIT CODE</u>	<u>LETTER</u>	<u>2-DIGIT CODE</u>
A	* 21	N	* 62
B	* 22	O	* 63
C	* 23	P	* 71
D	* 31	Q	* 11
E	* 32	R	* 72
F	* 33	S	* 73
G	* 41	T	* 81
H	* 42	U	* 82
I	* 43	V	* 83
J	* 51	W	* 91
K	* 52	X	* 92
L	* 53	Y	* 93
M	* 61	Z	* 12

## Alphabetic Code Listing

Press \* before entering the two-digit code

Q 11 1	Z 12 2	A B C 21 22 23 3
G H I 41 42 43 4	J K L 51 52 53 5	M N O 61 62 63 6
P R S 71 72 73 7	T U V 81 82 83 8	W X Y 91 92 93 9
*	0	#

**AEVS: (800) 456-AEVS (2387)**

## Function Keys

### Keys      Purpose

[#]	End data entry in a field; proceed to next field
[* #]	Repeat the menu option
[* *]	Delete the current data entry in a field
[* 99 #]	Return to the main menu

## STAFF MAKING REPORT

RCDMH CLIENT ID#

1. Physical injury to any client or clinic visitor requiring medical attention.
2. Suicide.
3. Significant injury caused by suicide attempt.
4. Homicide.
5. Significant injury caused by physical assault/battery by client upon another.
6. Significant injury caused by physical assaults on clients or visitors.
7. Significant injury to client while at clinic site.
8. Death of client by other than natural causes.

[illegible]

TIME: \_\_\_\_\_

TO WHOM SUBMITTED \_\_\_\_\_

Attachment 13  
Page 1 of 1



## COUNTY OF RIVERSIDE DEPARTMENT OF MENTAL HEALTH

**REPORT OF INCIDENT FORM**

DMH FORM 408-6

Involved Individuals:

Last Name	First Name	Client ID# (if applicable)
Address	Street	City
(Area Code)	Telephone No.	Age

Involved Is: Client \_\_\_\_\_ Employee \_\_\_\_\_ Visitor \_\_\_\_\_

Report File By: \_\_\_\_\_  
Name/Title Date Telephone No. Clinic

Date, Time &amp; Location of Incident: \_\_\_\_\_ Date of this Report: \_\_\_\_\_

Type of Incident: \_\_\_\_\_ Primary DX (when applicable): \_\_\_\_\_

Severity of Incident: \_\_\_\_\_

IS THIS A POSSIBLE LICENSE VIOLATION? \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client on Meds? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown. If yes, list meds and dosages: \_\_\_\_\_

Suspected or Known Alcohol or Drug Abuse: \_\_\_\_\_

Primary Psychiatrist (when applicable): \_\_\_\_\_

Brief Description of Incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family/Legal Guardian – Aware of Incident: \_\_\_\_\_ Yes \_\_\_\_\_ No

## COUNTY OF RIVERSIDE DEPARTMENT OF MENTAL HEALTH

**REPORT OF INCIDENT FORM**

DMH FORM 408-6

Family Attitude \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Witness: Name: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Account of Incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Witness: Name: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Account of Incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Regional/Program Manager Notified? \_\_\_\_ Yes \_\_\_\_ No Date &amp; Time Notified: \_\_\_\_\_

**DO NOT FILE THIS FORM IN CLIENT RECORDED – DO NOT DUPLICATE**

Original to: Professional Risk Management. Copy to: Medical Director

# RCDMH MHP CSI DATA COLLECTION

Attachment 15

Pg 1 of 2

## (MH Admission / Admission Screen)

Last Name First Name Middle Name SFX, i.e., Jr., Sr., etc.

Birth Name (If different from above) **(Enter in CSI Admission Screen)**

Social Security Number

Mother's First Name **(Enter in CSI Admission Screen)**

### Living arrangement:

<input type="checkbox"/> Adult Res. Facility, Social Rehab Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility	<input type="checkbox"/> Inpatient psychiatric hospital, Psychiatric Health Facility (PHF), or Veteran's Affairs (VA) Hospital
<input type="checkbox"/> Board and Care	<input type="checkbox"/> Justice related (Juvenile .Hall, CYA home, correctional facility, jail, etc.)
<input type="checkbox"/> Community Treatment Facility	<input type="checkbox"/> Mental Health Rehabilitation Center (24 hour)
<input type="checkbox"/> Foster Family Home	<input type="checkbox"/> Other
<input type="checkbox"/> Group Home (includes Levels 1-12 for children)	<input type="checkbox"/> Residential Treatment Center (Includes Levels 13-14 for children)
<input type="checkbox"/> Homeless, No identifiable residence	<input type="checkbox"/> Skilled Nursing Facility (SNF)/Intermediate Care Facility/Institute of Mental Disease (IMD)
<input type="checkbox"/> House or apartment (Includes trailers, hotels, dorms, barracks, etc.)	<input type="checkbox"/> State Hospital
<input type="checkbox"/> House or apartment and requiring daily support & supervision (applies to adults only)	<input type="checkbox"/> Supported Housing (applies to adults only)
<input type="checkbox"/> House or apartment and requiring some support with daily living activities(applies to adults only)	<input type="checkbox"/> Unknown/Not Reported

### Marital Status

<input type="checkbox"/> Single/Never married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced/Annulled	<input type="checkbox"/> Married
<input type="checkbox"/> Widowed	<input type="checkbox"/> Unknown	<input type="checkbox"/> Remarried	

## (MH Admission / Demographics Screen)

### Employment Status

<input type="checkbox"/> Full Time 32+ Hours A Week (Not including Armed Forces)	<input type="checkbox"/> Not in Labor Force - Retired	<input type="checkbox"/> Part Time, less than
<input type="checkbox"/> Full Time – 35 Hr or more per wk – Non-Comp	<input type="checkbox"/> Not in Labor Force - Student	<input type="checkbox"/> Part time, less than 35 Hrs Week Non-Comp
<input type="checkbox"/> In the Armed Forces	<input type="checkbox"/> Not in Labor Force – Unable to Work Due to MH, Developmental Disability, or A+D	<input type="checkbox"/> Unemployed – On Layoff From Job
<input type="checkbox"/> Not in Labor Force - Homemaker	<input type="checkbox"/> Not in Labor Force – Due to Other Disorder or Disability	<input type="checkbox"/> Unemployed Seeking Employment
<input type="checkbox"/> Not in Labor Force – Other Not Seeking Employment in Past 30 Days	<input type="checkbox"/> Part Time (1-15 Hours A Week (Not including Armed Forces)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Not in Labor Force – Resident/Inmate of Institution	<input type="checkbox"/> Part Time (16-32 Hours A Week Not Including Armed Forces	<input type="checkbox"/> Volunteer

### Occupation

<input type="checkbox"/> Administrative Support including clerical	<input type="checkbox"/> Machine Operators and Tenders, except Precision	<input type="checkbox"/> Production Inspectors, Testers, Samplers, and Weighers
<input type="checkbox"/> Construction Trade	<input type="checkbox"/> Mechanics and repairs	<input type="checkbox"/> Professional Specialty
<input type="checkbox"/> Executive, Administrative, and Managerial	<input type="checkbox"/> Military Occupations	<input type="checkbox"/> Protective Service Occupation
<input type="checkbox"/> Extractive Occupations	<input type="checkbox"/> Never Employed	<input type="checkbox"/> Sales Occupation
<input type="checkbox"/> Fabrication, Assemblers, and Hand-working	<input type="checkbox"/> Precision Production	<input type="checkbox"/> Svc Occupation except Protective and Household
<input type="checkbox"/> Farming, Forestry, Fishing	<input type="checkbox"/> Preschooler or Student	<input type="checkbox"/> Technicians & Related Support
<input type="checkbox"/> Handlers, Equipment Cleaners, Helpers, and Laborers	<input type="checkbox"/> Private household	<input type="checkbox"/> Transportation and Material Moving
		<input type="checkbox"/> Unknown

Submit this form to ACT / CARES along with the Initial Assessment / Care Plan, Extension Request, or Quarterly Report

ACT Fax: 951 687-5819 or CARES Fax: 951 358-5253

February 2012

Confidential Client Information – See CA W&I Code 5328

# RCDMH MHP CSI DATA COLLECTION

Attachment 15

Pg 2 of 2

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

**What is the consumer's education level?** \_\_\_\_\_ 98=other \_\_\_\_\_ 99=Unknown

(State numeric years i.e., 14= High School Grad + 2 additional years)

**Smoker/Tobacco** ☐ Current every day ☐ Current some days ☐ Former Smoker ☐ Never ☐ Unknown

## (Supplemental Screen)

**Sexual Orientation:** ☐ Heterosexual ☐ Bi-Sexual ☐ Gay ☐ Lesbian ☐ Questioning ☐ Unreported

**Does client self –identify as Transgendered:** ☐ Yes ☐ No

## (CSI Admission Screen)

### Consumer's Place of Birth (County only in CA)

County	State	Country
<b>Ethnicity:</b> <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown /Not reported <input type="checkbox"/> Hispanic or Latino		

### Special Population:

- |   |  |
|---|--|
| <input type="checkbox"/> Assisted Outpatient Treatment Service(s) (AB 1421) | <input type="checkbox"/> (AB 3632) Individual Education Plan (IEP) |
| <input type="checkbox"/> Governor's Homeless Initiative (GHI) Service(s)    | <input type="checkbox"/> No Special Population Services            |
|   | <input type="checkbox"/> Welfare-to-work Plan Specified Service(s) |

**Is Substance Abuse Affecting Mental Health?** ☐ Yes ☐ No ☐ Unknown

**Are Developmental Disabilities Affecting Mental Health?** ☐ Yes ☐ No ☐ Unknown

**Are Physical Health Disorders Affection Mental Health?** ☐ Yes ☐ No ☐ Unknown

### Conservator court status:

- |  |  |
|--|--|
| <input type="checkbox"/> Temporary conservatorship (W&I Code, Section 5353)                    | <input type="checkbox"/> Juvenile Court, Dependent of the Court (W&I Code, Section 300)  |
| <input type="checkbox"/> Lanterman-Petris-Short (W&I Code, Section 5358)                       | <input type="checkbox"/> Juvenile Court, Ward- Status Offender (W&I Code, Section 601)   |
| <input type="checkbox"/> Murphy (W&I Code, Section 5008)                                       | <input type="checkbox"/> Juvenile Court, Ward- Juvenile Offender (W&I Code, Section 602) |
| <input type="checkbox"/> Probate (Probate Code, Division 4, Section 1400)                      | <input type="checkbox"/> Not applicable  |
| <input type="checkbox"/> PC 2974 (Penal Code, Section 2974)                                    | <input type="checkbox"/> Unknown, not reported   |
| <input type="checkbox"/> Representative payee without conservatorship (W&I Code, Section 5686) |  |

**Number of children less than 18 yrs of age that the client cares for/ is responsible for at least 50% of the time:** \_\_\_\_\_

**Number of dependent adult 18 yrs of age and above that the client cares for/ is responsible for at least 50% of the time:** \_\_\_\_\_

**Preferred Language:** \_\_\_\_\_

**Race** (select up to five from the choices listed below): \_\_\_\_\_

American Indian	Asian Indian	Black or African American	Cambodian	Chinese	Filipino	Guamanian	Hmong	Japanese	Korean
Laotian	Mien	Native Hawaiian	Other Asian	Other Pacific Islander	Other	Samoan	Unknown/Not Reported	Vietnamese	White

**Is consumer an IRC consumer?** ☐ Yes ☐ No

**If so, IRC case worker's name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Provider name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Agency Name:** \_\_\_\_\_

Submit this form to ACT / CARES along with the Initial Assessment / Care Plan, Extension Request, or Quarterly Report

ACT Fax: 951 687-5819 or CARES Fax: 951 358-5253

February 2012

Confidential Client Information – See CA W& I Code 5328

Riverside County Mental Health Plan  
**PROVIDER REFERRAL REQUEST FORM**

Attachment 16

Date: \_\_\_\_\_

Type of Plan: ☐ DPSS (ACT) ☐ Group Home/FFA (CARES) ☐ Medi-Cal / RCHC (CARES)

Provider: \_\_\_\_\_ Provider #: 33 \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

Consumer Name: \_\_\_\_\_ Consumer DOB: \_\_\_\_\_

Consumer SSN: \_\_\_\_\_ Medi-Cal #: \_\_\_\_\_

Consumer Phone #: \_\_\_\_\_

Caretaker Name: \_\_\_\_\_ Caretaker Phone Number(s): \_\_\_\_\_

Primary Language of Consumer: \_\_\_\_\_ Primary Language of Caretaker: \_\_\_\_\_

Best Time to Reach Caretaker: \_\_\_\_\_

Consumer Address: \_\_\_\_\_

Type of Referral (\*\*This form is to be used ONLY for additional service referrals. Use Discharge Form if you will no longer be providing any services):

☐ Psychiatric Evaluation Recommended Provider: (Optional) \_\_\_\_\_

☐ Therapy Evaluation Recommended Provider (Optional): \_\_\_\_\_

☐ County Clinic for all Service Due to Consumer's Severity of Symptoms (Provider to Send Discharge Form)

\* Psychological Testing\* use Referral for Psychological Testing Form Only

☐ Other: \_\_\_\_\_ Recommended Provider (Optional): \_\_\_\_\_

Diagnosis:

Axis I: \_\_\_\_\_

Secondary \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

(Specific Psychosocial Stressors)

Axis V: \_\_\_\_\_ / \_\_\_\_\_

Current

Highest in Past Year

Reason for Referral(Please describe problematic behavior; be as specific as possible):

Is consumer aware of your desire to refer? ☐ Yes ☐ No

Is consumer (or caretaker) in agreement with referral? ☐ Yes ☐ No

Provider's Signature / Title \_\_\_\_\_

Date \_\_\_\_\_

Provider's Printed Name / Title \_\_\_\_\_

Send form to appropriate Authorization Unit

Community Access, Referral, Evaluation, & Support (CARES) \* P O Box 7549 \* Riverside, CA 92513 \* Fax: (951) 358-5352  
Assessment and Consultation Team (ACT) \* P.O. Box 7549 \* Riverside, CA 92513 \* Fax: (951) 687-5819

Provider/Agency Name: \_\_\_\_\_

## **CERTIFICATION OF CLAIMS AND PROGRAM INTEGRITY FORM**

### Medi-Cal Eligible Certification of Claims and Program Integrity

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the contract with the Riverside County Department of Mental Health (RCDMH) for Medi-Cal beneficiaries. The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary. The services included in the claim were actually provided to the beneficiary. Medical necessity was established for the beneficiary as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the contract with the RCDMH.

\_\_\_\_\_  
Signature of Authorized Provider

\_\_\_\_\_  
Date

### Non-Medi-Cal Eligible Certification of Claims and Program Integrity

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the contract with the Riverside County Department of Mental Health (RCDMH) for consumers who are referred by the Central Assess Team (CARES) or the Assessment and Consultation Team (ACT) for mental health specialty services. The beneficiary was referred to receive services at the time the services were provided to the beneficiary. The services included in the claim were actually provided to the beneficiary and for the timeframe in which the services were provided. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the contract with the RCDMH.

\_\_\_\_\_  
Signature of Authorized Provider

\_\_\_\_\_  
Date



# RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

*Jerry A. Wengerd, Director*

## Riverside County Department of Mental Health Therapeutic Behavioral Services Referral

### **INSTRUCTIONS**

**Please fax TBS referral packet to: TRAC – Fax: (951) 358-6865**

**DMH Clinic referrals:** TBS referral packet includes this referral and the following 5 attachments:

- 1) Client Care Plan (please include “Refer to TBS” under each goal that is related to the target behaviors);
- 2) Assessment; 3) Client Registration; 4) Consent for TBS (if minor is a ward or dependent attach minute order to Consent for TBS) and; 5) TBS Eligibility Criteria form.

**All other referrals:** TBS referral packet includes this referral and the following 3 attachments:

- 1) Initial Assessment/Client Care: (please include “Refer to TBS” under each goal that is related to the target behaviors); 2) Consent for TBS (if minor is a ward or dependent attach minute order to Consent for TBS); and 3) TBS Eligibility Criteria form.

Client Name: \_\_\_\_\_ Gender: \_\_\_\_\_ SS#: \_\_\_\_\_

Consumer DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Client ID #: \_\_\_\_\_

Full scope Medi-cal: ☐yes ☐no Client MediCal #: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Legal Status: \_\_\_\_\_

Client's Current Residence: \_\_\_\_\_  
(Street) \_\_\_\_\_, \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Phone #: \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

☐Parent Home ☐Relative Home ☐Foster Home ☐FFA ☐Group Home RCL \_\_\_\_ ☐Other

Name of Group Home (if applicable) \_\_\_\_\_

Contact Person/Caregiver: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Contact Person's Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

DPSS Worker: \_\_\_\_\_ Phone #: \_\_\_\_\_ Region: \_\_\_\_\_

Probation Officer: \_\_\_\_\_ Phone #: \_\_\_\_\_ Region: \_\_\_\_\_

SMH Therapist/CM: \_\_\_\_\_ Phone #: \_\_\_\_\_ Clinic: \_\_\_\_\_

GH Therapist: \_\_\_\_\_ Phone #: \_\_\_\_\_ Clinic: \_\_\_\_\_

Date of last Therapeutic Service: \_\_\_\_\_ Times per week client receives Therapy: \_\_\_\_\_

Other services: ☐Group Therapy ☐Family Therapy ☐Case Management ☐Day Treatment

☐Residential Treatment ☐Medication Services

Number of Psychiatric Hospitalizations: \_\_\_\_\_ Date of last hospitalization: \_\_\_\_\_



**Confidential Client Information, See W&I Code 5328**

Revised: 05/09/2011 Page 1 of 2

**Specific Behaviors to be Targeted:**

(Example: Physical Aggression as evidenced by – hitting others, kicking others, pulling hair, etc;  
and/or Property Damage as evidenced by – hitting holes in walls, throwing objects, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Targeted Behaviors Frequency and Time of Occurrence:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Antecedents to Target Behaviors:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Successful Interventions:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Client's Strengths and Interests:**

\_\_\_\_\_  
\_\_\_\_\_

**Client's and Family's View of Services Needed and Behavior to be Targeted:**

\_\_\_\_\_

**Clinicians Recommendations:**

Requested Number of TBS Hours Per Week: \_\_\_\_\_ Estimated Number of Weeks for TBS: \_\_\_\_\_

Requested days and times of day for TBS:

☐ Mon \_\_\_Hrs ☐ Tues \_\_\_Hrs ☐ Wed \_\_\_Hrs ☐ Thurs \_\_\_Hrs ☐ Fri \_\_\_Hrs ☐ Sat \_\_\_Hrs ☐ Sun \_\_\_Hrs

TBS Coach - Gender preference: \_\_\_\_\_ Language preference: \_\_\_\_\_

**Clinician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinic/Facility Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Signature of Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH TBS INFORMED CONSENT AND CONSENT TO TREATMENT

### **Informed Consent/Limits to Confidentiality**

Therapeutic Behavioral Services (TBS) is an intensive Mental Health Service, which utilizes a collaborative team approach. As such, information regarding the TBS case for you and your family may be shared with other TBS Treatment Team members. Treatment Team members may include, but not limited to, employees of the Department of Mental Health, Department of Public Social Services, Probation, your Therapist, Family/Caregiver/Group Home Staff, and the TBS Coach and Clinical Supervisor. Releases of information must be signed by a parent/guardian to allow these Treatment Team members to discuss your case with anyone else.

All Treatment Team members are Mandated Reporters. This means that under the laws of the State of California, these members are required to report information to the police or other government social service agencies regarding the following situations:

- Incidents revealed about child abuse, whether actual or suspected including physical abuse, sexual abuse, and neglect;
- Incidents revealed about dependent adult or elderly abuse including physical abuse, sexual abuse, neglect, abandonment and fiduciary abuse;
- Threats to harm self or others.

If you make statements regarding any of the above topics to any member of the Treatment Team, reports will be made to the appropriate agency as required by law.

### **Consent to Treatment**

I understand that I am expected to benefit from treatment through Therapeutic Behavioral Services (TBS), but there is no implied or expressed guarantee that I will.

I also understand that I have the right to terminate treatment at anytime. I understand that I also have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I consent and agree voluntarily to receive psychological services from Riverside County Department of Mental Health through TBS. Services I receive may include, but are not limited to: diagnostic assessments, behavioral coaching, crisis intervention, consultations and referrals to other professionals.

### **Acknowledgement of Understanding and Receipt**

I, the parent/legal guardian of \_\_\_\_\_ D.O.B. \_\_\_\_\_ do agree that Therapeutic Behavioral services (TBS) are needed for my child on a short-term basis to address behaviors/symptoms which put him/her at risk of placement or hospitalization. I understand that I must work closely with the clinician for my child and the TBS provider to make a plan for these services to be delivered to my child. At any time, I can request a change in the service or termination of the service through a discussion with my clinician and TBS provider.

I have read the above information and by signing below I am stating that I understand and agree to the above information regarding: Informed Consent/Limits to Confidentiality and Consent to Treatment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Riverside County Department of Mental Health**  
**Consent for Therapeutic Behavioral Services**  
**(Revised 6/14/01)**

I, the parent/legal guardian of \_\_\_\_\_ D.O.B. \_\_\_\_\_  
do agree that Therapeutic Behavioral services (TBS) are needed for my child on a short-term basis to address  
behaviors/symptoms which put him/her at risk of placement or hospitalization. I understand that I must work  
closely with the clinician for my child and the TBS provider to make a plan for these services to be delivered to my  
child. At any time, I can request a change in the service or termination of the service through a discussion with my  
clinician and TBS provider.

I hereby give permission for the above mentioned minor to go on outings with \_\_\_\_\_  
(TBS Coach), and I also authorize any emergency treatment by proper medical authorities for any accident or illness while  
in the care of the above mentioned TBS Coach. I also give permission for this form to be photocopied.

Parent/Care Provider's Name (please print) \_\_\_\_\_

Relationship \_\_\_\_\_

Address/City \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Family Doctor's Name \_\_\_\_\_

Address/City \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ Member Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**PERSON(S) TO CONTACT IN CASE OF EMERGENCY, IF PARENT/ CARE PROVIDER NOT AT HOME**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address/City \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address/City \_\_\_\_\_

*Signature of Parent or Guardian* \_\_\_\_\_ *Date* \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Copy to: ☐ Parent(s) ☐ Clinician ☐ TBS Worker ☐ TBS Supervisor

**A COPY OF THIS FORM IS AS GOOD AS THE ORIGINAL**

**Departamento de Salud Mental del Condado de Riverside**  
**Consentimiento para Servicios Terapéuticos Relativos al Comportamiento**  
**(Revisión del 14-6-01)**

Yo, el padre de familia o tutor legal de \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_  
 estoy de acuerdo en que mi hijo(a) necesita servicios Terapéuticos del Comportamiento (TBS) por sus siglas en inglés, por un  
 termino corto, para atender los síntomas y/o el comportamiento que lo ponen en riesgo de ser colocado en una instalación o ser  
 hospitalizado(a). Entiendo que tengo que trabajar en conjunto con el clínico para ayudar a mi hijo(a) y que el proveedor TBS  
 formulará un plan para que estos servicios se le provean a mi hijo(a). En cualquier momento dado, puedo pedir cambios en los  
 servicios o que los mismos cesen, hablando con el clínico y con el proveedor de Servicios Terapéuticos Relativos al  
 Comportamiento.

Por medio del presente, doy autorización para que el menor de edad antes mencionado pueda ir a las excursiones  
 con \_\_\_\_\_ (El Entrenador del Programa TBS), y autorizo cualquier tratamiento de urgencia  
 prestado por las autoridades médicas apropiadas que surjan por cualquier accidente o enfermedad mientras esté bajo el cuidado del  
 entrenador de TBS antes mencionado. Además, doy permiso para que este formulario se a fotocopiado.

Padre de familia / nombre del Proveedor de Tratamiento (letra de molde)

Parentesco \_\_\_\_\_

Domicilio/Ciudad \_\_\_\_\_

Teléfono de día \_\_\_\_\_ Teléfono de Noche \_\_\_\_\_

Nombre del Médico la Familia \_\_\_\_\_

Domicilio/Ciudad \_\_\_\_\_ Teléfono \_\_\_\_\_

Seguro médico \_\_\_\_\_ Número de Membresía \_\_\_\_\_ Fecha en que caduca \_\_\_\_\_

**Si el padre de familia del proveedor de servicio no está en casa.**

Nombre: \_\_\_\_\_ Parentesco: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Domicilio/Ciudad \_\_\_\_\_

Nombre: \_\_\_\_\_ Parentesco: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Domicilio/Ciudad \_\_\_\_\_

***Firma del padre de familia o guardián*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

**Parentesco al menor:** \_\_\_\_\_

**UNA COPIA DE ESTE FORMULARIO TIENE EL MISMO VIGOR QUE LA ORIGINAL**

## Therapeutic Behavioral Services

### Eligibility Criteria

**In order for a child/youth to be eligible to receive services, the child/youth must meet all of the following. Please check all that apply.**

<b>Name of Client being Referred:</b>	<b>Client Number:</b>
---------------------------------------	-----------------------

**A. MUST BE 1-4**

- ☐ (1) Child/Youth is a full scope Medi-Cal beneficiary under 21.
- ☐ (2) Meet's medical necessity criteria.
- ☐ (3) The Child/Youth is receiving other specialty mental health services.
- ☐ (4a) It is likely (in the clinical judgment of mental health provider) that without TBS that the child/youth will need a higher level of residential care, including acute care; or
- ☐ (4b) Needs this support to transition to a lower level of care.

**B. AND at least ONE of the following (check all that apply)**

- ☐ (5) Child/youth is placed in a group home of RCL 12 or above and/or a locked treatment facility.
- ☐ (6) Child/youth is being considered for placement in a facility as described above. If checked then see ***REQUIRED*** step below:
  - ☐ Attach Interagency Placement Screening Committee Form Parts A & B, ***-OR-***
  - ☐ Attach a Progress Note reflecting consultation with Children's Case Management clinician indicating that client's behaviors places him/her at risk of an RCL 12 level of care or above.
- ☐ (7) Child/youth has undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.
- ☐ (8) Child/youth previously received TBS while a member of the certified class.

**C. AND must meet 9-15**

Child/youth presents with conditions requiring TBS and the service is not solely:

- ☐ (9) For the convenience of the caretaker.
- ☐ (10) To provide supervision or assure compliance with probation.
- ☐ (11) To ensure the child/youth's physical safety or the safety of others.
- ☐ (12) To address conditions not part of the child/youth's mental condition.

**AND**

- ☐ (13) Child/youth cannot sustain non-impulsive self-directed behavior; cannot handle themselves appropriately in social situations with peers and are unable to appropriately handle transitions during the day.
- ☐ (14) The child/youth has the capacity to develop skills in order to be able to sustain non-impulsive self-directed behavior and engaged in appropriate community activities without full-time supervision.
- ☐ (15) The child/youth is not an in-patient in a hospital, psychiatric health facility, nursing facility, IMD or crisis residential program.

<b>Signature of Referring Staff/Title:</b>
<div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="flex-grow: 1; border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="text-align: right; flex-grow: 1;"> <b>Date:</b> <span style="border-bottom: 1px solid black; display: inline-block; width: 150px;"></span> </div> </div> <div style="border-top: 1px solid black; margin-top: 5px; text-align: center;"> <b>(Please Print/Type Name and Title)</b> </div>

## **Riverside County Department of Mental Health**

### **Procedure for TBS Eligibility Criteria Section B**

If you are requesting TBS for a minor who:

- ☐ Has never been in out of home placement
- ☐ Has never been psychiatrically hospitalized
- ☐ Has never received TBS previously
- ☐ And is **only** eligible in section B (of the TBS Eligibility Criteria form) due to being considered for placement in an RCL 12 or higher group home,

The following steps must be taken prior to submitting a TBS referral packet, in addition to the normal procedures:

1. The referral must be staffed with Riverside County Department of Mental Health (RCDMH) Children's Case Manager, who has expertise in the arena of child/youth placement.
2. For this consultation you must call RCDMH Children's Case Management at (951) 358-6858 and request to speak with on duty Children's Case Manager for a consultation to determine if your client meets the RCL 12 "at risk" criteria. The consultation must be documented in the progress notes of your current chart.
3. If the Children's Case Manager agrees with your assessment that the child/youth is in danger of being placed in an RCL 12 or higher group home, submit that documentation with your TBS packet to substantiate that the minor does meet class for TBS under section B of the TBS Eligibility Criteria form.

## **ELIGIBILITY VERIFICATION VIA MEDI-CAL WEBSITE – SAMPLE**

1. Access Medi-Cal website via [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)
2. Once in website, highlight “Login” on the left column of the screen
3. Enter your user Id – XXXXXXXXXX (9 digits-numbers/letters)
4. Enter your password – XXXXXXXXX (8 digit-numbers) - click on submit
5. Click on “Single Subscriber”
6. Enter the client’s SSN in “Subscriber ID” box (000100000 no hyphens needed)
7. Enter client’s DOB in “Subscriber Birth Date” box (format 01/01/1965)
8. Enter Today’s date in “Issue Date” box (format 03/04/2004)
9. Enter any date of service in “Service Date” box to determine eligibility for that month/year (format 03/01/2004)
10. Click on “Submit”
11. The screen will provide the client’s name, (subscriber ID), service date, subscriber birth date, issue date, primary aid code, first, second and third special aid codes, subscriber county code, HIC number, Trace number, i.e., eligibility verification confirmation (EVC) #, and eligibility message
12. To leave web page click on “back” at the top of the web page and then click on clear to enter in the next consumer information.

Riverside County Mental Health Plan  
Community, Access, Referral, Evaluation, & Support (CARES)  
**PSYCHIATRIC TREATMENT AUTHORIZATION REQUEST**

Date: \_\_\_\_\_ ☐ Initial TAR ☐ Extension TAR ☐ Change TAR

Provider: \_\_\_\_\_ Provider #: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

Consumer Name: \_\_\_\_\_

Consumer DOB: \_\_\_\_\_ Consumer SSN: \_\_\_\_\_

Consumer Medi-Cal#: \_\_\_\_\_

Diagnosis: Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis  
III: \_\_\_\_\_

Axis  
IV: \_\_\_\_\_

Axis V: \_\_\_\_\_ / \_\_\_\_\_  
Current Highest in Past Year

Current Medication(s) and Dosage(s): \_\_\_\_\_

Prescribed By: \_\_\_\_\_

Symptoms that impair functioning: \_\_\_\_\_

Goal(s) of Treatment: \_\_\_\_\_

Target Date: \_\_\_\_\_

**PROPOSED TREATMENT**

☐ Psychiatric Evaluation: \_\_\_\_\_ 15 min session(s) per ☐ month ☐ quarter for \_\_\_\_\_ ☐ weeks ☐ months

Comments \_\_\_\_\_

Contractor's Signature and Title: \_\_\_\_\_ Date: \_\_\_\_\_

Consumer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Attachment 25

Medication Guidelines

Please go to the Mental Health Website to obtain the Medication Guidelines

[www.rcdmh.org](http://www.rcdmh.org)



IMD Psychiatrist/Psychologist  
Treatment Authorization Request

Dr. \_\_\_\_\_

Fax to: 951 358-5352

Facility: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name	Date of Birth	SSN (or Medi-Cal) Number	First Date of Service	✓ If Re-Auth Needed

# REFERRAL FOR SERVICES FOR FFA OR GROUP HOME CLIENT

(To avoid delay of services, complete ALL form sections)

Date: \_\_\_\_\_ Client Name: \_\_\_\_\_

Client DOB: \_\_\_\_\_ Client SSN: \_\_\_\_\_

Date of Placement: \_\_\_\_\_ Client Medi-Cal #: \_\_\_\_\_

Name of Client's Siblings: \_\_\_\_\_

Name of Group Home or FFA: \_\_\_\_\_

Client's Residence Address & Phone Number: \_\_\_\_\_

Foster Parent's Name: \_\_\_\_\_

School Client is Attending: \_\_\_\_\_ Grade \_\_\_\_\_

Desired Service: ☐ Therapy Service ☐ Psychiatric Services

Urgent due to: ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Out of Medication

List Current Medications: \_\_\_\_\_

Rationale for Change of Provider/Requested Services (must include symptoms and how symptoms impair consumer functioning):

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Developmental Delay? ☐ Yes ☐ No Regional Center Client? ☐ Yes ☐ No

Desired Provider (must specify): \_\_\_\_\_

Signature of Requestor: \_\_\_\_\_

Requestor's Printed Name and Title: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Requestor's Phone Number: \_\_\_\_\_

Requestor's Fax Number: \_\_\_\_\_

Fax to Community Access, Referral, Evaluation, & Support (C.A.R.E.S.) (951) 358-5352

Confidential patient information. See California Welfare and Institutions Code Section 5328

## Attachment 28

### SB785

Website:

[http://www.dmh.ca.gov/services\\_and\\_programs/Children\\_and\\_Youth/SB785.asp](http://www.dmh.ca.gov/services_and_programs/Children_and_Youth/SB785.asp)

## RIVERSIDE COUNTY MENTAL HEALTH PLAN INFORMING MATERIAL REORDER FORM

Please use this form to reorder Riverside County Mental Health Plan brochures and/or poster/flyers that you may need. Place a check mark inside the box next to each item needed. Please put amount requested of English and/or Spanish. Please note that the maximum order per brochure is 50. The maximum per Provider Report (Listing) is 10.

***Please check box for items needed and enter quantity for each language option.***

<input type="checkbox"/>	English _____	Spanish _____	<b>Riverside County Guide to Medi-Cal Mental Health Services Handbook</b> – This handbook must be given to each of your Riverside County Medi-Cal beneficiaries during the initial intake. It gives them important information about their treatment in the Mental Health Plan. This handbook is for Medi-Cal beneficiaries only. NOT FOR RCHC CONSUMERS.
<input type="checkbox"/>	_____ Maximum 10		<b>Provider Report (Listing)</b> – Consumers must be provided with a copy of the Provider Report (Listing) upon request, when the consumer initially accesses services and annually thereafter as long as the consumer remains in treatment.
<input type="checkbox"/>	English _____	Spanish _____	<b>Notice of Privacy Practices. (HIPAA) Form</b> – Notice of Privacy Practice form describing how the County of Riverside may use and disclose the personal health information of the consumer and how the consumer can obtain access to this information. Packet contains the “Acknowledgement of Receipt” of this information that must be kept in the consumer’s chart.

***THE FOLLOWING MUST BE DISPLAYED IN AN AREA (WAITING ROOM) THAT IS VISIBLE TO ALL CONSUMERS RECEIVING MENTAL HEALTH SPECIALTY SERVICES:***

<input type="checkbox"/>	English _____	Spanish _____	<b>Appeal/Grievance Procedure/Form Booklet</b> – This brochure must be available to all consumers. It provides the consumer with information on their rights and how to proceed if not satisfied with the mental health services being received.
<input type="checkbox"/>	English _____	Spanish _____	<b>Your Right to Make Decisions About Medical Treatment Brochure</b> – Must be given to each consumer at intake.
<input type="checkbox"/>	_____		<b>Quality Improvement Envelopes</b> – To mail appeal/grievance information.
<input type="checkbox"/>	English _____	Spanish _____	<b>Riverside County Medi-Cal/RCHC Beneficiaries 800 Number Poster</b> – Must be posted in an area where consumers can read its content. FOR POSTING ONLY. NOT TO BE DISTRIBUTED.
<input type="checkbox"/>	English _____	Spanish _____	<b>Notice About Translation Services Poster</b> – Must be posted in an area where consumers can read its content. FOR POSTING ONLY. NOT TO BE DISTRIBUTED.
<input type="checkbox"/>	English _____	Spanish _____	<b>Grievance Poster</b> – Must be posted in an area where consumers can read its content. FOR POSTING ONLY. NOT TO BE DISTRIBUTED.
<input type="checkbox"/>	English _____	Spanish _____	<b>Medical Doctor Notice to Consumer Poster</b> – Must be posted in an area where consumers can read its content. MDs ONLY - FOR POSTING ONLY. NOT TO BE DISTRIBUTED.

Please fax your request to 951-955-7361. No telephone orders please.

PROVIDER NAME:	
PROVIDER CONTACT NAME:	
PROVIDER ADDRESS:	
PROVIDER TELEPHONE:	
If a Riverside County Mental Health Clinic: Mail Stop Number:	

Attachment 30A

Riverside County Guide to Medi-Cal Mental Health Services (English)

Please go to the Mental Health Website to obtain the

Riverside County Guide to Medi-Cal Mental Health Services

[www.rcdmh.org](http://www.rcdmh.org)

Attachment 30B

Riverside County Guide to Medi-Cal Mental Health Services (Spanish)

Please go to the Mental Health Website to obtain the

Riverside County Guide to Medi-Cal Mental Health Services

[www.rcdmh.org](http://www.rcdmh.org)



# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW  
THE COUNTY OF RIVERSIDE MAY USE AND DISCLOSE  
YOUR PERSONAL HEALTH INFORMATION AND HOW  
YOU CAN OBTAIN ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.**

**EFFECTIVE DATE: APRIL 14, 2003**

The County creates records of health care to provide quality care and comply with legal requirements. The County understands your health information is personal and private, and commits to safeguarding it to the extent reasonably possible. The law requires the County to keep your health information private and to provide you this notice of our legal duties and privacy practices. The law also requires the County to follow the terms of this notice.

This notice outlines the limits on how the County will handle your health information. Under federal law, the County must provide a copy of this notice when you receive health care and related services from the County, or participate in certain health plans administered or operated by the County. The County reserves the right to change practices and make new provisions effective for all health information it maintains. You may request an updated copy of this notice at any time.

## **A. Use and Disclosure – General**

Generally, except as otherwise specified below, the County may use and disclose the following health information, as allowed by state and federal law:

1. **For treatment.** The County uses and discloses health information to provide you health care and related services. For instance:
  - Nurses, doctors, or other County employees may record your health information, and they may share such information with other County employees.
  - The County may disclose health information to people outside the County involved in your care who provide treatment and related services.
  - The County may use and disclose health information to contact you to remind you about appointments for treatment or health care-related services.
  - In emergencies, the County may use or disclose health information to provide you treatment. The County will make its best effort to obtain your permission to use or disclose your health information as soon as reasonably practical.
2. **For payment.** The County may bill you, insurance companies, or third parties. Information on or accompanying these bills may identify you, as well as diagnoses, assessments, procedures performed, and medical supplies used.
3. **For health care operations.** The County may use information in your health record to assess the care and outcomes in your case to improve our services, and in administrative processes such as purchasing medical devices, or for auditing financial data.
4. **For health plan administration.** As administrator of certain health plans, such as Medicare, Medi-Cal, and Exclusive Care, the County may disclose limited information to plan sponsors. The law only allows using such information for purposes such as plan eligibility and enrollment, benefits administration, and payment of health care expenses. The law specifically prohibits use for employment-related actions or decisions.

**County of Riverside  
Notice of Privacy Practices**

**B. Use and Disclosure Requiring Your Authorization**

On a limited basis, the County may use and disclose health information only with your permission, as required by state and federal law:

1. From mental health records.
2. From substance abuse treatment records.

**C. Use and Disclosure Requiring an Opportunity for You to Agree or Object**

In certain cases, the County may use and disclose health information only if it informs you in advance and provides an opportunity to agree or object, as required by state and federal law:

1. The County may include your name, location in the facility, general condition, and religious affiliation in a facility directory while you are a patient so your family, friends and clergy can visit you and know how you are doing.
2. To individuals assisting with your treatment or payment.
3. To assist with disaster relief to notify your family about you.

**D. Use and Disclosure NOT Requiring Permission or an Opportunity for You to Agree or Object**

In specific cases, the County may use and disclose the following health information without your permission and without providing you the opportunity to agree or object:

1. As required by law.
2. For public health activities, which may include the following:
  - Preventing or controlling disease, injury or disability;
  - Reporting births and deaths;
  - Reporting abuse or neglect of children, elders and dependent adults;
  - Reporting reactions to medications or problems with products;
  - Notifying people of recalls of products they may use; or,
  - Notifying a person exposed to or at risk to contract or spread a disease or condition.
3. For mandated reporting of abuse, neglect or domestic violence.
4. For health oversight activities necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
5. To the minimum extent necessary to comply with judicial and administrative proceedings when compelled by court order, or in response to a subpoena, discovery request or other lawful process as allowed by law.
6. To law enforcement:
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;



**County of Riverside  
Notice of Privacy Practices**

- About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the hospital; or,
  - In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description or location of a person who may have committed a crime.
7. To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.
  8. For organ donation once you are deceased.
  9. For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.
  10. To avert serious threats to the health and safety of you or others.
  11. Regarding military personnel for activities deemed necessary by a appropriate military command authorities to assure proper execution of a military mission.
  12. To determine your eligibility for or entitlement to veterans benefits.
  13. To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.
  14. To correctional institutions and other law enforcement custodial situations, inmates of correctional institutions or in custody of a law enforcement official.
  15. To determine your eligibility for or enroll you in government health programs.
  16. For Workers Compensation or similar programs, to the minimum extent necessary.

The County will not disclose your health information for marketing fundraising, or other reasons not listed above without your prior written permission, and you may withdraw that permission in writing at any time. If you do, the County will no longer use or disclose health information about you for the reasons you permitted. You understand the County is unable to retract disclosures already made with your permission, and must retain records of care already provided.

**E. Rights and Responsibilities**

With regard to health information, the County recognizes and commits to safeguard your:

1. **Right to request restrictions on certain use and disclosure.** You have the right to request restriction or limitation on the health information the County uses or discloses for treatment, payment or health care operations, though the law does not require the County to agree to your request. If the County agrees, it will comply except to provide emergency treatment. Requests must be in writing and state: the information you want to limit; whether to limit use, disclosure, or both; and, to whom limits apply. For instance, you may ask not to disclose to your spouse.
2. **Right to confidential communications.** You have the right to ask the County to communicate with you in a certain way, or at a certain location.
3. **Right to request to inspect and copy records.** You have the right to request to inspect and obtain copies of your health information. Requests may be required in writing, and the County may charge you a fee for the costs of fulfilling your request. The County may

**County of Riverside  
Notice of Privacy Practices**

deny requests to inspect or copy psychotherapy notes, mental health records, or materials for legal proceedings. You may ask for review of a denial by another health care professional chosen by the County. The County will comply with the results of that review.

4. **Right to amend health records.** If information the County has about you is incorrect or incomplete, you may ask to amend it. Requests must be in writing, and provide a reason supporting your request. The County may deny your request if it is not in writing, or does not include a reason supporting it. The County may deny requests if the information:
  - Was not created by the County;
  - Is not health information kept by or for the County;
  - Is not information you are permitted to inspect and copy; or,
  - Is accurate and complete.
5. **Right to an accounting of certain disclosures.** You have the right to ask for a listing of the last six years of disclosures of your health information since April 14, 2003, not pertaining to treatment, payment or health care operations. Requests must be in writing. The first list you request in a twelve-month period is free. The County may charge you the cost of providing or reproducing additional lists. When told the cost, you may withdraw or modify your request.
6. **Right to obtain a paper copy of the notice of privacy practices upon request.**
7. **Right to file complaints without fear of retaliation.** Under law, the County cannot penalize you for filing a complaint. If you believe the County violated your privacy rights, you may file a complaint with the department privacy officer, County privacy office, or with the U.S. Secretary of Health and Human Services.

**PRIVACY COMPLAINT CONTACTS**

**Riverside County  
Regional Medical Center**  
Privacy Officer  
26520 Cactus Avenue  
Moreno Valley, CA 92555  
(951) 486-4659

**Office on Aging**  
6296 Rivercrest Drive, Suite K  
Riverside, CA 92507  
(800) 510-2020

**Employee Assistance Program**  
3600 Lime Street, Suite 111  
Riverside, CA 92501  
(951) 778-3970

**Community Health Agency**  
Privacy Officer  
4065 County Circle Drive  
Riverside, CA 92503  
(951) 358-5000

**Public Social Services**  
Privacy Officer  
10281 Kidd Street  
Riverside, CA 92503  
(951) 358-3030

**★ County Privacy Office ★**  
P.O. Box 1569  
Riverside, CA 92502  
(951) 955-1000

**Mental Health**  
Privacy Officer  
4095 County Circle Drive  
Riverside, CA 92503  
(951) 358-4500

**Veterans Services**  
1153A Spruce Street  
Riverside, CA 92507  
(951) 955-6050

**Exclusive Care Plan**  
P.O. Box 1508  
Riverside, CA 92502  
(800) 962-1133

**U.S Department of Health & Human Services  
Region IX Office of Civil Rights**  
50 United Nations Plaza, Room 322  
San Francisco, CA 94102

TEL: (415) 437-8310 ♦ TDD: (415) 437-8311 ♦ FAX: (415) 437-8329



# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient or Subscriber Name: \_\_\_\_\_  
(Please print patient or subscriber name)

I, \_\_\_\_\_,  
(Print name of patient, subscriber, conservator, parent or legal guardian signing below)

acknowledge receipt of the Notice of Privacy Practices, which explains limits on ways in which the County may use or disclose personal health information to provide service, provided by the County of Riverside:

\_\_\_\_\_  
(Name of facility, provider or program)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by patient, indicate relationship: \_\_\_\_\_

NOTE: Parents must have legal custody. Legal guardians and conservators must show proof.

\*\*\*\*\*

## THIS SECTION TO BE FILLED OUT ONLY BY THE COUNTY OF RIVERSIDE

Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgment of Receipt because:

- ☐ Patient left office before Acknowledgment could be signed.
- ☐ Patient does not wish to sign this form.
- ☐ Patient cannot sign this form because: \_\_\_\_\_

Patient did not receive the Notice of Privacy Practices because:

- ☐ Patient required emergency treatment.
- ☐ Patient declined the Notice and signing this Acknowledgment.
- ☐ Other: \_\_\_\_\_

Name: \_\_\_\_\_  
(Print name of provider or provider's representative)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of provider or provider's representative)



## AVISO DE PRÁCTICAS DE PRIVACIDAD

**ESTE AVISO DESCRIBE CÓMO ES QUE  
EL CONDADO DE RIVERSIDE PUEDE USAR Y  
REVELAR SU INFORMACIÓN MÉDICA PERSONAL Y CÓMO  
PUEDE OBTENER ACCESO A DICHA INFORMACIÓN.  
POR FAVOR REPÁSELA CUIDADOSAMENTE.**

**FECHA DE VIGENCIA: 14 de abril de 2003**

El condado crea archivos médicos para proporcionar tratamiento de alta calidad y cumplir con los requisitos legales. El condado mantiene presente que su información médica es personal y privada, y se encarga de almacenar la misma con seguridad razonable. La ley requiere que el condado mantenga su información médica privada, y requiere que le proporcionemos esta informativa relativa a nuestros deberes legales y prácticas relacionadas a la privacidad. Además, la ley le exige al condado que cumpla con los términos de esta informativa.

Esta informativa estipula las limitaciones que el condado tiene relativas al manejo de su información médica. De acuerdo con la ley federal, el condado tiene la obligación de proporcionarle una copia de esta informativa cuando recibe tratamiento médico o servicios relacionados al mismo, o si es participante de ciertos planes médicos administrados u operados por el condado mismo. El Condado reserva el derecho de cambiar sus prácticas y hacer nuevas disposiciones eficaces relativas a toda información médica que el condado almacena. Usted puede pedir una copia vigente de esta informativa en cualquier momento dado.

### **A. Uso y Divulgación General**

Salvo estipulado lo contrario abajo, generalmente el condado puede usar y divulgar la siguiente información médica de acuerdo con las leyes estatales y federales:

1. **Para tratamiento.** El condado usa y divulga información médica para proporcionarle tratamiento y los servicios relacionados al mismo. Por ejemplo:
  - Es posible que las enfermeras, los médicos, u otros empleados del condado anoten su información médica y es posible que compartan dicha información con otros empleados del condado.
  - Es posible que el condado revele información médica a personas afuera del condado, cuyas están involucradas en su tratamiento y le proporcionan tratamiento y servicios relacionados al mismo.
  - El condado puede usar y divulgar información médica para avisarle o decirle de alguna cita de tratamiento médico o para servicios relacionados al mismo.
  - En emergencias, el condado puede usar o divulgar información médica para proporcionarle tratamiento. El condado hará todo lo posible para obtener su permiso para usar o divulgar su información médica lo más pronto posible.
2. **Para pago.** El condado puede cobrarle a usted, a las compañías de seguros, o a un tercero. La Información incluida en estos cobros puede identificarlo a usted, su diagnóstico, las determinaciones, los procedimientos realizados y los equipos médicos que se utilizaron.
3. **Para la administración de los procedimientos del tratamiento médico.** El condado puede usar la información en su expediente médico para evaluar el tratamiento prestado y los resultados relativos a su caso para mejorar sus servicios. Además, en los procesos administrativos, tal como la compra de dispositivos médicos, o para examinar la información financiera.

**Condado de Riverside**  
**Aviso de Prácticas de Privacidad**

4. **Para la administración del plan médico.** Como administrador de ciertos planes médicos, tales como; Medicare, Medi-Cal, y Exclusive Care, el condado puede divulgarle cierta información a los patrocinadores de dichos planes médicos. La ley sólo permite usar dicha información para propósitos de elegibilidad del plan médico y matriculación al mismo, administración de beneficios, y para el pago de gastos del tratamiento médico. La ley, específicamente prohíbe, el uso de dicha información para el uso en causas relacionadas al empleo o decisiones de las mismas.

**B. Uso y Divulgación que Requieren Su Autorización**

El condado puede usar y divulgar cierta información médica solamente obteniendo su permiso, tal como lo requieren las leyes estatales y federales:

1. De los expedientes de salud mental.
2. De los expedientes de tratamiento relativo al abuso de sustancias químicas.

**C. Uso y Divulgación que Requieren una Oportunidad para que Usted Acceda o se Oponga**

En ciertos casos, el condado puede usar y divulgar información médica solamente si se le deja saber de antemano, y si se le da la oportunidad de acceder u oponerse, tal como lo disponen las leyes estatales y federales:

1. Mientras usted es paciente, el condado solo puede incluir su nombre, dónde se encuentra en la instalación, su condición general, y la afiliación religiosa en el directorio de la instalación para que su familia, amigos, y clero puedan visitarlo y saber cómo se encuentra.
2. A aquellos individuos que ayudan con su tratamiento o pago del mismo.
3. Para asistir con alivio de situaciones de desastre y notificar a su familia acerca de usted mismo.

**D. Uso y Revelación que no Requieren Permiso u Oportunidad para que Usted acceda o se oponga.**

En casos específicos, el condado puede usar y puede divulgar la siguiente información médica sin su permiso y sin darle la oportunidad para acceder u oponerse.

1. Como lo dispone la ley.
2. Para las actividades de salubridad públicas que pueden incluir lo siguiente:
  - Evitando o controlando a las enfermedad, lesión o incapacidades;
  - Reportando los nacimientos y las muertes;
  - Reportando los abusos o el abandono de los menores, ancianos y adultos dependientes;
  - Reportando las reacciones a medicamentos o cualquier problema con algún producto;
  - Notificando a la gente acerca de los productos que se deben devolver que tal vez estén usando; o,
  - Notificando a la gente expuesta a o a riesgo de contraer o propagar alguna enfermedad o condición médica.

**Condado de Riverside**  
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3. Para reportar, de acuerdo con la ley, los abusos, el abandono o la violencia domestica.
4. Para la revisión de las actividades necesarias para que el gobierno puede vigilar al sistema de tratamiento médico, los programas gubernamentales, y el cumplimiento de las leyes relativas a los derechos humanos.
5. Cumplir con los procedimientos judiciales y administrativos, a su extensión mínima, cuando sea obligado por orden judicial, o como respuesta a una orden de comparecencia, petición de divulgación de información, u otro proceso legal permitido por la ley.
6. Para las entidades policiales:
  - Para identificar o localizar a un sospechoso, fugitivo, testigo importante, o persona perdida;
  - Relativo a la víctima de algún crimen si, bajo circunstancias limitadas, no podemos obtener la autorización de la persona;
  - Acerca de alguna muerte que creemos que resultó a consecuencia de conducta criminal;
  - Relativo a cualquier conducta criminal en el hospital; o,
  - En casos de emergencias, para reportar algún crimen, averiguar dónde se perpetro algún crimen o dónde se encuentra alguna victima, o la identidad de la misma, para obtener la descripción o ubicación de alguna persona que pudo haber cometido un crimen.
7. Para los médicos forenses, evaluadores médicos y directores funerarios; como sea necesario para que los mismos realicen sus deberes.
8. Para la donación de órganos después que muera.
9. Para las investigaciones de salubridad pública, cumpliendo con las condiciones estrictas aprobadas y supervisadas por una Mesa de Revisión Institucional.
10. Para impedir amenazas serias contra la salud y su propia seguridad o la de los demás.
11. Con respecto al personal militar para las actividades consideradas necesarias por las autoridades militares apropiadas para asegurar que las misiones militares se realicen debidamente.
12. Para determinar si tiene derecho de recibir los beneficios para los veteranos.
13. Para autorizar a los funcionarios para que realicen investigaciones informativas lícitas, contra-inteligencia, y otras actividades relacionadas a la seguridad nacional.
14. Para las instituciones correccionales y otras situaciones relacionada a la custodia relativa a hacer cumplir la ley, a los presos de instituciones correccionales, o la custodia de funcionarios policiales.
15. Para determinar su elegibilidad para o para hacerlo miembro de algún programa médico gubernamental.
16. Para la Compensación al Trabajador o algún programa semejante, a su extensión mínima necesaria.

**Condado de Riverside**  
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El condado no divulgará su información médica para recaudación de fondos relativos al comercio, ni otros motivos no alistados anteriormente, sin su autorización previa por escrito, y usted puede, en cualquier momento, retirar ese permiso que dio por escrito. Si retira su autorización, el condado no continuará usando ni divulgando su información médica por el motivo que indicaba su autorización. Mantenga presente que el condado no puede retraer la información que se ha divulgado con su previa autorización, y tiene que mantener los archivos relativos al tratamiento que ya se le habían divulgado.

**E. Derechos y Responsabilidades**

Con respecto a la información médica, el condado reconoce y se encarga de mantener seguro su:

1. **Derecho a solicitar que se limite cierto uso y divulgación.** Usted tiene el derecho de solicitar que se limite o restrinja la información médica que el condado usa o divulga para motivos de tratamiento, pago, o la administración de tratamiento médico, aunque la ley no requiere que el condado acceda a su petición. Si el condado está de acuerdo, llevará a cabo su petición, excepto cuando se trate de tratamiento urgente. Las peticiones deben ser por escrito e indicar: la información que quiere limitar, si quiere limitar el uso de la misma, la divulgación, o ambas cosas y a quién aplican dichos límites. Por ejemplo, usted puede pedir que la información no se le divulgue a su esposo(a.)
2. **Derecho a comunicaciones confidenciales.** Usted tiene el derecho de pedirle al condado que se comuniquen con usted de cierta manera o en cierto lugar.
3. **Derecho de solicitar para revisar y de obtener copias de sus archivos.** Usted tiene el derecho de solicitar para revisar y obtener copias de su información médica. Las peticiones pueden ser necesitadas por escrito, y el condado puede cobrarle una cuota por el costo de llevar a cabo su petición. El Condado puede negar las peticiones para revisar o copiar las notas relativas a la psicoterapia, los archivos de salud mental, o información para los procesos legales. Usted puede pedir que otro profesional médico reconsidere el motivo de negación, dicho profesional médico será elegido por el condado. El condado cumplirá con los resultados de esa reconsideración.
4. **Derecho de enmendar los archivos médicos.** Si la información que el condado tiene acerca de usted mismo(a) es errónea o no está completa, puede pedir que la misma se enmiende. La petición debe ser por escrito, y debe indicar el motivo que apoya su posición de modificación. Es posible que el condado rechace su petición, si la misma no se presenta por escrito, o no contiene motivos que apoyan su petición. El condado puede optar negar su petición si la información:
  - No fue creada por el condado;
  - No es información médica almacenada por, ni para el condado;
  - No es información que le permiten revisar ni copiar; o,
  - Es información correcta y completa.

**Condado de Riverside  
Aviso de Prácticas de Privacidad**

5. **Derecho a explicaciones acerca de ciertas divulgaciones.** Usted tiene el derecho de pedir una lista de los últimos seis años de divulgaciones de su propia información médica, lo que tomará vigencia el 14 de abril del 2003, no relacionado al tratamiento, pago, ni la administración de tratamiento médico. Las peticiones deben ser por escrito. La primera lista que pida, en un periodo de doce meses, es gratis. El Condado puede cobrarle el costo de proporcionarle o reproducir listas adicionales. Cuando le digan el costo, usted puede retirar su petición o puede modificar la misma.
6. **Derecho de obtener una copia de la información de prácticas de privacidad cuando lo solicite.**
7. **Derecho de presentar quejas sin temor a represalias.** Bajo la ley, el condado no puede castigarlo por presentar cualquier queja. Si usted cree que el condado violó sus derechos de privacidad, puede presentar una querrela con el funcionario del departamento de privacidad, la oficina de privacidad del condado, o con el U.S. Secretary of Health and Human Services (El Secretario de Salud y Servicios Humanitarios.)

**ENTIDADES PARA PRESENTAR QUEJAS DE PRIVACIDAD**

**Riverside County Regional  
Medical Center**  
(Centro Médico Regional  
del Condado de Riverside)  
Privacy Officer/ Funcionario de Privacidad  
26520 Cactus Avenue  
Moreno Valley, CA 92555  
(951) 486-4659

**Community Health Agency**  
(Agencia Comunitaria de Salud)  
Privacy Officer/Funcionario de Privacidad  
4065 County Circle Drive  
Riverside, CA 92503  
(951) 358-5000

**Mental Health**  
(Salud Mental)  
Privacy Officer/ Funcionario de Privacidad  
4095 County Circle Drive  
Riverside, CA 92503  
(951) 358-4500

**Office on Aging**  
(Oficina del envejecimiento)  
6296 Rivercrest Drive, Suite K  
Riverside, CA 92507  
(800) 510-2020

**Public Social Services**  
(Servicios Sociales Públicos)  
Privacy Officer  
10281 Kidd Street  
Riverside, CA 92503  
(951) 358-3030

**Veterans Services**  
(Servicios para los Veteranos)  
1153A Spruce Street  
Riverside, CA 92507  
(951) 955-6050

**Employee Assistance Program**  
(Programa de Asistencia para Empleados)  
3600 Lime Street, Suite 111  
Riverside, CA 92501  
(951) 778-3970

**★County Privacy Office★**  
(Oficina de Privacidad del Condado)  
P.O. Box 1569  
Riverside, CA 92502  
(951) 955-1000

**Exclusive Care Plan**  
(Plan Médico "Exclusive Care")  
P.O. Box 1508  
Riverside, CA 92502  
(800) 962-1133

**U.S. Department of Health & Human Services**  
(Departamento Federal de Salubridad y Servicios Humanos)  
**Office of Civil Rights Medical Privacy Complaint Division**  
(Oficina de Derechos Humanos, División de Quejas de Privacidad Médica)

50 United Nations Plaza, Room 322  
San Francisco, CA 94102  
TEL: (415) 437-8310 ♦ TDD: (415) 437-8311 ♦ FAX: (415) 437-8329





# CONFIRMACIÓN DE ENTREGA DEL AVISO DE PRÁCTICAS DE PRIVACIDAD

Nombre del paciente o suscriptor: \_\_\_\_\_  
(En letra de molde escriba el nombre del paciente o suscriptor)

Yo, \_\_\_\_\_,  
(En letra de molde escriba el nombre del paciente, suscriptor, tutor, padre o guardián que firma debajo)

confirmando haber recibido el Aviso de Prácticas de Privacidad, que explican los límites y las maneras en que el condado puede usar o puede divulgar información médica personal para prestar servicios suministrados por el Condado de Riverside:

\_\_\_\_\_  
(Nombre de establecimiento, proveedor o programa)

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_

Si no firmó el paciente, indique su relación al mismo:

AVISO: LOS PADRES TIENEN QUE TENER CUSTODIA LEGAL. TUTORES Y CONSERVADORES NECESITAN PRESENTAR PRUEBA DE SERLO.

\*\*\*\*\*

ESTA SECCIÓN SÓLO PUEDE SER LLENADA POR EL CONDADO DE RIVERSIDE

Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgment of Receipt because:

- ☐ Patient left office before Acknowledgment could be signed.
- ☐ Patient does not wish to sign this form.
- ☐ Patient cannot sign this form because: \_\_\_\_\_

Patient did not receive the Notice of Privacy Practices because:

- ☐ Patient required emergency treatment.
- ☐ Patient declined the Notice and signing this Acknowledgment.
- ☐ Other: \_\_\_\_\_

Name: \_\_\_\_\_  
(Print name of provider or provider's representative)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of provider or provider's representative)

**To obtain information on the status of a pending appeal or grievance, contact the Quality Improvement Coordinator at (800) 660-3570.**

### **State Fair Hearings**

Medi-Cal consumers may have any of their concerns addressed at any State Fair Hearing after completion of the Appeals/Grievance process. If you file a hearing within ten (10) days of a Notice of Action that your mental health services are being denied, reduced or terminated, there are circumstances where the services can be continued until the hearing. A Request for a State Fair Hearing Form is included with each Notice of Action to deny, reduce or terminate services. You may also request a State Fair Hearing by calling the State Department of Social Services at (800) 952-5253.

**[www.rcdmh.org](http://www.rcdmh.org)**

## **RIVERSIDE COUNTY MENTAL HEALTH PLAN**

### **APPEAL & GRIEVANCE PROCEDURE/REQUEST FORM**

**Jerry Wengerd, Director**



### **BOARD OF SUPERVISORS:**

District I	Bob Buster
District II	John Tavaglione
District III	Jeff Stone
District IV	John J. Benoit
District V	Marion Ashley

**August 2011**

**RIVERSIDE COUNTY  
DEPARTMENT OF MENTAL HEALTH  
APPEAL & GRIEVANCE PROCEDURE**

A consumer and/or consumer's representative may file an appeal, orally or in writing, with his/her service provider, the C.A.R.E.S. Team, or the Quality Improvement Program.

An **Appeal** is a request for a review of an action by the authorization unit C.A.R.E.S. Team or the RCDMH Program. An action is defined as the modification or denial of a requested service from a consumer and/or a reduction, suspension, or termination of a previously authorized service.

A **Grievance** is defined as an expression of dissatisfaction concerning services received from the Mental Health Plan. Examples of grievances might be as follows: the quality of care or services provided, aspects of interpersonal relationships - such as rudeness of an employee, etc.

Enclosed, is an Appeal/Grievance Request Form for the consumer and/or consumer's representative to use to file a written Appeal or Grievance. If you need assistance in completing the form, you can request help from your provider, or by calling the Quality

Improvement Program at (800) 660-3570, or Patients' Rights at (800) 350-0519, or locally (951) 358-4600.

The Appeal/Grievance Request Form can be submitted to your provider, the program supervisor, the C.A.R.E.S. Team, or mailed directly to Quality Improvement in the self-addressed envelope available in your provider's lobby or reception area.

**You will not be subject to discrimination or any other penalty for filing an Appeal or Grievance.**

For Appeals Only: Please indicate if the consumer is in any Medi-Cal funded residential treatment program. The Expedited Appeals block should be checked on the Appeal/Grievance Request Form when taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

**Medi-Cal beneficiaries may file for a State Fair Hearing after the completion of the Appeal or Grievance process.**

**Riverside County Mental Health Plan  
Quality Improvement Coordinator  
P.O. Box 7549  
Riverside, CA 92513  
1-800-660-3570**

***For Office Use Only:***  
**By:** \_\_\_\_\_ **Forward to:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**Date Consumer Notified:** \_\_\_\_\_  
**Outcome:** \_\_\_\_\_

## **APPEAL/GRIEVANCE REQUEST**

This form is used to file an Appeal Request. If you need assistance in completing this form, you can request help from your provider, or calling the Quality Improvement Program at (800) 660-3570 or Patients' Rights at (800) 350-0519, or locally, (909) 358-4600. A signed Release of Information Form needs to be submitted with this appeal request. The appeal request can be submitted to your clinician, the Program Supervisor, or mailed directly to the Quality Improvement Program at the address shown above.

**I wish to file:**      ☐ **Appeal**      ☐ **Grievance**

### **PLEASE PRINT**

Your address and phone number are important. We need this information to contact you about the outcome of your Appeal or Grievance.

Your Name: \_\_\_\_\_

Your Address: \_\_\_\_\_

Your Daytime Phone: \_\_\_\_\_

- ☐ Check here if you are currently a resident of a Medi-Cal funded residential treatment program.
- ☐ **Check here if you are requesting that your appeal request be processed through the Expedited Appeals Process**

Current Provider: \_\_\_\_\_

If Applicable, Person Representing You: \_\_\_\_\_

Their Address: \_\_\_\_\_

Their Daytime Phone: \_\_\_\_\_

**What is the problem?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What would you like the solution to be?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Whom have you talked to about the problem?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Client (or Client's Representative) Signature**

\_\_\_\_\_  
**Date**

**You will not be subject to discrimination or any other penalty for filing an Appeal or Grievance. Your confidentiality will be protected at all times in accordance with State and Federal law. You may request a State Fair Hearing following the completion of the Appeals or Grievance Process.**

Client's Last Name	First Name	Middle Name	Date of Birth
Street Address	City	Zip Code	Telephone Number

Health Care Provider Name		
Street Address		
City	State	Zip Code

☐ 2. Confined to records regarding admission and treatment for the following

medical condition or injury: \_\_\_\_\_  
\_\_\_\_\_ .

☐ 3. Confined to the following specified information: \_\_\_\_\_  
\_\_\_\_\_ .

☐ 4. All medical records.

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate three (3) months from the date of consent without express revocation.

\_\_\_\_\_  
Signature of Client, Legal Guardian, Representative (Please Circle)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure.**



**Para obtener información del estado de una apelación pendiente, llame al coordinador del mejoramiento de calidad al (800) 660-8570.**

### **Audiencias Estatales Imparciales**

Los consumidores de Medi-Cal puede dirigir cualquier preocupación en cualquier Audiencia Estatal Imparcial. Si usted entabla una audiencia dentro de diez (10) días de haber recibido un Aviso de Acción que sus servicios de salud mental están negándose, reduciéndose, o cancelándose, existen circunstancias bajo las cuales los servicios pueden continuar hasta que se celebre la audiencia.

Una Solicitud para la Petición de una Audiencia Estatal Imparcial se incluye con cada Aviso de Acción negar, reducir, o cancelar los servicios. Además, puede solicitar una Audiencia Estatal Imparcial llamando al Departamento Estatal de Servicios Sociales al (800) 952-5253.

**[www.rcdmh.org](http://www.rcdmh.org)**

## **PLAN DE SALUD MENTAL DEL CONDADO DE RIVERSIDE**

### **PROCESO DE APELACIÓN/ QUERRELLA FORMULARIO**

**Director, Jerry Wengerd**



### **JUNTA DE SUPERVISORES:**

Distrito I	Bob Buster
Distrito II	John Tavaglione
Distrito III	Jeff Stone
Distrito IV	John J. Benoit
Distrito V	Marion Ashley

**Agosto 2011  
(Revisado)**



## **DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE RIVERSIDE PROCESO DE APELACIÓN**

El consumidor y/o el representante del consumidor pueden entablar una apelación o una querella, oral o por escrito, con su proveedor de servicios, C.A.R.E.S., o el Programa del Mejoramiento de Calidad.

Una **apelación** es una petición para que se reconsidere alguna acción tomada por la unidad de autorización (C.A.R.E.S.) o el Programa RCDMH. Una acción se define como la modificación o negación de un servicio solicitado por un consumidor y/o una reducción, suspensión, o terminación de un servicio, suspensión, o terminación de un servicio que previamente fue autorizado.

Una **querella** se define como una expresión de descontento acerca de los servicios que se recibieron de parte del Plan de Salud Mental. Ejemplos de una querella pueden ser los siguientes: la calidad del tratamiento o los servicios prestados, los aspectos de las relaciones interpersonales tal como el que un empleado sea grosero, etc.

Adjunto, se encuentra el Formulario de Apelación/Querella para el consumidor y/o el representante del consumidor con el propósito de usarlo para

entablar una apelación o querella escrita. Si necesita asistencia para llenarla, puede pedirle a su proveedor que le ayude, o llamando al Programa del Mejoramiento de Calidad al (800) 660-3570, o a los Derechos del Paciente al (800) 350-0519, o localmente al (951) 358-4600.

El Formulario de Apelación/Querella puede someterse al proveedor, al supervisor del programa C.A.R.E.S., o mándelo directamente por correo al Mejoramiento de Calidad en el sobre con el domicilio disponible en la sala de espera de su proveedor de servicios o en el área de recepción.

**Usted no será sujeto a discriminación ni a ningún otro castigo por entablar un Apelación o Querella.**

En una Apelación favor de indicar si el consumidor se encuentra en un programa residencial de tratamiento pagado por Medi-cal. Debe marcar el cuadrado que indica Apelaciones cuando la apelación usual pueda poner en serio peligro la vida, salud, o la habilidad de obtener, mantener, o recuperar el funcionamiento máximo.

**Los beneficiarios de Medi-cal pueden entablar una petición para que se celebre un Audiencia Estatal después de completar el proceso de Apelación o Querella.**

**Quality Improvement Coordinator**  
**P.O. Box 7549**  
**Riverside, CA 92513**  
**1-800-660-3570**

**By:** \_\_\_\_\_ **Forward to:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**Date Consumer Notified:** \_\_\_\_\_  
**Outcome:** \_\_\_\_\_

### **SOLICITUD DE APELACIÓN/QUERELLA**

Este formulario se usa para entablar una apelación. Si requiere asistencia llenando este formulario, puede pedir ayuda de su proveedor, o llame al Programa del Mejoramiento de Calidad al (800) 660-3570 o a los Derechos del Paciente al (800) 350-0519, o localmente al (909) 358-4600. Necesita incluir una autorización para divulgar información con esta solicitud de apelación. Puede presentar esta apelación entregándosela al med.clínico, al Supervisor del Programa, o mándela directamente al Programa del Mejoramiento de Calidad al domicilio escrito arriba.

**Deseo archivar:**      ☐ **Apelación**      ☐ **Querella**

### **ESCRIBA EN LETRA DE MOLDE**

Su domicilio y teléfono son de suma importancia. Necesitamos esta información para comunicarnos con usted acerca del resultado de la apelación.

Su Nombre: \_\_\_\_\_

Su Domicilio: \_\_\_\_\_

Su Teléfono Durante el Día: \_\_\_\_\_

- ☐ Marque aquí si actualmente se encuentra en un programa de tratamiento residencial pagado por Medi-Cal.
- ☐ **Marque aquí si esta pidiendo que su solicitud de apelación sea procesada por el Proceso de Apelación expedito.**

Prestador de Servicios Actual: \_\_\_\_\_

Si aplica, Persona Responsable por Usted: \_\_\_\_\_

El Domicilio de esa Persona: \_\_\_\_\_

El Teléfono Durante el Día de esa Persona: \_\_\_\_\_

**¿Cuál es el Problema?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**¿Qué le gustaría que fuese la solución?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**¿Con quién ha hablado acerca del problema?** \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Firma del Cliente (o el Representante del Cliente)**

\_\_\_\_\_  
**Fecha**

**Usted no será sujeto a discriminación ni a ninguna otra penalidad por entablar esta apelación. En todo momento su confidencialidad será protegida, según lo disponen las leyes Estatales y Federales. Usted puede pedir una Audiencia Imparcial Estatal después de que haya completado el Proceso de Apelación.**

**Plan de Salud Mental del Condado de Riverside**  
**Autorización para Divulgar Información del Expediente Médico**

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Apellido del Cliente	Primer Nombre	Segundo Nombre	Fecha de Nacimiento
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Domicilio Teléfono	Ciudad	Zona Postal	Número de
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Yo, el suscrito, por el presente autorizo: (Nombre y domicilio del proveedor de servicios médicos con los archivos)

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Nombre del Proveedor de Tratamiento Médico

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Domicilio

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Ciudad	Estado	Zona Postal
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Y al: **Plan de Salud Mental del Condado de Riverside**  
**Mejoramiento de Calidad**  
**P.O. BOX 7549**  
**Riverside, CA 92513**

acceso a mis archivos médicos con el propósito de \_\_\_\_\_ .  
También autorizo a usted para que provea copias de las mismas según se soliciten.

La autorización está sujeta a las siguientes limitaciones:

- ☐ 1. Limitados a los archivos relativos al tratamiento del periodo comenzando con \_\_\_\_\_ hasta \_\_\_\_\_ .
- ☐ 2. Limitados a los archivos relativos al ingreso y el tratamiento para la condición médica o lesión siguiente: \_\_\_\_\_ .

☐ 3. Limitada a la siguiente información especificada: \_\_\_\_\_  
\_\_\_\_\_

☐ 4. Todo archivo médico.

Este consentimiento está sujeto a revocación por el suscrito en cualquier momento dado, excepto si algunos pasos hayan sido tomados confiando en el mismo, y si el mismo no ha sido revocado antes, el mismo deja de ser vigente en tres (3) meses de la fecha del consentimiento sin revocación expresa.

\_\_\_\_\_  
Firma del Cliente, el Tutor Legal, o el Representante (Favor de circular el apropiado)

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Testigo

\_\_\_\_\_  
Fecha

**Cualquier divulgación de información de los archivos médicos por el que tiene los mismos se prohíbe, excepto cuando se indique implícitamente en el área del propósito para la divulgación.**

have not filled in a written Individual Healthcare Instruction, you can discuss your wishes with your doctor and ask your doctor to list those wishes in your medical record, or you can discuss your wishes with your family members or friends, but it will probably be easier to follow your wishes if you write them down.

#### **What if I change my mind?**

You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

#### **What happens when someone else makes decisions about my treatment?**

The same rules apply to anyone who makes healthcare decisions on your behalf - a healthcare agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your healthcare instructions or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest. The people providing your healthcare must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes a disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

#### **Will I still be treated if I do not make an advance directive?**

Absolutely. You will still get medical treatment. We just want you to know that if you become too

sick to make decisions, someone else will have to make them for you. Remember that a Power of Attorney for Healthcare lets you name an agent to make decisions for you. Your agent can make most medical decisions - not just those about life sustaining treatment - when you cannot speak for yourself. You can also let your agent make decisions earlier if you wish. You can create an Individual Healthcare Instruction by writing down your wishes about healthcare or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an Individual Healthcare Instruction provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf. These two types of Advance Healthcare Directives may be used together or separately.

#### **How can I get more information about making an Advance Healthcare Directive?**

Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an Advance Healthcare Directive for you, or you can complete an Advance Healthcare Directive by filling in the blanks on a form.

Complaints concerning noncompliance with the Advance Healthcare Directive may be filed with the California Department of Health Services Licensing and Certification by calling 1-800-236-9747 or by mail at P.O. Box 99743, Sacramento, CA 95899-1413.

# **YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICAL TREATMENT**



**COUNTY OF  
RIVERSIDE  
DEPARTMENT  
OF  
MENTAL HEALTH**



This brochure explains your right to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future. A federal law requires us to give you this information. We hope this information will help you increase your control over your medical treatment.

### **Who decides about my treatment?**

Your doctors will give you information and advice about treatment. You have the right to choose. You can say “yes” to treatments you want. You can say “no” to any treatment that you do not want – even if the treatment might keep you alive longer.

### **How do I know what I want?**

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have side effects. Your doctor must offer you information about problems that medical treatment is likely to cause you. Often, more than one treatment might help you, and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor cannot choose for you. That choice is yours to make and depends on what is important to you.

### **Can other people help with my decisions?**

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

### **Can I choose a relative or friend to make healthcare decisions for me?**

Yes. You can tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare “surrogate” in your medical record. The surrogate’s control over your medical decisions is effective only during treatment for your current illness or injury or, if you are in a medical facility, until you leave the facility.

### **What if I become too sick to make my own healthcare decisions?**

If you have not named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of time that works, but sometimes everyone does not agree about what to do. That is why it is helpful if you can say in advance what you want to happen if you cannot speak for yourself.

### **Do I have to wait until I am sick to express my wishes about healthcare?**

No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an Advance Healthcare Directive to say who you want to speak for you and what kind of treatment you want. These documents are called “advance” because you prepare one before healthcare decisions need to be made. They are called “directives” because they state who will speak on your behalf and what should be done. In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a Power of Attorney for Healthcare. The part where you can express what you want done is called an Individual Healthcare Instruction.

### **Who can make an Advance Healthcare Directive?**

You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

### **Who can I name as my agent?**

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

### **When does my agent begin making my medical decisions?**

Usually, a healthcare agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the Power of Attorney for Healthcare that you want the agent to begin making decisions immediately.

### **How does my agent know what I would want?**

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your Advance Healthcare Directive.

### **What if I do not want to name an agent?**

You can still write out your wishes in your Advance Healthcare Directive without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment. Even if you

otro tipo de tratamiento médico. Aunque usted no haya llenado las Instrucciones individuales de Tratamiento Médico, usted puede hablar de sus deseos con su doctor y pedirle a su doctor que escriba esos deseos en su expediente médico, o puede hablar acerca de sus deseos con miembros de familia o amigos, sin embargo, probablemente será más fácil llevar a cabo sus deseos si los escribe.

#### **¿Qué tal si cambio de opinión?**

Usted puede cambiar o cancelar sus directivas avanzadas en cualquier momento dado, siempre y cuando usted pueda comunicar sus deseos. Para cambiar a la persona que quiere que haga sus decisiones médicas, usted tiene que firmar una declaración o necesita decirle al doctor encargado de su tratamiento.

#### **¿Qué pasa cuando otra persona hace decisiones acerca de mi tratamiento?**

Las mismas reglas aplican a cualquier persona que hace decisiones médicas por usted—un agente de salud, algún sustituto cuyo nombre usted le dio al médico, o una persona asignada por el tribunal para que haga decisiones por usted. Se requiere que todos sigan sus instrucciones médicas o, si no existen, entonces sus deseos generales relativos al tratamiento, incluyendo el detener algún tratamiento. Si se desconocen sus deseos médicos, el sustituto tiene que tratar de determinar lo que sea mejor para usted. Las personas que le proveen su tratamiento médico tienen que seguir las decisiones de su agente o sustituto, a menos que el tratamiento que se solicite se considere mala práctica médica o no eficaz para ayudarle a usted. Si esto causa algún desacuerdo que no se puede resolver, el proveedor de servicios tiene que, razonablemente, tratar de encontrar a otro prestador de servicios para que tome cargo de su tratamiento.

#### **¿Se me proveerá tratamiento aunque no tenga directivas anticipadas?**

Absolutamente. Aun recibirá tratamiento médico. Simplemente queremos que sepa que si está

demasiado(a) enfermo(a) como para hacer decisiones, otra persona las tendrá que hacer por usted. Recuerde que una Carta Poder para tratamiento médico le permite a usted nombrar su propio agente para que éste haga decisiones por usted. Su agente puede hacer la mayoría de las decisiones, no se limita a las decisiones acerca del tratamiento que sostiene la vida, cuando usted no puede hablar por sí mismo(a). Además, usted puede permitir que su agente haga decisiones antes de que esto ocurra, si usted lo desea.

Usted puede crear Instrucciones de Tratamiento médico Individual por escrito, escribiendo sus deseos acerca del tratamiento médico o hablando con su doctor y pidiéndole al doctor que registre sus deseos en su expediente médico. Si usted sabe en que momento le gustaría o no ciertos tipos de tratamiento, los Instrucciones de tratamiento médico Individuales son una buena manera para poner en claro sus deseos y dárselas a su doctor o a cualquier persona que esté involucrada en hacer decisiones (de su parte) acerca de su tratamiento. Puede usar estos dos tipos de Directivas Avanzadas de Tratamiento Médico separadas o mancomunadamente.

#### **¿Cómo puedo obtener más información acerca de hacer Directivas Anticipadas de Tratamiento Médico?**

Pídale a su médico, enfermera, trabajador social, o al proveedor de tratamiento médico que le dé más información. Usted puede pedirle a un abogado que escriba sus Directivas Avanzadas de Tratamiento Médico, o usted mismo(a) puede llenar las Directivas Avanzadas de Tratamiento Médico llenando las líneas en blanco en el formulario.

Las Querellas acerca de la falta de cumplimiento de las Directivas Avanzadas pueden entablarse con el Departamento de Licencias y Certificación de los Servicios Médicos de California llamando al 800-236-9747 o por correo al P.O. Box 99743, Sacramento, CA 95899-1413.

# **SU DERECHO DE HACER DECISIONES ACERCA DE SU TRATAMIENTO MÉDICO**



**CONDADO DE RIVERSIDE  
DEPARTAMENTO  
OF  
SALUD MENTAL**

[www.mentalhealth.co.riverside.ca.us](http://www.mentalhealth.co.riverside.ca.us)



Este folleto explica su derecho de hacer decisiones médicas y la manera en que puede, actualmente, planear su tratamiento médico si no pudiese hablar por sí mismo(a) en el futuro. Una ley federal requiere que le demos esta información. Esperamos que esta información le ayude aumentar el control que tiene sobre el tratamiento médico.

### **¿Quién decide acerca de mi tratamiento?**

Su médico le dará información y consejos acerca del tratamiento. Usted tiene el derecho de decidir. Usted puede decir “sí” al tratamiento que usted quiera. Usted puede decir “no” al tratamiento que no quiere—aunque el tratamiento lo/la mantenga vivo(a) por más tiempo.

### **¿Cómo se lo que quiero?**

Su médico tiene que decirle acerca de su condición médica y acerca de las alternativas de tratamiento, y el control del dolor y cómo estas cosas pueden ayudarlo. Muchos tratamientos tienen efectos secundarios. Su médico tiene que ofrecerle a usted información acerca de los problemas que el tratamiento médico puede causarle. Frecuentemente, es posible que más de un tratamiento pueda ayudarlo—y las personas tienen diferentes ideas acerca de lo que es mejor. Su médico puede decirle cuáles tratamientos están disponibles para usted, sin embargo, su médico no puede hacer la decisión por usted. Esa decisión es suya para hacer y depende en lo que es importante para usted.

### **¿Otras personas pueden ayudar con la decisión?**

Sí. Seguido los pacientes piden la ayuda de sus parientes o amigos para hacer decisiones médicas. Estas personas pueden ayudarlo a considerar las opciones que tiene. Puede pedirle al médico y las enfermeras que hablen con sus parientes y sus amigos. Ellos pueden hacerle preguntas al doctor y a las enfermeras por usted.

### **¿Puedo elegir a un pariente o amigo para que haga decisiones médicas por mí ?**

Sí. Usted puede decirle a su médico que usted quiere que otra persona haga las decisiones médicas por usted. Pídale al doctor que nombre a esa persona como su “substituto” en sus expedientes médicos. El control del “substituto” acerca de sus decisiones médicas tiene vigencia, solamente, durante el tratamiento de su enfermedad actual o lesión o, si usted se encuentra en una instalación médica, hasta que usted salga de esa instalación.

### **¿Qué tal si estoy tan enfermo(a) que no puedo hacer decisiones médicas yo mismo(a)?**

Si usted no ha nombrado su sustituto, su doctor le pedirá a su pariente o amigo más cercano que ayude a decidir lo que es mejor para usted. La mayoría del tiempo esto funciona, sin embargo, a veces no todos están de acuerdo acerca de los pasos que se necesitan tomar. Por eso, ayuda el que usted diga de antemano lo que quiere que ocurra si usted no puede comunicar sus deseos.

### **¿Necesito esperar hasta estar enfermo(a) antes de expresar mis deseos acerca de mi cuidado médico?**

No. Es mas, es mejor decidir antes de estar demasiado enfermo(a) o tener que ser hospitalizado(a), en un hospicio para ancianos, o en otra instalación médica. Usted puede usar las Directivas Avanzadas Médicas para indicar quién quiere que hable por usted y qué tipo de tratamiento desea. Estos documentos se denominan “anticipadas” porque uno los prepara antes de que las decisiones médicas tengan que hacerse. Además, se llaman “directivas” porque indican quién hablará de su parte y lo que debe hacerse. En California, la parte de las directivas avanzadas en la cual usted puede nombrar un agente para que haga decisiones médicas se llama “Poder Notarial para Tratamiento Médico. La parte en la cual usted puede expresar lo que quiere que se haga se llama Instrucciones de Tratamiento Médico del Individuo.

### **¿Quién puede hacer Directivas Médicas Anticipadas ?**

Usted puede hacerlo, si tiene 18 años o mayor de edad y si tiene la capacidad de hacer sus propias decisiones médicas. No necesita un abogado.

### **¿A quién puedo nombrar como mi agente?**

Puede elegir a un pariente adulto o a cualquier otra persona en la que confíe, para que hable por usted cuando decisiones médicas tengan que hacerse.

### **¿Cuándo comienza mi agente a hacer mis decisiones médicas?**

Generalmente, el agente de tratamiento médico solamente hace decisiones después de que usted pierda la habilidad de hacerlas por sí mismo(a). Sin embargo, si usted lo desea, usted puede indicar en la Carta Poder de Tratamiento Médico que usted quiere que el agente comience a hacer las decisiones inmediatamente.

### **¿Cómo sabe mi agente lo que yo quisiera que se hiciera?**

Después de haber elegido su agente, hable con la persona acerca de lo que usted quiere. A veces las decisiones de tratamiento son difíciles de hacer, y realmente ayuda si su agente sabe lo que usted quiere. También puede escribir sus deseos en sus Directivas Anticipadas de Tratamiento Médico.

### **¿Y, si no quiero nombrar un agente?**

De cualquier manera usted puede escribir sus deseos en las Directivas Anticipadas de Tratamiento Médico sin nombrar un agente. Usted puede indicar que quiere que lo/la mantengan viva por todo el tiempo posible. O, puede indicar que no quiere que el tratamiento lo mantenga vivo. Además, puede expresar sus deseos acerca del uso de medicamentos para quitar el dolor o cualquier



***Riverside County  
Medi-Cal/RCHC  
Beneficiaries  
Can Access Mental Health Services  
by Calling  
1 (800) 706-7500***





***Beneficiarios de  
Medi-Cal/RCHC  
del Condado de Riverside  
Pueden Obtener Servicios de  
Salud Mental Llamando al  
1 (800) 706-7500***





# MENTAL HEALTH PATIENTS' RIGHTS



MOSAIC FOREST

Alice Washington, 2004

**Mental health patients have the same legal rights guaranteed to everyone by the Constitution and laws of the United States and California.**

## YOU HAVE THE RIGHT:

- To dignity, privacy and humane care
- To be free from harm including unnecessary or excessive physical restraint, medication, isolation, abuse and neglect
- To receive information about your treatment and to participate in planning your treatment
- To consent or refuse to consent to treatment, unless there is a legally-defined emergency or a legal determination of incapacity
- To client-centered services designed to meet your individual goals, diverse needs, concerns, strengths, motivations and disabilities
- To treatment services which increase your ability to be more independent
- To prompt medical care and treatment
- To services and information in a language you can understand and that is sensitive to cultural diversity and special needs
- To keep and use your own personal possessions including toilet articles
- To have access to individual storage space for your private use
- To keep and spend a reasonable sum of your own money for small purchases
- To have reasonable access to telephones—both to make and to receive confidential calls or have such calls made for you
- To have access to letter-writing material and stamps—to mail and to receive unopened correspondence
- To wear your own clothes
- To social interaction, participation in community activities, physical exercise and recreational opportunities
- To see visitors every day
- To see and receive the services of a patient-advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services
- To religious freedom and practice
- To participate in appropriate programs of publicly supported education
- To be free from hazardous procedures
- And all other rights as provided by law or regulation

FOR MORE INFORMATION, CONTACT YOUR LOCAL COUNTY PATIENTS' RIGHTS ADVOCATE:

Advocates Please  
Place Your Address &  
Phone Number Here

IF YOU ARE UNABLE TO CONTACT YOUR LOCAL COUNTY PATIENTS' RIGHTS ADVOCATE, YOU MAY CONTACT:

Office of Patients' Rights—(916) 575-1610  
Office of Human Rights—(916) 654-2327



# DERECHOS DE LOS PACIENTES DE SALUD MENTAL



MOSAIC FOREST

Alice Washington, 2004

## Los pacientes de salud mental tienen los mismos derechos legales garantizados a todos por la Constitución y por las leyes de los Estados Unidos y de California.

### USTED TIENE EL DERECHO:

- A dignidad, privacidad, y trato humano
- A no sufrir daño, incluyendo excesivo o innecesario uso de restricción física, aislamiento, medicamento, o abuso y descuido
- A recibir información sobre su tratamiento y a participar en planear su tratamiento
- A dar su consentimiento a tratamiento, o a rehusar tratamiento, a menos que exista una emergencia según la definición legal, o que haya una determinación legal de incapacidad
- A servicios enfocados en el cliente diseñados para cumplir sus propias metas, necesidades diversas, preocupaciones, habilidades, o motivaciones
- A servicios de tratamiento que aumenten su habilidad de ser mas independiente
- A cuidado y tratamiento médico lo mas pronto posible
- A servicios en el idioma que usted comprenda y con sensibilidad a diversas culturas y necesidades especiales
- A tener y usar artículos personales incluyendo artículos de tocador
- A tener su propio lugar privado para guardar sus artículos personales
- A tener y gastar una cantidad razonable de su propio dinero para compras pequeñas
- A tener acceso razonable a teléfonos—para hacer y recibir llamadas confidenciales o para que alguien haga la llamada por usted
- A tener acceso razonable a papel y pluma para escribir, incluyendo estampillas de correo y de recibir su correspondencia cerrada
- A usar su propia ropa
- A actividades sociales, participación en actividades de la comunidad, ejercicio físico y oportunidades de recreo
- A recibir visitas diariamente
- A ver y recibir servicios de un representante de pacientes que no tiene responsabilidad clínico ni administrativa, directa o indirecta, por la persona que recibe servicios de salud mental
- A tener la libertad de practicar su religión
- A participar en programas apropiados de educación publica
- A estar libre de procedimientos peligrosos
- A tener todos los otros derechos proporcionados por ley o reglamento

PARA MÁS INFORMACIÓN, LLAME AL REPRESENTANTE DE DERECHOS DE PACIENTES EN SU CONDADO LOCAL:

Representative Name  
Phone Number  
Address  
Phone Number

SI NO PUEDE PONERSE EN CONTACTO CON EL REPRESENTANTE DE DERECHOS DE PACIENTES DE SU CONDADO LOCAL, LLAME A LA OFICINA DE:

Office of Patients' Rights—(916) 575-1610  
Office of Human Rights—(916) 654-2327

## CONSUMER GRIEVANCE/APPEAL/STATE FAIR HEARING INFORMATION

If you have a problem with your Medi-Cal mental health services, we would like to help. We have a three level problem-solving process. You can file a Grievance, an Appeal, or a State Fair Hearing to help resolve your problem. A grievance can be filed at any time. An Appeal must be filed within 90 days of the date of the action you are appealing when you receive a Notice of Action. There are no deadlines for filing an Appeal when you do not receive a Notice of Action. You must complete the MHP's internal problem-solving process before filing a State Fair Hearing.

Your provider has an Appeal Procedure brochure and a Formal Grievance Procedure brochure that explains the process and has a Grievance and Appeal form inside. You can allow a friend, a relative, or a legal representative to act for you on an Appeal, Grievance or State Fair Hearing.

If you need help, people who can assist you are: your mental health provider, the Department's Quality Improvement staff (800) 660-3570, or Patients' Rights staff (800) 350-0519 or (951) 358-4600, collect calls accepted.

**Grievance:** A consumer and/or consumer's representative may file a Grievance, orally or in writing, with his/her service provider, the Central Access Team, or the Quality Improvement Program.

**Appeal:** To file an Appeal you, or your representative, must complete an Appeal form, sign a written request allowing for release of information, attach written materials, if any, supporting your point of view.

**State Fair Hearing:** A State Fair Hearing is available to you only after completing the MHP's internal problem-solving process.

**Assistance:** If you need assistance in completing the Grievance, Appeal, or State Fair Hearing forms, you can request help from your provider, or by calling: Quality Improvement Coordinator at (800) 660-3570, or Patients' Rights at (800) 350-0519, or locally, (951) 358-4600.

**Status:** If you want to know the status of a Grievance, Appeal, or a State Fair Hearing, contact the Quality Improvement Coordinator at (800) 660-3570.

If you have Medi-Cal benefits and you receive mental health services, you have the right to request an Appeal when your service provider recommends:

1. Service denial
2. Termination
3. Reduction of services

### STATE FAIR HEARING

If you are a Medi-Cal beneficiary and you do not agree with the recommendations or decisions, you or your representative can request a State Fair Hearing within 90 days of the postmark date of the Appeal decision.

If you want Medi-Cal to continue your services until a State Fair Hearing decision is made, your request for a State Fair Hearing must be submitted within 10 days of the date of the notice.

You or your representative may obtain the State Fair Hearing Request form from the service provider or by contacting the Patients' Rights Office, long distance areas (800) 350-0519, or (951) 358-4600, collect calls accepted; or you may call the toll free number of the Public Inquiry and Response Unit at (800) 952-5253.

When you complete the State Fair Hearing form, mail the notice to:

**State Hearing Division**

California Department of Social Services

P.O. Box 944243, Mail Station 19-37

Sacramento, CA 94244-2430

**To obtain information on the status of a pending Formal Grievance, an Appeal, or a State Fair Hearing contact the Quality Improvement Coordinator at (800) 660-3570.**

**MEDI-CAL BENEFICIARIES HAVE THE RIGHT, FOR ANY REASON, TO USE THE GRIEVANCE PROCESS OR APPEAL PROCESS. YOU MAY REQUEST A STATE FAIR HEARING ONLY AFTER COMPLETING THE MHP'S INTERNAL PROBLEM-SOLVING PROCESS.**

**MEDI-CAL BENEFICIARIES HAVE THE RIGHT, FOR ANY REASON, TO USE THE GRIEVANCE PROCESS OR APPEAL PROCESS. YOU MAY REQUEST A STATE FAIR HEARING ONLY AFTER COMPLETING THE MHP'S INTERNAL PROBLEM-SOLVING PROCESS.**



## INFORMACION ACERCA DE QUEJAS FORMALES DEL CONSUMIDOR

Si usted tiene algún problema con los servicios de salud mental de Medi-Cal, nos gustaría ayudarle. Tenemos un proceso para solución de problemas de tres niveles. Usted puede presentar una Queja formal, una Apelación, o pedir una Audiencia Imparcial Estatal para ayudar a resolver su problema. La Queja Formal se puede presentar en cualquier momento dado. La Apelación tiene que entablarse dentro de 90 días de la fecha que usted reciba el Aviso de Acción. No hay límite de tiempo para presentar una Apelación si no recibe un Aviso de Acción. Tiene que agotar todo proceso de resolución interno del MHP antes de entablar una Audiencia Imparcial Estatal.

Su proveedor de servicios tiene un folleto del Proceso para Quejas formales y un folleto del Proceso de Apelación que explica el proceso e incluye una solicitud de Queja formal y Apelación. Usted puede permitir que un amigo, pariente, ó representante legal lo represente en la Queja formal, Apelación, ó Audiencia Imparcial Estatal.

Si usted necesita ayuda, las personas que pueden ayudarle son: su proveedor de salud mental, los empleados del Departamento de Mejoramiento de Calidad, comunicándose al 1-(800) 660-3570, ó los empleados de los Derechos de los Pacientes al 1-(800) 350-0519 o al (951)358-4600. Aceptamos llamadas por cobrar.

**Queja Formal:** Para entablar una Queja formal, usted o su representante, tiene que llenar una solicitud de Queja formal, tiene que firmar una solicitud permitiéndonos divulgar información, y si existe alguno, tiene que adjuntar los materiales escritos que apoyen su punto de vista.

**Apelación:** Para entablar una Apelación usted o su representante, debe de llenar una forma para apelar, firmar una petición por escrito para facilitar el acceso a su información, y si existe alguno, tiene que adjuntar los materiales escritos que apoyen su punto de vista.

**Audiencia Imparcial Estatal:** Tras haber agotado todo proceso de resolución interno del MHP usted puede entablar una Audiencia Imparcial Estatal.

**Asistencia:** Si requiere asistencia para llenar la Queja formal, Apelación o de Audiencia Imparcial Estatal, puede pedirle ayuda a su proveedor de servicios, ó llamando a: Departamento de Mejoramiento de Calidad al 1-(800) 660-3570, ó a Los Derechos de los Pacientes al 1-(800) 350-0519, ó localmente al (951) 358-4600.

**Estado:** Si quiere saber el estado de su Queja formal, Apelación, o Audiencia Imparcial Estatal, comuníquese con la Coordinadora de Mejoramiento de Calidad al 1-(800) 660-3570.

Si usted tiene beneficios de Medi-Cal y recibe servicios de salud mental, tiene el derecho a solicitar una Apelación cuando su proveedor de servicios recomienda lo siguiente:

1. Negación de Servicios
2. Terminación
3. Reducción de Servicios

### AUDIENCIA IMPARCIAL ESTATAL

Si usted es beneficiario de Medi-Cal y no está de acuerdo con la recomendación o con las decisiones, usted o su representante puede solicitar que se realice una Audiencia Imparcial Estatal dentro de 90 días a partir de la fecha en que fue tomada la decisión de la Apelación.

Si usted quiere que el Medi-Cal continúe prestando sus servicios hasta que la Audiencia Imparcial Estatal quede decidida, tiene que presentar su solicitud para la Audiencia Imparcial Estatal dentro de 10 días de la fecha del aviso.

Usted o su representante puede obtener la solicitud para Audiencia Imparcial Estatal a través de su proveedor de servicios o solicitándola con la Oficina de Los Derechos de los Pacientes, llamando al 1-(800) 350-0519, o al (951) 358-4600. Aceptamos llamadas por cobrar, ó puede llamar gratis a la Unidad de Información Pública al 1-(800) 952-5253.

Tras llenar la solicitud de la Audiencia Imparcial Estatal, envíela a:

#### La División de Audiencia Estatal

Departamento de Servicios Sociales de California

P.O. Box 944243, Mail Station 19-37

Sacramento, CA 94244-2430

**Para obtener información del estado de una Queja formal, de una Apelación, o una Audiencia Imparcial Estatal comuníquese con la Coordinadora de Mejoramiento de Calidad al 1-(800) 660-3570**

**LOS BENEFICIARIOS DE MEDI-CAL TIENEN EL DERECHO DE, POR CUALQUIER MOTIVO, USAR EL PROCESO DE QUEJA FORMAL O APELACION. PUEDE SOLICITAR UNA AUDIENCIA IMPARCIAL ESTATAL TRAS AGOTAR TODO EL PROCESO DE RESOLUCION INTERNO DEL MHP.**

## GRIEVANCE LOG

Date Received	Beneficiary Name	Grievance Name	Description of Grievance	Agreed Resolution Date	Actual Resolution Date	How Resolved



# **Advance Health Care Directives**

© 2000 – Disability Rights California

**Disability Rights California**  
100 Howe Avenue, Suite 185-N  
Sacramento CA 95825  
1-800-776-5746

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# **ADVANCE HEALTH CARE DIRECTIVE**

## **GENERAL INFORMATION**

### **1. What is an Advance Directive?**

An Advance Directive provides a way for people to direct their own healthcare even when they are in a coma, have dementia or are mentally incapacitated or unable to communicate. A person can use an Advance Directive to spell out her<sup>♦</sup> wishes regarding physical and mental healthcare and to select someone to make health care decisions when she is unable to do so.

In California, an Advance Directive is made of up two parts, (1) Appointment of an Agent for Healthcare and (2) Individual Health Care Instructions. A person may choose to complete either one or both of these parts. Either part is legally binding by itself.

### **2. What is a Healthcare Agent?**

A person may use her Advance Directive to appoint a Healthcare Agent. A Healthcare Agent is responsible for making healthcare decisions should the person lose the ability to make these decisions for herself. A Healthcare Agent is responsible for carrying out the person's wishes as she has expressed them in her Advance Directive or in discussions with the Agent.

It is not necessary to name a Healthcare Agent in order to complete an Advance Directive. If the person has not chosen a Healthcare Agent, the healthcare provider is still required to follow the person's wishes, as expressed in the Individual Healthcare Instructions.

If both parts of the Advance Directive are filled out, the Healthcare Agent must follow the specific wishes spelled out in the second part of the document which is called the Individual Healthcare Instructions.

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<sup>♦</sup> A single gender (female) is used to simplify the writing style, but all information applies to both men and women.

### **3. What are Individual Healthcare Instructions?**

Individual Healthcare Instructions are the way in which a person can tell her doctor, family or Agent what her decisions are regarding physical or mental health treatment. Individual Healthcare Instructions are verbal or written directions about health care. A person can use Individual Healthcare Instructions to let her healthcare provider know what she wants done and under what circumstances. This may include agreeing to certain treatments or refusing specific treatments or services.

### **4. What can an Advance Directive do for a person with a psychiatric disability?**

A person with a psychiatric disability can benefit from having an Advance Directive in a number of ways:

- An Advance Directive can empower the person to make her treatment choices known in the event she needs mental health treatment and is found to be incapable of making healthcare decisions.
- An Advance Directive can improve communication between the person and her doctor. Completing an Advance Directive is a good way to open up discussion with healthcare providers about treatment plans and the full spectrum of choices in treatment.
- An Advance Directive can help the person prevent clashes with family members and/or healthcare providers over treatment during a crisis by allowing those discussions to take place when a person is filling out her Advance Directive.
- Completing an Advance Directive creates an opportunity for the person to discuss her wishes in detail with family and/or friends. This may help family and/or friends more effectively advocate for the person when she is unable to advocate for herself and to advocate in ways that reflect the person's wishes.
- An Advance Directive may prevent forced treatment.
- An Advance Directive may reduce the need for long hospital stays.

## **5. Who can fill out an Advance Directive?**

Any person 18 years or older who has the “capacity” to make health care decisions may fill out an Advance Directive. “Capacity” to make healthcare decisions means the person understands the nature and consequences of the proposed healthcare, including the possible risks and benefits and is able to make and communicate decisions about that healthcare. Legally, a person is assumed to be competent unless proven otherwise.

## **6. How does an Advance Directive become official?**

An Advance Directive must contain all of the following to be official:

- A statement of the person’s intent to create an Advance Directive.
- The signature of the person writing the Advance Directive
- The signatures of either two witnesses or a notary public
- The date the Advance Directive was signed.

## **7. When does an Advance Directive go into effect?**

An Advance Directive only goes into effect when the person’s primary physician decides that the person does not have the “capacity” to make her own healthcare decisions. This means the physician believes that the person is not able to understand the nature and consequences of proposed healthcare or is not able to make or communicate her healthcare decisions. The fact that a person has been admitted to a mental health facility does not, in itself, mean that the person lacks capacity to make her own healthcare decisions.

The Advance Directive is no longer in effect as soon as the person regains the capacity to make her own healthcare decisions.

## **8. Who can help with filling out an Advance Directive?**

Writing an Advance Directive can sometimes seem confusing or complicated. If a person needs help writing her Advance Directive, she should ask someone who respects her right to make these decisions for herself and will help without pressuring her to make one decision or another.

It also a good to ask someone who is knowledgeable or experienced in writing Advance Directive to help. The Office of Medi-Cal Ombudsman Services for Mental Health can help people in finding someone nearby to answer questions and assist in writing Advance Directives. The telephone number for Ombudsman Services for Mental Health is (800) 896-4042.

## **9. Is a Healthcare Agent necessary?**

No, a person does not have to name a Healthcare Agent in order to write a valid Advance Directive. Someone who does not have a trusted family member or friend may choose not to name a Healthcare Agent. If the person does not have a Healthcare Agent, her healthcare provider must still follow her wishes as expressed in her Individual Healthcare instructions.

However, there are good reasons to name a Healthcare Agent. A Healthcare Agent can advocate for the person when she is unable to advocate for herself and can ensure that the person's choices are respected. A Healthcare Agent can also contact others for assistance in enforcing the Advance Directive if the person's choices are being ignored. This is why it is so important for the person to choose only someone she knows and trusts to be her Healthcare Agent.

Whether or not to name an Agent and who to name as Agent are two of the most important decisions a person will have to make when writing an Advance Directive.

## **10. What happens when a person wants to change an Individual Healthcare Instruction?**

The requirements for changing any Healthcare Instruction are the same as those for completing an Advance Directive.

To change an Individual Healthcare Instruction, the person must

- be at least 18 years old,
- be acting freely and without pressure from anyone, and
- have the "capacity" to make healthcare decisions.

A person can change an Individual Healthcare Instruction by writing a new Advance Directive with the changes in it that she wants to make. If the person writes a new Advance Directive she must take all the same steps she did in writing the first Advance Directive, including having it witnessed.

A person can also revoke their Advance Directive orally, by telling their healthcare provider that they no longer want either the entire document or any parts of it enforced.

#### **11. Who should have a copy of the Advance Directive?**

The person should keep a copy of the Advance Directive for herself in a place that is safe, but easily accessible.

The person should give a copy of the Advance Directive to her Agent if she has one. The Agent's job is to make sure that the person's decisions are known and followed. To do this, the Agent must have a copy of the Advance Directive that appoints her as the person's Agent.

Each of the person's healthcare providers should have a copy of the Advance Directive and are legally required to place the Advance Directive in the person's medical records. This is important because the healthcare provider cannot follow the person's Individual Healthcare Instructions unless they know what those instructions are. If the person does not have an Agent or the Agent is unavailable, the healthcare provider will still know what the wishes are if the document includes Individual Healthcare Instructions.

The person should keep track of who has a copy of her Advance Directive. If the patient decides to change or revoke (cancel) her designation of an Agent or any individual healthcare instruction, she should let everyone who has a copy of the Advance Directive know about the change/revocation to avoid confusion.

#### **12. Does a healthcare provider have to follow an Advance Directive?**

Yes. Healthcare providers must follow both the person's Individual Healthcare Instructions and the decisions made on the person's behalf by her Agent.

### **13. Who can help if an Advance Directive is ignored/not followed?**

If a healthcare provider refuses to follow the person's Individual Healthcare Instructions or refuses to comply with the decisions of the person's Agent, contact the county patients' rights advocate and/or Disability Rights California. Disability Rights California and the county patients' rights advocate can work with the person or her Agent to make sure that the Advance Directive is followed.

The telephone number for Disability Rights California is **(800) 776-5746** and the telephone numbers for county patients' rights advocate are posted on the walls in all inpatient mental health facilities.



# **ADVANCE HEALTH CARE DIRECTIVE**

## **EXPLANATION OF TERMS FOR ADVANCE DIRECTIVES**

The first part of your Advance Health Care Directive is written to inform the reader of the Codes in both federal and state law that apply to the Advance Directives you have written.

The listing of specific codes at the end of paragraphs is included so that people can check them out, if they wish. Mostly, attorneys and health care providers need to know these; consumers may go to the regulations listed if they want to become better informed of their rights.

Some important legal terms in this section are:

1. Capacity – in this document, “capacity” refers to your ability to understand, make and communicate your healthcare decisions; when you are determined to “lack capacity” to do this is when the Advance Directive goes into effect.
2. Duration – in California there is no automatic time limit on an Advance Directive. Unless you state a specific date when you want your document to expire, your Advance Directive stays in effect until you decide to revoke it.
3. Revocability – in California you have the right under the law to say all or any part of your Advance Directive is no longer binding.
4. Liability – in California health care providers can be sued for “damages” (including fines and attorney’s fees) if they are found to have failed to follow an Advance Health Care Directive.
5. Immunity – In California health care providers who are following an Advance Directive in good faith are protected from being prosecuted for a crime and from being sued for complying with the Advance Directive.

6. Discrimination – in California no one can make you have an Advance Health Care Directive, or take away your right to have one, as a condition for giving you health care, or admitting you to a place of treatment, or providing you with insurance.

## **PART I: APPOINTMENT OF AN AGENT FOR HEALTH CARE**

7. Health Care Agent – This is the person you choose to speak for you and assert your health care decisions. Although you do not *have* to choose an agent under California law, you may want to choose someone who is willing to represent your wishes with regard to your health treatment.
8. Conservator – this is someone whom the court may appoint to oversee your affairs and make treatment decisions if you are determined by the court to be unable to provide for your own basic needs due to a mental disorder. You may want to identify someone whom you prefer to be your conservator, in case the court decides to do this.

## **PART II(a): STATEMENT OF INDIVIDUAL MENTAL HEALTH CARE INSTRUCTIONS**

9. Incapacity – this is another way of saying that you “lack capacity.” It means you are not able to make or communicate your own health care decisions at a particular time.
10. Treatment Facility – this would be any licensed place that is permitted by law to provide psychiatric care on a 24-hour basis. It is often a hospital.
11. Primary Physician – for the purposes of this section, this is the medical doctor who has been identified by you as the one who has first responsibility for providing your mental health care.

12. Emergency Situations – these are the kinds of crises that mental health treatment facilities often see as justifying the use of such methods as *seclusion* and *restraint* in order to control you.
  - a. Seclusion – a method of control that removes you and isolates you by making you stay in a separate area.
  - b. Restraint – a method of control that physically limits your ability to move.
13. Side Effects – the usually unpleasant or destructive things that may happen to your body when you take certain medications.
  - a. *Tardive Dyskinesia* – movements of the face, hands, etc. that are not able to be stopped at will that are the side effects of taking certain medications.
  - b. *Motor Restlessness* – being unable to stop yourself from moving as a side effect of taking certain medications.
  - c. *Muscle/Skeletal Rigidity* – extreme stiffness that is a side effect of taking certain medications.
  - d. *Neuroleptic Malignant Syndrome* – the name given to a group of sometimes life-threatening side effects to certain medications.
14. Electroconvulsive Therapy – sometimes called ECT or “shock treatments,” this involves the use of electricity to provoke controlled brain seizures, and is sometimes used in the treatment of depression.
15. Drug Trials – this is the use of people as subjects of research for the testing of new medications.

## **PART II(b): INDIVIDUAL PHYSICAL HEALTH CARE INSTRUCTIONS**

16. Life Sustaining Treatment – this is the term doctors and hospitals use to describe the technology and machinery that has been invented to prolong life when otherwise a person would die.

17. Persistent Vegetative State – this is the term used to describe a human being whose ability to function has been severely reduced, who is being kept alive on machines.
18. Anatomical Gift – this is the donation of all or part of your body for medical or scientific purposes after you have died.
19. Autopsy – this is the medical examination of your body after death to determine the cause of death.

# **ADVANCE HEALTH CARE DIRECTIVE OF:**

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(name)

## **ATTENTION HEALTH CARE PROVIDERS:**

This document is an Advance Health Care Directive – a legally binding document under state and federal law, which dictates the health care treatment that may be given to an individual who lacks capacity to make health care decisions. Cal. Probate Code Section 4600 *et seq.*; 42 Code of Federal Regulations Sections 431.20, 489.100, 489.102, and 489.104.

This Advance Health Care Directive contains a Power of Attorney for Health Care and/or Individual Health Care Instructions. If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

## **SPECIFIC DUTIES OF HEALTH CARE PROVIDERS INCLUDE:**

- ✧ Maintaining this document in the patient's health records. Cal. Probate Code Section 4731(a).
- ✧ Notifying the designated agent that the patient lacks or has recovered capacity. Cal. Probate Code Section 4732.
- ✧ Providing the designated agent access to the patient's health records. Cal. Probate Code Section 4678.

## **DURATION AND REVOCABILITY:**

Advance Health Care Directives do not expire unless a specific expiration date is stated in the document. Cal. Probate Code Section 4686.

A patient having capacity may revoke the designation of an agent by a signed writing or by personally informing the health care provider, and may revoke any and all other parts of an Advance Health Care Directive in any manner that communicates an intent to revoke. Cal. Probate Code Section 4695.

Be aware that an agent is not authorized to make a health care decision if the patient objects to the decision. Before implementing a health care decision made for a patient, the health care provider must promptly inform the patient about the decision and the identity of the person making the decision. Cal. Probate Code Sections 4689, 4730.

In addition, this document states that no individual mental or physical health care instruction may be carried out against the wishes of the patient. If the patient objects to his or her agent's health care decision or to the implementation of an individual mental or physical health care instruction contained in this document, the matter concerning that particular procedure shall be governed by the law that would apply if there were no Power of Attorney for Health Care or Individual Health Care Instruction regarding that procedure. Cal. Probate Code Section 4689.

#### **LIABILITY AND IMMUNITY:**

Failure to follow an Advance Health Care Directive may result in liability for damages specified in California law or actual damages, whichever is greater, plus attorney's fees. Cal. Probate Code Section 4742. Violators may also be liable for negligence, malpractice and battery claims.

Health care providers are not subject to civil or criminal liability or to discipline for unprofessional conduct for compliance with Advance Health Care Directives. Cal. Probate Code Section 4740.

#### **DISCRIMINATION PROHIBITED:**

Health care providers and health care insurers may not require or prohibit the execution or revocation of an Advance Health Care Directive as a condition for providing health care, admission to a facility, or furnishing insurance. Cal. Probate Code Section 4677.

## **ADVANCE HEALTH CARE DIRECTIVE: Explanation**

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

*Part I* of this form is a power of attorney for health care. Part I lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

- (e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

*Part II(a)* of this form lets you give specific instructions about any aspect of your mental health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision of mental health care, and at the end of Part II(a), space is provided for you to add any additional choices about mental health care which are not covered elsewhere.

*Part II(b)* of this form lets you give specific instructions about any aspect of your physical health care, including end-of-life decisions and instructions about anatomical gifts, autopsy, and disposition of your remains.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

If you or your agent have difficulty enforcing this advance health care directive, contact your county patient's rights advocate or Disability Rights California (1-800-776-5746).



**Advance Health Care Directive of \_\_\_\_\_**  
(Your name)

**Instructions Included in My Directive**

*Put a check mark in the left-hand column for each section you have completed.*

#	<b>PART I</b> <b>Appointment of an Agent for Healthcare</b>
1	Designation of Health Care Agent Designation of Alternate Health Care Agent
2	Authority Granted to My Agent
3	My choice as to a Court Appointed Conservator
#	<b>PART II(a)</b> <b>Statement of Individual Mental Health Care Instructions</b>
4	Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?
5	My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being
6	My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:
7	My Choices about primary Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable
8	My Choices Regarding Methods for Avoiding Emergency Situations
9	My Choices Regarding Emergency Interventions
9(a)	My Choices Regarding <b>Routine</b> Medications for Psychiatric Treatment
9(b)	My Choices Regarding <b>Emergency</b> Psychiatric Medication
10	My Choices Regarding Electroconvulsive Therapy
11	The Following People Are to be Prohibited from Visiting Me
12	Other Instructions About Mental Health Care

#	<b>PART II(b)</b> <b>Individual Physical Health Care Instructions</b>
13	My Primary Physician who is to Have Primary Responsibility for my Physical Health Care is:
14	Statement of Desires, Special Provisions and Limitations
15	My Choices Regarding Experimental Studies and Drug Trials
16	My Instructions Regarding Life Sustaining Treatment
17	My Choices Regarding Contribution of Anatomical Gift
18	My Instructions Regarding Autopsy
19	Choices Regarding Disposition of My Remains

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

**PART I**  
**APPOINTMENT OF AN AGENT FOR HEALTH CARE**

**\*\*MAKE SURE YOU GIVE YOUR AGENT  
A COPY OF ALL SECTIONS OF THIS DOCUMENT\*\***

If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

**STATEMENT OF INTENT TO APPOINT AN AGENT:**

I, (your name) \_\_\_\_\_, being of sound mind, authorize a health care agent to make certain decisions of my behalf regarding my health treatment when I am incompetent to do so unless I mark this box ☐, in which case my agent's authority to make health care decisions for me takes effect immediately. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

## **1. Designation of Health Care Agent**

A. I hereby designate and appoint the following person as my agent to make health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## **Designation of Alternate Health Care Agent**

If the person named above is unavailable, unable or unwilling to serve as my agent, I hereby appoint and desire immediate notification of my alternative agent as follows:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## 2. Authority Granted to My Agent

If I become incapable of giving informed consent to health care treatment, or if I marked the box under "Statement of Intent to Appoint an Agent" causing my agent's authority to make decisions for me to immediately become effective, I hereby grant to my agent full power and authority to make health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive EXCEPT as I state here. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

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## 3. My Choice as to a Court-Appointed Conservator

In the event a court decides to appoint a conservator who will make decisions regarding my health treatment, I desire the following person to be appointed:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

The appointment of a conservator or other decision maker shall not give the conservator or decision maker the power to revoke, suspend, or terminate my individual health care instructions or the powers of my agent.

**\*\*MAKE SURE YOU GIVE YOUR AGENT AND ALTERNATE AGENT  
A COPY OF ALL SECTIONS OF THIS DOCUMENT\*\***

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

**PART II(a)**  
**STATEMENT OF INDIVIDUAL**  
**MENTAL HEALTH CARE INSTRUCTIONS**

*In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials before the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.*

**NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES.**

**4. Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?** *Be sure to include the agent and any alternate agent you designate in your Durable Power of Attorney, if you have one.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**5. My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being**

\_\_\_\_\_ A. In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at the following programs/facilities instead of psychiatric hospitalization.

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_ B. In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_ C. I do not wish to be admitted to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_



**6. My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:**

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Pager \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**7. My Choices about the Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable**

Put your initials before the letter and complete if you wish either or both paragraphs to apply.

\_\_\_\_ A. My choice of treating physician if the above physician is unavailable is:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

OR if neither is available

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

OR if none of the above is available

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_ B. I do not wish to be treated by the following, for the reasons stated:

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

## 8. My Choices Regarding Methods for Avoiding Emergency Situations

If during my admission or commitment to a mental health treatment facility it is determined that I am engaging in behavior that **may** make emergency intervention necessary, I prefer the following choices to help me regain control:

*Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If your choice is not listed, write it in after "other" and give it a number as well.*

- ☐ Provide a quiet private place
- ☐ Have a staff member of my choice talk with me one-on-one
- ☐ Allow me to engage in physical exercise
- ☐ Offer me recreational activities
- ☐ Assist me with telephoning a friend or family member
- ☐ Offer me the opportunity to take a warm bath
- ☐ Offer me medication
- ☐ Offer me a cigarette
- ☐ Allow me to go outside
- ☐ Provide me with materials to journal or do artwork
- ☐ Offer me assistance with breathing or calming exercises
- ☐ Provide me with a radio to listen to
- ☐ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 9. My Choices Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made as follows. I prefer these interventions in the following order:

*Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well. If you do not want a listed intervention ever used, cross it out and explain why under "Reasons for my choices."*

	Reasons for my choices
<input type="checkbox"/> Seclusion	_____
<input type="checkbox"/> Physical restraints	_____
<input type="checkbox"/> Seclusion and physical restraint (combined)	_____
<input type="checkbox"/> Medication by injection	_____
<input type="checkbox"/> Medication in pill form	_____
<input type="checkbox"/> Liquid medication	_____
<input type="checkbox"/> During seclusion and/or restraint, I prefer to be checked by <b>female</b> staff	_____
<input type="checkbox"/> During seclusion and/or restraint, I prefer to be checked by <b>male</b> staff	_____
<input type="checkbox"/> Other: _____	_____
	_____
<i>See Section 9(b) for choices regarding emergency medication</i>	_____

I expect the choice of medication in an emergency situation to reflect any choices I have expressed in this section and in Section 9(b). **The choices I express in this section and Section 9(b) regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.**

**9(a). My Choice Regarding *Routine* Medications for Psychiatric Treatment**

*In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.*

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

\_\_\_\_ A. I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

\_\_\_\_ B. I consent to and authorize my agent to consent to the administration of:

<b>Medication Name or Medication Type</b>	<b>Not to exceed the following dosage/day</b>	<b>OR</b>	<b>In such dosage(s) as determined by</b>
_____	_____		Dr. _____
_____	_____		
_____	_____		Or if unavailable, then by
_____	_____		
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		

\_\_\_\_ C. I consent to the medications deemed appropriate by Dr. \_\_\_\_\_ ,  
whose address and phone number are: \_\_\_\_\_  
\_\_\_\_\_

**9(a) Continued**

\_\_\_\_ D. I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents:

Name of Drug	Reason for Refusal
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_ E. I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

\_\_\_\_ F. I am concerned about the side effects of medications and do ***not*** consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at 1% or greater level of incidence (*check all that apply*).

- |   |   |
|---|---|
| <input type="checkbox"/> Tardive dyskinesia       | <input type="checkbox"/> Tremors                        |
| <input type="checkbox"/> Loss of Sensation        | <input type="checkbox"/> Nausea/vomiting                |
| <input type="checkbox"/> Motor Restlessness       | <input type="checkbox"/> Neuroleptic Malignant Syndrome |
| <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Muscle/skeletal rigidity | _____   |
|   | _____   |

\_\_\_\_ G. I have the following other choices about psychiatric medications:

\_\_\_\_\_  
\_\_\_\_\_

### 9(b) My Choices Regarding *Emergency* Psychiatric Medication

If during my admission or commitment to a mental health facility, it is determined that I am engaging in behavior that requires emergency psychiatric medication, I prefer the following medication:

Medication Name or Medication Type	Not to exceed the following dosage/day	OR	In such dosage(s) as determined by
_____	_____		Dr. _____
_____	_____		
_____	_____		Or if unavailable, then by
_____	_____		
_____	_____		Dr. _____
_____	_____		
_____	_____		

**The choices expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.**

### 10. My Choices Regarding Electroconvulsive Therapy

\_\_\_\_ A. I **do not** consent to administration of electroconvulsive therapy.

B. Under California law, this Directive **cannot** be used to consent for electroconvulsive therapy. However, if I am administered electroconvulsive therapy, I have the following choices:

- ☐ I will be administered no more than the following number of treatments \_\_\_\_ .
- ☐ I will be administered the number of treatments deemed appropriate by  
Dr. \_\_\_\_\_, whose phone number and address is:  
\_\_\_\_\_.

**11. The Following People Are to be Prohibited from Visiting Me:**

**Name**

**Relationship**

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**12. Other Instructions About Mental Health Care**

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*(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)*

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

**PART II(b)**  
**INDIVIDUAL PHYSICAL HEALTH CARE INSTRUCTIONS**

**NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES**

**13. My Primary Physician who is to have primary responsibility for my physical health care is:**

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Pager \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

OR if the above physician is unavailable, then I request:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

OR if neither of the above is available, then I request:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

I specifically do not want to be treated by the following physicians:

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_



#### **14. Statement of Desires, Special Provisions and Limitations**

\_\_\_\_ A. I specifically express the following desires concerning these health care decisions:

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\_\_\_\_ B. And I specifically limit this Advance Directive as follows:

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*(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)*

## 15. My Choices Regarding Experimental Studies and Drug Trials

☐ I **will not** participate in experimental studies or drug trials.

Under recent changes to California law, a health care agent, if one has been appointed, a conservator, a family member, or domestic partner may consent to participation in a medical experiment on behalf of a person who is unable to consent under very specific circumstances. See Health and Safety Code, section 24178 for a list of these specific circumstances.

Complete this section **only** if you do not consent to participation in medical experiments under any circumstances.

## 16. My Instructions Regarding Life Sustaining Treatment

\_\_\_\_ A. I **do not** want my life to be prolonged and I **do not** want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. I want the relief of suffering and the quality as well as the possible extension of my life considered in making decisions concerning life-sustaining treatment.

**OR**

\_\_\_\_ B. I want my life to be prolonged and I want life sustaining treatment to be provided **unless I am in a coma or vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I **do not** want life-sustaining treatment to be provided or continued.

**OR**

\_\_\_\_ C. I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of procedures.

**AND/OR**

\_\_\_\_ D. I specifically express the following desires concerning life-sustaining treatment.

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## 17. My Choices Regarding Contribution of Anatomical Gift

*If either statement reflects your desires, sign the line next to the statement. You do not have to sign either statement. If you do not wish to sign either statement, your agent (if you have one) and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.*

☐ I **do** want to make a gift under the Uniform Anatomical Gift Act, effective upon my death, of:

☐ Any needed organs or parts; or

☐ The parts or organs listed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature)

☐ I **do not** want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to do so.

\_\_\_\_\_  
(Signature)

## 18. My Instructions Regarding Autopsy

*If either statement reflects your desires, sign the line next to the statement. You **do not** have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to authorize an autopsy.*

☐ I **do** authorize an examination of my body after death to determine the cause of my death.

\_\_\_\_\_  
(Signature)

☐ I **do not** authorize an examination of my body after death to determine the cause of my death.

\_\_\_\_\_  
(Signature)

## 19. Choices Regarding Disposition of my Remains

If either statement reflects your desires, sign the line beneath the statement. You do not have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to direct the disposition of your remains.

☐ I **do** authorize

\_\_\_\_\_  
(name) (phone)

\_\_\_\_\_  
(address/city/state/zip)

to direct the disposition of my remains by the following method:

☐ Burial

☐ Cremation

\_\_\_\_\_  
(signature)

**OR**

☐ I have described the way I want my remains disposed of in:

☐ A written contract for funeral services with:

\_\_\_\_\_  
(name and phone of mortuary/cemetery)

\_\_\_\_\_  
(address/city/state/zip)

☐ My will.

☐ Other: \_\_\_\_\_

\_\_\_\_\_  
(signature)

**By signing below, I am executing this advance directive for health care and, by so doing, am revoking any prior durable power of attorney for health care.**

**EFFECT OF COPY:** A copy of this form has the same effect as the original.

**SIGNATURE:** Sign and date the form here in the presence of your witnesses/notary.

\_\_\_\_\_  
*(date)*

\_\_\_\_\_  
*(signature)*

\_\_\_\_\_  
*(address)*

\_\_\_\_\_  
*(print your name)*

\_\_\_\_\_  
*(city)* *(state)*

**STATEMENT OF WITNESSES:** I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

Second Witness

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state)

\_\_\_\_\_  
(city) (state)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(date)

**ADDITIONAL STATEMENT OF WITNESSES:** At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California, that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(signature of witness)

**SPECIAL WITNESS REQUIREMENT:** The following statement is required only if you are a patient in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

**STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(city) (state)



## ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California)

County of \_\_\_\_\_ )

On \_\_\_\_\_, before me, \_\_\_\_\_ (here insert name and title of the officer), personally appeared \_\_\_\_\_ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

Signature: \_\_\_\_\_ (Seal)

**This document is valid only if signed by two witnesses OR acknowledged before a notary public.**

# **Directivas anticipadas de atención de la salud**

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**Protection & Advocacy, Inc.**  
100 Howe Avenue, Suite 185-N  
Sacramento CA 95825  
1-800-776-5746

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# Directiva anticipada de atención de la salud

## Información general

### 1. ¿Qué es una directiva anticipada?

Una directiva anticipada les brinda a las personas una manera de dirigir su propia atención de la salud, aunque estén en coma, tengan demencia o estén incapacitadas mentalmente o no puedan comunicarse. Una persona puede usar una directiva anticipada para expresar sus deseos relacionados con la atención de la salud física y mental y seleccionar a alguien para que tome decisiones de atención de la salud cuando la persona no pueda hacerlo.

En California, una directiva anticipada consta de dos partes: (1) Designación de un agente para la atención de la salud e (2) Instrucciones individuales de atención de la salud. La persona puede llenar una o ambas partes. Cualquiera tiene validez legal por sí misma.

### 2. ¿Qué es un agente para la atención de la salud?

Una persona puede usar su directiva anticipada para nombrar a un agente para la atención de la salud, quien es responsable de tomar decisiones sobre la atención de la salud en caso de que la persona pierda la capacidad de tomar estas decisiones por sí misma. El agente es responsable de llevar a cabo los deseos de la persona, tal como los expresó en la directiva anticipada o según lo que platique con el agente.

No es necesario nombrar a un agente para la atención de la salud para poder completar una directiva anticipada. Si la persona no ha elegido a un agente para la atención de la salud, de cualquier manera se requiere que el proveedor de atención de la salud cumpla los deseos de la persona, tal como estén expresados en las instrucciones individuales de atención de la salud.

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Para simplificar el estilo usamos un sólo género (femenino) en el escrito, pero toda la información es aplicable tanto a hombres como a mujeres.

Si se llenan ambas partes de la directiva anticipada, el agente de atención de la salud tiene que cumplir con los deseos específicos expresados en la segunda parte del documento, llamada Instrucciones individuales de atención de la salud.

### **3. ¿Qué son las instrucciones individuales de atención de la salud?**

Las instrucciones individuales de la atención de la salud describen cómo una persona le puede decir a su médico, familia o agente cuáles son sus decisiones relacionadas con el tratamiento para la salud física o mental. Las instrucciones individuales son indicaciones orales o escritas sobre atención de la salud. Una persona puede usar estas instrucciones para notificarle a su proveedor de atención de la salud lo que quiere que se haga y bajo qué circunstancias. Esto puede incluir acordar ciertos tratamientos o rechazar tratamientos o servicios específicos.

### **4. ¿Qué puede hacer una directiva anticipada por una persona con una discapacidad psiquiátrica?**

Una persona con una discapacidad psiquiátrica se puede beneficiar al tener una directiva anticipada de diversas maneras:

- La directiva anticipada puede facultar a la persona para que se conozcan sus elecciones de tratamiento en caso de que necesite tratamiento de salud mental y se determine que es incapaz de tomar decisiones de atención de la salud.
- La directiva anticipada puede mejorar las comunicaciones entre la persona y su médico. Completar una directiva anticipada es una buena manera de hablar con los proveedores de atención de la salud sobre los planes de tratamiento y sobre toda la variedad de opciones en el tratamiento.
- Una directiva anticipada puede ayudar a la persona a prevenir los choques con los familiares y/o proveedores de atención de la salud respecto al tratamiento durante una crisis, al permitir clarificar estos temas cuando la persona está llenando la directiva anticipada.
- Llenar la directiva anticipada crea una oportunidad para que la persona hable sobre sus deseos en detalle con sus familiares y/o amigos. Esto puede ayudar para que la familia y/o amigos defiendan con más eficacia a la persona cuando no pueda defenderse a sí misma y defenderla de manera que refleje los deseos de la persona.
- Una directiva anticipada puede prevenir un tratamiento forzado.

- Una directiva anticipada puede reducir la necesidad de permanecer internado en el hospital por mucho tiempo.

## **5. ¿Quién puede llenar una directiva anticipada?**

Toda persona de 18 años de edad o más que tenga la “capacidad” de tomar decisiones sobre atención de la salud puede llenar una directiva anticipada. “Capacidad” para tomar decisiones sobre atención de la salud significa que la persona entiende la naturaleza y las consecuencias de la atención de la salud propuesta, incluyendo los posibles riesgos y beneficios, y puede tomar y comunicar sus decisiones sobre esa atención de la salud. Legalmente, se asume que la persona es competente a menos que se demuestre lo contrario.

## **6. ¿Cómo se hace oficial una directiva anticipada?**

La directiva anticipada tiene que incluir todo lo siguiente para que sea oficial:

- Una declaración de la intención de la persona para crear una directiva anticipada.
- La firma de la persona que escribe la directiva anticipada.
- Las firmas de dos testigos o de un notario público.
- La fecha en que se firmó la directiva anticipada.

## **7. ¿Cuándo entra en vigor una directiva anticipada?**

La directiva anticipada solamente entra en vigor cuando el médico de atención primaria de la persona decide que la persona no tiene la “capacidad” de tomar sus propias decisiones de atención de la salud. Esto significa que el médico cree que la persona no puede entender la naturaleza y las consecuencias de la atención de la salud propuesta o que no puede tomar o comunicar sus decisiones sobre atención de la salud. El hecho de que se admita a una persona en un establecimiento de salud mental no significa, en sí mismo, que a la persona le falte capacidad de tomar sus propias decisiones de atención de la salud.

La directiva anticipada ya no está en vigor tan pronto como la persona recupera la capacidad de tomar sus propias decisiones de atención de la salud.

## **8. ¿Quién puede ayudar a llenar una directiva anticipada?**

A veces, llenar una directiva anticipada puede parecer confuso o complicado. Si la persona necesita ayuda para llenar su directiva anticipada, debe pedir ayuda a alguien que respete su derecho de tomar esas decisiones por sí misma y que le ayudará sin presionarla a tomar una decisión u otra.

También es buena idea pedirle ayuda a alguien que tiene conocimientos o experiencia en llenar directivas anticipadas. La Oficina del Defensor del Pueblo de Medi-Cal para Servicios de Salud Mental puede ayudar a las personas a encontrar alguien en su zona que responda preguntas y ayude a escribir las directivas anticipadas. El número de teléfono del Defensor del Pueblo para Servicios de Salud Mental es (800) 896-4042.

## **9. ¿Es necesario tener un agente de atención de la salud?**

No, una persona no tiene que nombrar a un agente de atención de la salud para poder escribir una directiva anticipada válida. Alguien que no tenga un familiar o amigo de confianza puede elegir no designar a un agente de atención de la salud. Si la persona no tiene a un agente de atención de la salud, el proveedor de atención de la salud igualmente tiene que cumplir con sus deseos, tal como los exprese en las instrucciones individuales de atención de la salud.

Sin embargo, existen buenas razones para designar a un agente de atención de la salud. Un agente de atención de la salud puede defender a la persona cuando no pueda defenderse a sí misma y puede asegurar que se respeten las decisiones de la persona. El agente de atención de la salud también puede ponerse en contacto con otros para recibir ayuda y hacer cumplir la directiva anticipada si se están ignorando las elecciones de la persona. Por eso es tan importante que la persona elija sólo a alguien que conozca y en quien confíe para que sea su agente.

Designar o no a un agente y a quién nombrar como agente son dos de las decisiones más importantes que la persona tendrá que tomar cuando llene una directiva anticipada.

## **10. ¿Qué pasa cuando la persona quiere cambiar una instrucción individual de atención de la salud?**

Los requisitos para cambiar alguna instrucción de atención de la salud son los mismos que para completar una directiva anticipada.

Para cambiar una instrucción individual de atención de la salud, la persona tiene que:

- Tener por lo menos 18 años de edad,
- Actuar libremente y sin presión de alguien, y
- Tener la “capacidad” de tomar decisiones de atención de la salud.

Una persona puede cambiar una instrucción individual de atención de la salud escribiendo una nueva directiva anticipada con los cambios que desea hacer. Si la persona llena una nueva directiva, tiene que seguir todos los pasos que completó al llenar la primera directiva, incluyendo contar con testigos.

Una persona también puede revocar la directiva anticipada de manera oral, al decirle a su proveedor de atención de la salud que ya no quiere que se haga cumplir el documento completo o alguna parte del mismo.

## **11. ¿Quién debe tener una copia de la directiva anticipada?**

La persona debe mantener una copia de la directiva anticipada para sí misma en un lugar que sea seguro, pero accesible fácilmente.

La persona debe darle una copia de la directiva anticipada a su agente, si lo tiene. La función del agente es asegurarse de que se conozcan y se cumplan las decisiones de la persona. Para hacerlo, el agente tiene que tener una copia de la directiva anticipada que lo designe como agente de esa persona.

Cada uno de los proveedores de atención de la salud de la persona debe tener una copia de la directiva anticipada y se exige legalmente que coloque la directiva anticipada en los registros médicos de la persona. Esto es importante, porque el proveedor de atención de la salud no puede seguir las instrucciones individuales de atención de la salud si no las conoce. Si la persona no tiene un agente o éste no está disponible, el proveedor de atención de la salud igualmente sabrá cuáles son sus deseos, si el documento incluye instrucciones individuales de atención de la salud.

La persona debe estar al tanto de quién tiene copias de su directiva anticipada. Si el paciente decide cambiar o revocar (cancelar) su designación de un agente o de alguna instrucción individual de atención de la salud, debe avisar a todos



los que tengan una copia de la directiva sobre el cambio/revocación, para evitar confusiones.

**12. ¿El proveedor de la salud tiene que cumplir con la directiva anticipada?**

Sí. Los proveedores de atención de la salud tienen que cumplir con las instrucciones individuales de atención de la salud y las decisiones tomadas a nombre de la persona a través de su agente.

**13. ¿Quién puede ayudar si se ignora/no se sigue una directiva anticipada?**

Si un proveedor de atención de la salud se rehúsa a seguir las instrucciones individuales de atención de la salud o se rehúsa a cumplir con las decisiones del agente de la persona, póngase en contacto con el defensor de derechos de los pacientes del condado y/o de Protection and Advocacy Incorporated (PAI). PAI y el defensor de derechos de los pacientes del condado pueden trabajar con la persona o su agente para asegurarse de que se cumpla con la directiva anticipada.

El número de teléfono de Protection and Advocacy, Inc. es **(800) 776-5746** y los números de teléfono del defensor de derechos de los pacientes del condado se publican en las paredes de todos los establecimientos de internación para pacientes de salud mental.

# Directiva anticipada de atención de la salud

## Explicación de los términos para las directivas anticipadas

La primera parte de su directiva anticipada de atención de la salud informa al lector sobre los códigos de las leyes federales y estatales que corresponden a las directivas anticipadas que ha escrito.

Se incluye la lista de los códigos específicos al final del párrafo, para que las personas los puedan consultar, si lo desean. En su mayoría, los abogados y los proveedores de atención de la salud necesitan conocerlas; los consumidores pueden consultar los reglamentos enumerados si desean estar mejor informados sobre sus derechos.

Algunos términos legales importantes en esta sección son:

1. **Capacidad:** En este documento, “capacidad” se refiere a su potencial de entender, tomar y comunicar sus decisiones sobre la atención de la salud; cuando se determine que le “falta capacidad” de hacerlo es cuando entra en vigor la directiva anticipada.
2. **Duración:** En California no hay límite de tiempo automático para una directiva anticipada. A menos que declare una fecha específica para el vencimiento de su documento, su directiva anticipada sigue vigente hasta que se decida a revocarla.
3. **Revocabilidad:** En California tiene el derecho, conforme a la ley, de decir que toda o alguna parte de su directiva anticipada ya no es válida.
4. **Responsabilidad:** En California, a los proveedores de atención de la salud se les puede demandar por “daños y perjuicios” (incluidas las multas y los honorarios de abogado) si se encuentra que han incumplido el seguimiento de una directiva anticipada de atención de la salud.
5. **Inmunidad:** En California, los proveedores de atención de la salud que siguen una directiva anticipada de buena fe están protegidos de que los procesen por un delito y de que los demanden por cumplir con la directiva anticipada.

6. Discriminación: En California nadie puede obligarlo a tener una directiva anticipada de atención de la salud o quitarle su derecho a tenerla como condición para recibir atención de la salud, admitirlo en un lugar de tratamiento, u ofrecerle un seguro.

### **Parte I:** Designación de un agente para la atención de la salud

7. Agente de atención de la salud: Es la persona a quien elige para que hable en su nombre y haga valer sus decisiones de atención de la salud. Aunque usted no *tiene* que elegir a un agente según la ley de California, tal vez quiera elegir a alguien que esté dispuesto a representar sus deseos con respecto a su tratamiento de salud.
8. Encargado de cuidados: Es alguien a quien el tribunal puede designar para supervisar sus asuntos y tomar decisiones de tratamiento si el tribunal determina que usted no puede atender sus propias necesidades básicas debido a un trastorno mental. Tal vez quiera identificar a alguien que prefiera que sea su encargado de cuidados, en caso de que el tribunal decida hacerlo.

### **Parte II(a):** Declaración de instrucciones individuales de atención de la salud mental

9. Incapacidad: Es otra manera de decir que “no tiene capacidad”. Significa que usted no puede tomar o comunicar sus propias decisiones de atención de la salud en un momento en particular.
10. Establecimiento de tratamiento: Sería todo lugar licenciado que tiene derecho legal a ofrecer atención psiquiátrica las 24 horas del día. A menudo es un hospital.
11. Médico de atención primaria: Para fines de esta sección, es el médico que usted ha identificado como el que tiene la primera responsabilidad de ofrecerle atención de salud mental.
12. Situaciones de emergencia: Son los tipos de crisis que los establecimientos de tratamiento de salud mental ven a menudo como una

manera de justificar el uso de métodos como *reclusión* y *restricción* para poder controlarlo.

- a. Reclusión: Método de control en el que lo llevan de donde está y lo aíslan, manteniéndolo en un área por separado.
  - b. Restricción: Método de control que limita físicamente su capacidad de moverse.
13. Efectos secundarios: Las cosas usualmente desagradables o destructivas que le pueden ocurrir a su cuerpo cuando toma ciertos medicamentos.
- a. *Discinesia tardía*: Movimientos de la cara, manos, etc., que no se pueden detener a voluntad, y que son efectos secundarios de tomar ciertos medicamentos.
  - b. *Inquietud motora*: No poder dejar de moverse como efecto secundario de tomar ciertos medicamentos.
  - c. *Rigidez músculo-esquelética*: Rigidez extrema, que es un efecto secundario de tomar ciertos medicamentos.
  - d. *Síndrome maligno neurolépticos*: Nombre dado a un grupo de efectos secundarios ante ciertos medicamentos, que en ocasiones ponen en peligro la vida.
14. Terapia electroconvulsiva: A veces se le llama ECT o “tratamientos de choque”, que involucra el uso de electricidad para provocar convulsiones cerebrales controladas, y en ocasiones se usa en el tratamiento para la depresión.
15. Pruebas de drogas: Es el uso de personas como sujetos de investigación para hacer pruebas de nuevos medicamentos.

## **Parte II(b): Instrucciones individuales de atención de la salud física**

16. Tratamiento para mantener la vida: Es el término que usan los médicos y los hospitales para describir la tecnología y maquinaria que se ha

inventado para prolongar la vida cuando de otra manera la persona moriría.

17. Estado vegetativo persistente: Es el término utilizado para describir a un ser humano cuya capacidad para funcionar se ha reducido gravemente, y a quien se le mantiene vivo con máquinas.
18. Donación anatómica: Es la donación de todo o parte de su cuerpo para fines médicos o científicos después de haberse muerto.
19. Autopsia: Es el examen médico de su cuerpo después de su muerte para determinar la causa de su muerte.

# Directiva anticipada de atención de la salud de:

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(nombre)

## **Atención, proveedores de atención de la salud:**

Este documento es una directiva anticipada de atención de la salud. Es un documento legal según las leyes estatales y federales, que dicta el tratamiento de atención de la salud que se puede proporcionar a una persona que carece de capacidad para tomar decisiones sobre atención de la salud. Código Testamentario de California, sección 4600 y siguientes; Código 42 de Reglamentos Federales, secciones 431.20, 489.100, 489.102, y 489.104.

Esta directiva anticipada de atención de la salud contiene un poder legal para la atención de la salud y/o instrucciones individuales para la atención de la salud. Si no se designa a algún agente en la sección del poder legal para la atención de la salud de este documento, o si el agente no puede localizarse, aún así los proveedores de atención de la salud tienen que cumplir con las instrucciones individuales de atención de la salud contenidas en este documento. Código Testamentario de California, secciones 4670, 4671. Un agente tiene prioridad sobre cualquier otra persona para tomar decisiones de atención de la salud para los pacientes. Código Testamentario de California, sección 4685.

## **Las obligaciones específicas de los proveedores de atención de la salud incluyen:**

- ✧ Mantener este documento en los registros de salud del paciente. Código Testamentario de California, sección 4731(a).
- ✧ Notificar al agente designado que el paciente carece de capacidad o que la ha recuperado. Código Testamentario de California, sección 4732.
- ✧ Permitir al agente designado el acceso a los registros de salud del paciente. Código Testamentario de California, sección 4678.

## **Duración y revocabilidad:**

Las directivas anticipadas de atención de la salud no tienen vencimiento, a menos que se declare una fecha de vencimiento específica en el documento. Código Testamentario de California, sección 4686.

El paciente que tenga capacidad puede revocar la designación de un agente por medio de un documento por escrito o informando personalmente al proveedor de atención de la salud, y puede revocar cualquiera y todas las demás partes de una directiva anticipada de atención de la salud de cualquier manera que comunique un interés por revocar. Código Testamentario de California, sección 4695.

Tome en cuenta que el agente no está autorizado para tomar una decisión de atención de la salud si el paciente objeta la decisión. Antes de poner en práctica una decisión de atención de la salud tomada para un paciente, el proveedor de atención de la salud debe informar rápidamente al paciente sobre la decisión y la identidad de la persona que toma la decisión. Código Testamentario de California, secciones 4689 y 4730.

Además, este documento declara que no debe llevarse a cabo ninguna instrucción individual sobre atención de la salud física o mental contra los deseos del paciente. Si el paciente objeta la decisión de atención de la salud de su agente o la implementación de una instrucción individual sobre atención de la salud física o mental contenida en este documento, la cuestión relacionada con ese procedimiento en particular estará regida por la ley que aplicaría si no hubiera un poder legal de atención de la salud o instrucción individual de atención de la salud relacionado con ese procedimiento. Código Testamentario de California, sección 4689.

## **Responsabilidad e inmunidad:**

Incumplimiento de una directiva anticipada de atención de la salud podría resultar en responsabilidad por daños y perjuicios especificada en las leyes de California o por daños reales, los que sean mayores, además de los honorarios del abogado. Código Testamentario de California, sección 4742. Quienes incumplan también pueden ser responsables de negligencia, mala praxis y reclamos por malos tratos.

Los proveedores de atención de la salud no están sujetos a responsabilidad civil o penal o a medidas disciplinarias por conducta no profesional por cumplir con las directivas anticipadas de atención de la salud. Código Testamentario de California, sección 4740.

### **Prohibida la discriminación:**

Los proveedores de atención de la salud y las aseguradoras de atención de la salud no pueden requerir o prohibir la ejecución o revocación de una directiva anticipada de atención de la salud como condición para ofrecer atención de la salud, admisión a un establecimiento o proporcionar seguro. Código Testamentario de California, sección 4677.

### **Directiva anticipada de atención de la salud: Explicación**

Usted tiene derecho a dar instrucciones acerca de su propia atención de la salud. También tiene el derecho de nombrar a alguien más para que tome decisiones de atención de la salud en su nombre. Este formulario le permite hacer una o ambas cosas. También le permite expresar sus deseos relacionados con la donación de órganos y la designación de su médico de atención primaria. Si utiliza este formulario, puede completarlo o modificarlo todo o parte del mismo. Tiene la libertad de usar un formulario diferente.

La *Parte I* de este formulario es un poder legal para la atención de la salud. La Parte I le permite designar a una persona como agente para tomar decisiones de atención de la salud por usted si queda incapaz de tomar sus propias decisiones o si quiere que alguien más tome esas decisiones por usted ahora, aunque todavía sea capaz. También puede nombrar a un agente alterno para que actúe en su nombre si su primera opción no está dispuesta, no puede o no está disponible razonablemente para tomar decisiones en su nombre. (Su agente no puede ser operador o empleado de un establecimiento de atención comunitaria o de un establecimiento de cuidados residenciales donde esté recibiendo atención, ni el proveedor a cargo de supervisar su atención de la salud, ni empleado del establecimiento de atención de la salud donde reciba atención, a menos que su agente sea su pariente o un compañero de trabajo.)

A menos que el formulario que firme limite su autoridad, su agente puede tomar todas las decisiones de atención de la salud en su nombre. Este formulario le proporciona un lugar para que usted limite la autoridad de su agente. No necesita limitar su autoridad si desea depender de su agente para todas las



decisiones de atención de la salud que pueda tener que tomar. Si elige no limitar la autoridad de su agente, éste tendrá el derecho de:

- (a) Consentir o negar el consentimiento a cualquier atención, tratamiento, servicio o procedimiento para mantener, diagnosticar o de otra manera afectar una condición física o mental.
- (b) Seleccionar o excluir proveedores e instituciones de atención de la salud.
- (c) Aprobar o desaprobado pruebas de diagnóstico, procedimientos quirúrgicos y programas de medicamentos.
- (d) Dirigir la disposición, retención o retiro de nutrición e hidratación artificial y todas las demás formas de atención de la salud, incluyendo la resucitación cardiopulmonar.
- (e) Hacer donaciones de anatomía, autorizar una autopsia y dirigir la disposición de los restos.

La *Parte II(a)* de este formulario incluye instrucciones específicas sobre cualquier aspecto de su atención de salud mental, ya sea que designe o no a un agente. Se le ofrecen opciones para que exprese sus deseos relacionados con la disposición de la atención de salud mental, y al final de la Parte II(a) se incluye espacio para que agregue cualquier elección adicional sobre la atención de salud mental que no esté cubierta en otra parte.

La *Parte II(b)* de este formulario incluye instrucciones específicas sobre cualquier aspecto de su atención de salud física, incluyendo decisiones al final de la vida e instrucciones sobre donaciones de anatomía, autopsia y disposición de sus restos.

Después de llenar el formulario, firme y ponga la fecha al final del formulario. El formulario debe ser firmado por dos testigos calificados o reconocido ante un notario público. Entregue una copia del formulario firmado y llenado a su médico, a cualquier otro proveedor de atención de la salud que pueda tener, a cualquier institución de atención de la salud en la que esté recibiendo atención, o a cualesquiera agentes de atención de la salud que haya designado. Debe hablar con la persona que haya designado como agente para asegurarse de que entienda sus deseos y que esté dispuesta a asumir la responsabilidad.

Tiene el derecho de revocar esta directiva anticipada de atención de la salud o de reemplazar este formulario en cualquier momento.

Si usted o su agente tienen problemas para hacer cumplir esta directiva anticipada de atención de la salud, póngase en contacto con su defensor de derechos de los pacientes del condado o con Protection and Advocacy, Inc. (1-800-776-5746).

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

Directiva anticipada de atención de la salud de \_\_\_\_\_  
(Su nombre)

**Instructions Included in My Directive**  
**Instrucciones incluidas en mi directiva**

*Put a check mark in the left-hand column for each section you have completed.*  
*Ponga una marca en la columna de la izquierda para cada sección que haya completado.*

<b>#</b>	<b>Part I</b> <b>Parte I</b>  <b>Appointment of an Agent for Health Care</b> <b>Designación de un agente para la atención de la salud</b>
1 <input type="checkbox"/>	Designation of Health Care Agent Designación de un agente para la atención de la salud  Designation of Alternate Health Care Agent Designación de un agente alterno para la atención de la salud
2 <input type="checkbox"/>	Authority Granted to My Agent Autoridad otorgada a mi agente
3 <input type="checkbox"/>	My choice as to a Court Appointed Conservator Mi elección en cuanto a un encargado de cuidados nombrado por el tribunal
<b>#</b>	<b>Part II(a)</b> <b>Parte II(a)</b>  <b>Statement of Individual Mental Health Care Instructions</b> <b>Declaración de instrucciones individuales de atención de salud mental</b>
4 <input type="checkbox"/>	Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?  ¿A quién, además de mi agente de atención de la salud, se le debe notificar de inmediato de mi admisión a un establecimiento psiquiátrico?
5 <input type="checkbox"/>	My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being  Mi elección de un establecimiento de tratamiento y mis opciones de alternativas para la hospitalización si se considera médicamente necesario contar con atención las 24 horas al día para mi bienestar y seguridad

6 <input type="checkbox"/>	<p>My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:</p> <p>Mi médico de atención primaria, quien tiene la responsabilidad principal de mi atención de salud mental, es:</p>
7 <input type="checkbox"/>	<p>My Choices about primary Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable</p> <p>Mis elecciones sobre los médicos de atención primaria que me atenderán si estoy hospitalizado y mi médico de atención primaria no está disponible</p>
8 <input type="checkbox"/>	<p>My Choices Regarding Methods for Avoiding Emergency Situations</p> <p>Mis elecciones respecto a los métodos para evitar las situaciones de emergencia</p>
9 <input type="checkbox"/>	<p>My Choices Regarding Emergency Interventions</p> <p>Mis elecciones respecto a las intervenciones de emergencia</p>
9(a) <input type="checkbox"/>	<p>My Choices Regarding <b>Routine</b> Medications for Psychiatric Treatment</p> <p>Mis elecciones respecto a los medicamentos <b>de rutina</b> para el tratamiento psiquiátrico</p>
9(b) <input type="checkbox"/>	<p>My Choices Regarding <b>Emergency</b> Psychiatric Medication</p> <p>Mis elecciones respecto a los medicamentos psiquiátricos <b>de emergencia</b></p>
10 <input type="checkbox"/>	<p>My Choices Regarding Electroconvulsive Therapy</p> <p>Mis elecciones respecto a la terapia electroconvulsiva</p>
11 <input type="checkbox"/>	<p>The Following People Are to be Prohibited from Visiting Me</p> <p>Queda prohibido que las siguientes personas me visiten</p>
12 <input type="checkbox"/>	<p>Other Instructions About Mental Health Care</p> <p>Otras instrucciones sobre la atención de la salud mental</p>

#	<b>Part II(b)</b> <b>Parte II(b)</b> <b>Individual Physical Health Care Instructions</b> <b>Instrucciones individuales para la atención de la salud física</b>
13 <input type="checkbox"/>	My Primary Physician who is to Have Primary Responsibility for my Physical Health Care is: Mi médico de atención primaria, quien tiene la responsabilidad principal de mi atención de la salud física, es:
14 <input type="checkbox"/>	Statement of Desires, Special Provisions and Limitations Declaración de deseos, disposiciones especiales y limitaciones
15 <input type="checkbox"/>	My Choices Regarding Experimental Studies and Drug Trial Mis elecciones respecto a investigaciones experimentales y pruebas con drogas
16 <input type="checkbox"/>	My Instructions Regarding Life Sustaining Treatment Mis instrucciones respecto al tratamiento para mantener la vida
17 <input type="checkbox"/>	My Choices Regarding Contribution of Anatomical Gift Mis elecciones respecto a las contribuciones de donación de anatomía
18 <input type="checkbox"/>	My Instructions Regarding Autopsy Mis instrucciones respecto a una autopsia
19 <input type="checkbox"/>	Choices Regarding Disposition of My Remains Elecciones respecto a la disposición de mis restos

**Advance Health Care Directive of** \_\_\_\_\_  
(Your name)

**Directiva anticipada de atención de la salud de** \_\_\_\_\_  
(Su nombre)

**Part I**  
**Parte I**

**Appointment Of An Agent For Health Care**  
**Designación de un agente para la atención de la salud**

**\*\*Make sure you give your agent a copy of all sections of this document\*\***  
**\*\*Asegúrese de darle a su agente una copia de todas las secciones de este documento\*\***

If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

Si no ha designado a un agente en la sección del poder legal para la atención de la salud de este documento, o si no se puede encontrar al agente, los proveedores de atención de la salud igualmente tienen que cumplir con todas las instrucciones individuales de atención de la salud contenidas en este documento. Código Testamentario de California, secciones 4670 y 4671. El agente tiene prioridad sobre cualquier otra persona para tomar decisiones de atención de la salud para los pacientes. Código Testamentario de California, sección 4685.

**Statement of intent to appoint an agent:**

**Declaración de la intención de designar a un agente:**

I, (your name) \_\_\_\_\_, being of sound mind, authorize a health care agent to make certain decisions of my behalf regarding my health treatment when I am incompetent to do so unless I mark this box ☐, in which case my agent's authority to make health care decisions for me takes effect immediately. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

Yo, (su nombre) \_\_\_\_\_, teniendo mi mente sana, autorizo a mi agente de atención de la salud para que tome ciertas decisiones en mi nombre relacionadas con mi tratamiento de salud cuando sea incompetente para hacerlo, a menos que marque este cuadro ☐, en cuyo caso la autoridad de mi agente para que tome decisiones de atención de la salud en mi nombre entra en vigor de inmediato. Pretendo que estas decisiones se hagan de conformidad con mis deseos expresados, tal como se establecen en este documento. Si no he expresado mi elección en este documento, autorizo a mi agente para que tome la decisión que determine que sería la decisión que yo tomaría si fuera competente para hacerlo.

## 1. Designation of Health Care Agent

### Designación de un agente para la atención de la salud

- A. I hereby designate and appoint the following person as my agent to make health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Por medio de la presente designo y nombro a la siguiente persona como mi agente, para que tome decisiones de atención de la salud en mi nombre, tal como se autoriza en este documento. Se debe notificar de inmediato a esta persona si se me admite a un establecimiento psiquiátrico.

Name:

Nombre: \_\_\_\_\_

Address:

Dirección: \_\_\_\_\_

City, State, Zip Code:

Ciudad, estado, código postal: \_\_\_\_\_

Day Phone:

Teléfono de día: \_\_\_\_\_

Evening Phone:

Teléfono de noche: \_\_\_\_\_

Pager:

Localizador: \_\_\_\_\_

Cell phone:

Teléfono celular: \_\_\_\_\_

### Designation of Alternate Health Care Agent

### Designación de un agente alternativo para la atención de la salud

If the person named above is unavailable, unable or unwilling to serve as my agent, I hereby appoint and desire immediate notification of my alternative agent as follows:

Si la persona mencionada anteriormente no está disponible, no puede o no está dispuesta a servir como mi agente, por la presente designo y deseo notificar de inmediato a mi agente alternativo tal como sigue:

Name:

Nombre: \_\_\_\_\_

Address:

Dirección: \_\_\_\_\_

City, State, Zip Code:

Ciudad, estado, código postal: \_\_\_\_\_

Day Phone:

Teléfono de día: \_\_\_\_\_

Evening phone:

Teléfono de noche: \_\_\_\_\_

Pager:

Localizador: \_\_\_\_\_

Cell phone:

Teléfono celular: \_\_\_\_\_

## **2. Authority Granted to My Agent Autoridad otorgada a mi agente**

If I become incapable of giving informed consent to health care treatment, or if I marked the box under "Statement of Intent to Appoint an Agent" causing my agent's authority to make decisions for me to immediately become effective, I hereby grant to my agent full power and authority to make health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive EXCEPT as I state here. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so. /

Si quedo incapaz de dar un consentimiento fundamentado para un tratamiento de atención de la salud, o si he marcado el cuadro en "Declaración de la intención de nombrar a un agente" con lo que ocasiono que la autoridad de mi agente para tomar decisiones en mi nombre entre en vigor de inmediato, por la presente otorgo a mi agente poder y autoridad total para que tome decisiones de atención de la salud en mi nombre, incluyendo el derecho de consentir, rehusar el consentimiento o retirar el consentimiento ante cualquier atención de la salud, tratamiento, servicio o procedimiento congruente con cualquier instrucción y/o limitación que he establecido en esta directiva anticipada EXCEPTO como lo declaro aquí. Si no he expresado mi elección en esta directiva anticipada, autorizo a mi agente para que tome la decisión que determine que sería la decisión que yo tomaría si fuera competente para hacerlo.

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### **3. My Choice as to a Court-Appointed Conservator**

#### **Mi elección en cuanto a un encargado de cuidados nombrado por el tribunal**

In the event a court decides to appoint a conservator who will make decisions regarding my health treatment, I desire the following person to be appointed:

En caso de que el tribunal decida designar a un encargado de cuidados que tomará decisiones respecto a mi tratamiento de salud, deseo designar a la siguiente persona:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Nombre: \_\_\_\_\_ Relación: \_\_\_\_\_

Address: \_\_\_\_\_  
Dirección: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_  
Ciudad, estado, código postal: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Teléfono de día: \_\_\_\_\_ Teléfono de noche: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Localizador: \_\_\_\_\_ Teléfono celular: \_\_\_\_\_

The appointment of a conservator or other decision maker shall not give the conservator or decision maker the power to revoke, suspend, or terminate my individual health care instructions or the powers of my agent.

El nombramiento de un encargado de cuidados u otro encargado de la toma de decisiones no dará al encargado de cuidados o de la toma de decisiones el poder de revocar, suspender o terminar mis instrucciones individuales de atención de la salud o los poderes de mi agente.

**\*\*Make sure you give your agent and alternate agent a copy of  
all sections of this document\*\***

**\*\*Asegúrese de darle una copia de todas las secciones de este documento  
a su agente y a su agente alterno\*\***

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

Directiva anticipada de atención de la salud de \_\_\_\_\_  
(Su nombre)

**Part II(a)**  
**Parte II(a)**

**Statement of Individual Mental Health Care Instructions**  
**Declaración de las instrucciones individuales de atención de la salud mental**

*In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials before the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.*

*En esta parte usted declara cómo desea que le den tratamiento (por ejemplo, a qué hospital desea que lo lleven, qué medicamentos prefiere) en caso de quedar incapacitado o incapaz para expresar sus propios deseos. Si quiere que un párrafo aplique, ponga sus iniciales antes de la letra del párrafo. Si no quiere que aplique, deje la línea en blanco.*

**No individual mental or physical health care instruction contained in this document may be carried out against my wishes.**

**Ninguna de las instrucciones individuales de atención de la salud física o mental contenidas en este documento puede llevarse a cabo en contra de mis deseos.**

**4. Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?** *Be sure to include the agent and any alternate agent you designate in your Durable Power of Attorney, if you have one.*

**¿A quién, además de mi agente de la atención de la salud, se le debe avisar de inmediato de mi admisión a un establecimiento psiquiátrico?** *Asegúrese de incluir al agente y a cualquier agente alterno que designe en su poder legal duradero, si lo tiene.*

Name:

Nombre: \_\_\_\_\_

Address:

Dirección: \_\_\_\_\_

City, State, Zip Code:

Ciudad, estado, código postal: \_\_\_\_\_

Day Phone:

Teléfono de día: \_\_\_\_\_

Evening Phone:

Teléfono de noche: \_\_\_\_\_

Pager:

Localizador: \_\_\_\_\_

Cell Phone:

Teléfono celular: \_\_\_\_\_

Name:

Nombre: \_\_\_\_\_

Address:

Dirección: \_\_\_\_\_

City, State, Zip Code:

Ciudad, estado, código postal: \_\_\_\_\_

Day Phone:

Teléfono de día: \_\_\_\_\_

Evening Phone:

Teléfono de noche: \_\_\_\_\_

Pager:

Localizador: \_\_\_\_\_

Cell Phone:

Teléfono celular: \_\_\_\_\_

Name:

Nombre: \_\_\_\_\_

Address:

Dirección: \_\_\_\_\_

City, State, Zip Code:

Ciudad, estado, código postal: \_\_\_\_\_

Day Phone:

Teléfono de día: \_\_\_\_\_

Evening Phone:

Teléfono de noche: \_\_\_\_\_

Pager:

Localizador: \_\_\_\_\_

Cell Phone

Teléfono celular: \_\_\_\_\_

Name: Nombre: _____	
Address: Dirección: _____	
City, State, Zip Code: Ciudad, estado, código postal: _____	
Day Phone: Teléfono de día: _____	Evening Phone: Teléfono de noche: _____
Pager: Localizador: _____	Cell Phone: Teléfono celular: _____

**5. My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being**

**Mi elección de un establecimiento de tratamiento y mis opciones de alternativas para la hospitalización si se considera médicamente necesario contar con atención las 24 horas al día para mi bienestar y seguridad**

- ☐ A. In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at the following programs/facilities instead of psychiatric hospitalization.

En caso de que mi condición psiquiátrica sea lo suficiente grave como para necesitar atención las 24 horas al día y no tenga condiciones físicas que requieran de un acceso inmediato a la atención médica de emergencia, preferiría recibir esta atención en los siguientes programas/establecimientos, en lugar de recibir hospitalización psiquiátrica.

Facility Name:

Nombre del establecimiento: \_\_\_\_\_

Reason:

Razón: \_\_\_\_\_

Facility Name:

Nombre del establecimiento: \_\_\_\_\_

Reason:

Razón: \_\_\_\_\_

Facility Name:

Nombre del establecimiento: \_\_\_\_\_

Reason:

Razón: \_\_\_\_\_

- 
- ☐ B. In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

En caso de que me admitan a un hospital para recibir atención las 24 horas al día, preferiría recibir atención en los siguientes hospitales:

Facility Name:

Nombre del establecimiento: \_\_\_\_\_

Reason:

Razón: \_\_\_\_\_

Facility Name:

Nombre del establecimiento: \_\_\_\_\_

Reason:  
Razón: \_\_\_\_\_

Facility Name:  
Nombre del establecimiento: \_\_\_\_\_

Reason:  
Razón: \_\_\_\_\_

☐ C. I do not wish to be admitted to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

No deseo ser admitido en los siguientes hospitales o programas/establecimientos para atención psiquiátrica por las razones que he señalado:

Facility Name:  
Nombre del establecimiento: \_\_\_\_\_

Reason:  
Razón: \_\_\_\_\_

Facility Name:  
Nombre del establecimiento: \_\_\_\_\_

Reason:  
Razón: \_\_\_\_\_

Facility Name:  
Nombre del establecimiento: \_\_\_\_\_

Reason:  
Razón: \_\_\_\_\_

**6. My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:**

**Mi médico de atención primaria, quien tiene la responsabilidad principal para mi atención de salud mental, es:**

Dr. \_\_\_\_\_

Phone:  
Teléfono \_\_\_\_\_

Address:  
Dirección: \_\_\_\_\_

Pager:  
Localizador: \_\_\_\_\_

City, State, Zip:  
Ciudad, estado, código postal: \_\_\_\_\_

**7. My Choices about the Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable**

**Mis elecciones sobre los médicos que me atenderán si estoy hospitalizado y mi médico de atención primaria no está disponible**

Put your initials before the letter and complete if you wish either or both paragraphs to apply.

Ponga sus iniciales antes de la letra y complete los espacios si desea que aplique alguno o ambos párrafos.

- ☐ A. My choice of treating physician if the above physician is unavailable is:  
Mi elección del médico a cargo si el médico anterior no está disponible es:

Dr. \_\_\_\_\_ Phone: \_\_\_\_\_  
Teléfono: \_\_\_\_\_

Address: \_\_\_\_\_  
Dirección: \_\_\_\_\_

OR if neither is available  
O si ninguno está disponible

Dr. \_\_\_\_\_ Phone: \_\_\_\_\_  
Teléfono: \_\_\_\_\_

OR if none of the above is available  
O si ninguno de los anteriores está disponible

Dr. \_\_\_\_\_ Phone: \_\_\_\_\_  
Teléfono: \_\_\_\_\_

- ☐ B. I do not wish to be treated by the following, for the reasons stated:  
No deseo que me atiendan los siguientes médicos, por las razones señaladas:

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_  
Razón: \_\_\_\_\_

OR  
O

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_  
Razón: \_\_\_\_\_

OR  
O

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_  
Razón: \_\_\_\_\_

## 8. My Choices Regarding Methods for Avoiding Emergency Situations

### Mis elecciones respecto a los métodos para evitar las situaciones de emergencia

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made as follows. I prefer these interventions in the following order:

Si durante mi admisión o internación en un establecimiento de tratamiento de salud mental se determina que me estoy comportando de tal manera que **podría** hacer necesaria la intervención de emergencia, prefiero las siguientes elecciones para ayudarme a recuperar el control:

*Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If your choice is not listed, write it in after "other" and give it a number as well.*

*Llene con números, poniendo el 1 a su primera opción, el 2 a la segunda y así sucesivamente hasta que todas tengan un número. Si su elección no está en la lista, escríbala después de "otra" y póngale el número correspondiente.*

- ☐ Provide a quiet private place  
Proporcionarme un lugar privado y tranquilo
- ☐ Have a staff member of my choice talk with me one-on-one  
Que un miembro del personal que yo elija hable conmigo a solas
- ☐ Allow me to engage in physical exercise  
Permitirme hacer ejercicio físico
- ☐ Offer me recreational activities  
Ofrecerme actividades recreativas
- ☐ Assist me with telephoning a friend or family member  
Ayudarme para llamar a un amigo o familiar por teléfono
- ☐ Offer me the opportunity to take a warm bath  
Darme la oportunidad de tomar un baño tibio
- ☐ Offer me medication  
Ofrecerme medicamentos
- ☐ Offer me a cigarette  
Ofrecerme un cigarrillo
- ☐ Allow me to go outside  
Permitirme salir al aire libre
- ☐ Provide me with materials to journal or do artwork  
Darme materiales para un escribir en un diario o hacer proyectos artísticos gráficos



☐ Offer me assistance with breathing or calming exercises  
Ofrecerme ayuda con ejercicios para respirar o tranquilizarme

☐ Provide me with a radio to listen to  
Darne una radio para escuchar

☐ Other:  
Otra: \_\_\_\_\_

## 9. My Choices Regarding Emergency Interventions

### Mis elecciones respecto a las intervenciones de emergencia

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency in:

Si durante una admisión o internación en un establecimiento de tratamiento de salud mental se determina que me estoy comportando de una manera que requiere intervención de emergencia (ejemplo, reclusión y/o restricción física y/o medicamentos) mis deseos respecto a qué formas de intervenciones de emergencia deben aplicarse son como siguen. Prefiero estas intervenciones en el orden siguiente:

*Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well. If you do not want a listed intervention ever used, cross it out and explain why under "Reasons for my choices."*

*Llene con números, poniendo el 1 a su primera opción, el 2 a la segunda y así sucesivamente hasta que todas tengan un número. Si la intervención que prefiere no está en la lista, escríbala después de "otra" y póngale el número correspondiente. Si no quiere que se use alguna de las intervenciones mencionadas, táchela y explique por qué en "Razones de mis elecciones".*

	Reasons for my choices Razones de mis elecciones
<input type="checkbox"/> Seclusion Reclusión	_____
<input type="checkbox"/> Physical Restraints Restricciones físicas	_____
<input type="checkbox"/> Seclusion and physical restraint (combined) Reclusión y restricción física (combinadas)	_____
<input type="checkbox"/> Medication by injection Medicamentos inyectados	_____
<input type="checkbox"/> Medication in pill form Medicamentos en píldoras	_____
<input type="checkbox"/> Liquid medication Medicamentos líquidos	_____
<input type="checkbox"/> During seclusion and/or restraint, I prefer to be checked by <b>female</b> staff Durante la reclusión y/o restricción, prefiero que me revise <b>una mujer</b> del personal	_____ _____ _____

☐ During seclusion and/or restraint, I prefer to be checked by **male** staff. Durante la reclusión y/o restricción, prefiero que me revise **un hombre** del personal.

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Other:

Otra: \_\_\_\_\_

\_\_\_\_\_

*See Section 9(b) for choices regarding emergency medication*

*Vea las elecciones respecto a medicamentos de emergencia en la Sección 9(b)*

I expect the choice of medication in an emergency situation to reflect any choices I have expressed in this section and in Section 9(b). **The choices I express in this section and Section 9(b) regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.**

Espero que la elección de medicamentos en una situación de emergencia refleje todas las elecciones que he expresado en esta sección y en la Sección 9(b). **Las elecciones que expreso en esta sección y en la Sección 9(b) respecto a medicamentos en situaciones de emergencia no constituyen el consentimiento para usar medicamentos en un tratamiento que no sea de emergencia.**

### 9(a). My Choice Regarding *Routine* Medications for Psychiatric Treatment

#### Mis elecciones respecto a los medicamentos *de rutina* para el tratamiento psiquiátrico

*In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.*

*En esta sección puede elegir cualquiera de los párrafos A a G que desee que se apliquen. Asegúrese de poner sus iniciales en los que elija.*

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

Si se determina que no soy legalmente competente para consentir o para rechazar medicamentos relacionados con mi tratamiento de salud mental, deseo lo siguiente:

- ☐ A. I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

Consiento en los medicamentos que acuerde mi agente, después de consultar con el médico que me atiende y con otras personas que mi agente considere apropiado, con las excepciones, si hubiera, descritas en (D) a continuación.

- ☐ B. I consent to and authorize my agent to consent to the administration of: Consiento y autorizo a mi agente para que consienta en la administración de:

**Medication Name  
or Medication Type**

**Nombre o tipo de  
medicamento**

**Not to exceed the  
following dosage/day**

**Que no exceda la  
siguiente dosis por día**

**OR O**

**In such dosage(s) as  
determined by:**

**En dosis según las  
determine:**

Dr. \_\_\_\_\_

Or if unavailable,  
then by:

O si no está disponible,  
entonces por:

Dr. \_\_\_\_\_

- ☐ C. I consent to the medications deemed appropriate by Dr. \_\_\_\_\_ whose address and phone number are:

Consiento a los medicamentos que considere apropiados el Dr. \_\_\_\_\_, cuya dirección y número de teléfono son: \_\_\_\_\_

**9(a) Continued**  
**Continuación**

- ☐ D. I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents:

Específicamente, no consiento y no autorizo a mi agente a que consienta en la administración de los siguientes medicamentos o su respectiva marca comercial, nombre comercial o equivalentes genéricos:

**Name of Drug**  
**Nombre del medicamento**

**Reason for Refusal**  
**Razón del rechazo**

_____	_____
_____	_____
_____	_____
_____	_____
	_____
	_____

- ☐ E. I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

Estoy dispuesto a tomar los medicamentos excluidos en (D) arriba si mi única razón para excluirlos es los efectos secundarios, y la dosis se puede ajustar para eliminar esos efectos secundarios.

- ☐ F. I am concerned about the side effects of medications and do **not** consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at 1% or greater level of incidence (*check all that apply*).

Me preocupan los efectos secundarios de los medicamentos y **no** consiento ni autorizo a mi agente a que consienta en algún medicamento que tenga alguno de los efectos secundarios que he marcado abajo al 1% o mayor nivel de incidencia (*marque todas las que correspondan*).

- ☐ Tardive dyskinesia  
Discinesia tardía
- ☐ Loss of sensation  
Pérdida de la sensación
- ☐ Motor Restlessness  
Inquietud motora
- ☐ Seizures  
Convulsiones
- ☐ Muscle/skeletal rigidity  
Rigidez músculo-esquelética

- ☐ Tremors  
Temblores
- ☐ Nausea/vomiting  
Náusea/vomito
- ☐ Neuroleptic Malignant Syndrome  
Síndrome maligno neuroléptico
- ☐ Other  
Otro \_\_\_\_\_

- 
- ☐ G. I have the following other choices about psychiatric medications:  
Tengo estas otras elecciones para los medicamentos psiquiátricos:

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**9(b) My Choices Regarding *Emergency* Psychiatric Medication**  
**Mis elecciones respecto a los medicamentos psiquiátricos *de emergencia***

If during my admission or commitment to a mental health facility, it is determined that I am engaging in behavior that requires emergency psychiatric medication, I prefer the following medication:

Si durante mi admisión o mi internación en un establecimiento de salud mental se determina que me comporto de una manera que requiere medicamentos psiquiátricos de emergencia, prefiero los siguientes medicamentos:

<b>Medication Name or Medication Type</b> <b>Nombre o tipo de medicamento</b>	<b>Not to exceed the following dosage/day</b> <b>Que no exceda la siguiente dosis por día</b>	<b>OR O</b>	<b>In such dosage(s) as determined by:</b> <b>En dosis según las determine:</b>
<hr/>	<hr/>		Dr. <hr/>
<hr/>	<hr/>		
<hr/>	<hr/>		Or if unavailable, then by:
<hr/>	<hr/>		O si no está disponible, entonces por:
<hr/>	<hr/>		
<hr/>	<hr/>		Dr. <hr/>
<hr/>	<hr/>		

**The choices expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.**

**Las elecciones expresadas en esta sección sobre medicamentos en situaciones de emergencia no constituyen un consentimiento de usar los medicamentos para tratamientos que no sean de emergencia.**

**10. My Choices Regarding Electroconvulsive Therapy**  
**Mis elecciones respecto a la terapia electroconvulsiva**

- ☐ A. I **do not** consent to administration of electroconvulsive therapy.  
**No** consiento a la aplicación de terapia electroconvulsiva.

B. Under California law, this Directive **cannot** be used to consent for electroconvulsive therapy. However, if I am administered electroconvulsive therapy, I have the following choices:

Según la ley de California, esta directiva **no se puede** usar para consentir al uso de terapia electroconvulsiva. Sin embargo, si se me aplica la terapia electroconvulsiva, tengo las siguientes elecciones:

- ☐ I will be administered no more than the following number of treatments  
Se me aplicará no más del siguiente número de tratamientos \_\_\_\_\_ .
- ☐ I will be administered the number of treatments deemed appropriate by  
Dr.\_\_\_\_, whose phone number and address is:
- ☐ Se me aplicará el número de tratamientos que el Dr. considere apropiado, y su número  
de teléfono y dirección son \_\_\_\_\_



**11. The Following People Are to be Prohibited from Visiting Me:**  
**Queda prohibido que las siguientes personas me visiten:**

**Name**  
**Nombre**

**Relationship**  
**Relación**

_____	_____
_____	_____
_____	_____
_____	_____

**12. Other Instructions About Mental Health Care**  
**Otras instrucciones sobre la atención de la salud mental**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

*(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document).*

*(Puede anexar páginas adicionales si necesita más espacio para completar su declaración. Si anexa páginas adicionales, tiene que firmar y poner la fecha en CADA una de las páginas adicionales al momento de firmar y poner la fecha en este documento.)*

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

Directiva anticipada de atención de la salud de \_\_\_\_\_  
(Su nombre)

**Part II(b)**

**Parte II(b)**

**Individual Physical Health Care Instructions**  
**Instrucciones individuales para la atención de la salud física**

No individual mental or physical health care instruction contained in this document may be carried out against my wishes.

Ninguna de las instrucciones individuales de atención de la salud física o mental contenidas en este documento puede llevarse a cabo en contra de mis deseos.

**13. My Primary Physician who is to have primary responsibility for my physical health care is:**

**Mi médico de atención primaria, quien tiene la responsabilidad principal de mi atención de la salud física, es:**

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Teléfono \_\_\_\_\_

Address \_\_\_\_\_ Pager \_\_\_\_\_  
Dirección \_\_\_\_\_ Localizador \_\_\_\_\_

City, State, Zip \_\_\_\_\_  
Ciudad, estado, código postal \_\_\_\_\_

OR if the above physician is unavailable, then I request:  
O si el médico anterior no está disponible, entonces solicito a:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Teléfono \_\_\_\_\_

Address \_\_\_\_\_  
Dirección \_\_\_\_\_

City, State, Zip \_\_\_\_\_  
Ciudad, estado, código postal \_\_\_\_\_

OR if neither of the above is available, then I request:  
O si ninguno de los mencionados está disponible, entonces solicito a:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Teléfono \_\_\_\_\_

Address \_\_\_\_\_  
Dirección \_\_\_\_\_

City, State, Zip \_\_\_\_\_  
Ciudad, estado, código postal \_\_\_\_\_

I specifically do not want to be treated by the following physicians:  
Específicamente, no quiero que me atiendan los siguientes médicos:

Dr. \_\_\_\_\_

Reason:

Razón: \_\_\_\_\_

OR

O

Dr. \_\_\_\_\_

Reason:

Razón: \_\_\_\_\_

OR

O

Dr. \_\_\_\_\_

Reason:

Razón: \_\_\_\_\_

**14. Statement of Desires, Special Provisions and Limitations**  
**Declaración de deseos, disposiciones especiales y limitaciones**

- ☐ A. I specifically express the following desires concerning these health care decisions:  
Específicamente, expreso los siguientes deseos relacionados con estas decisiones de atención de la salud:

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- ☐ B. And I specifically limit this Advance Directive as follows:  
Y específicamente limito esta directiva anticipada de la siguiente manera:

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*(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document).*

*(Puede anexar páginas adicionales si necesita más espacio para completar su declaración. Si anexa páginas adicionales, tiene que firmar y poner la fecha en CADA una de las páginas adicionales al momento de firmar y poner la fecha en este documento.)*

**15. My Choices Regarding Experimental Studies and Drug Trials**  
**Mis elecciones respecto a investigaciones experimentales y pruebas con drogas**

☐ **I will not** participate in experimental studies or drug trials.  
**No** participaré en investigaciones experimentales ni pruebas con drogas.

Under recent changes to California law, a health care agent, if one has been appointed, a conservator, a family member, or domestic partner may consent to participation in a medical experiment on behalf of a person who is unable to consent under very specific circumstances. See Health and Safety Code, section 24178 for a list of these specific circumstances.

De acuerdo con cambios recientes a las leyes de California, un agente de atención de la salud, si se ha nombrado, un encargado de cuidados, un familiar o un compañero doméstico puede consentir a la participación en un experimento médico a nombre de una persona que no pueda consentir, en circunstancias muy específicas. Vea una lista de estas circunstancias específicas en el Código de Salud y Seguridad, sección 24178.

Complete this section **only** if you do not consent to participation in medical experiments under any circumstances.

Complete esta sección **solamente** si no consiente en participar en experimentos médicos bajo ninguna circunstancia.

## 16. My Instructions Regarding Life Sustaining Treatment

### Mis instrucciones respecto al tratamiento para mantener la vida

- ☐ A. I **do not** want my life to be prolonged and I **do not** want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. I want the relief of suffering and the quality as well as the possible extension of my life considered in making decisions concerning life-sustaining treatment.

Yo **no** quiero que mi vida se prolongue y **no** quiero que se me proporcione ni continúe el tratamiento para mantener la vida si: (1) estoy en un coma irreversible o en un estado vegetativo persistente, o (2) si estoy enfermo en grado terminal y la aplicación de los procedimientos para mantener la vida sólo servirán para retrasar artificialmente el momento de mi muerte, o (3) bajo alguna otra circunstancia donde la carga del tratamiento supera los beneficios esperados. Quiero que se considere el alivio del sufrimiento y la calidad, así como la posible extensión de mi vida, al tomar decisiones relacionadas con un tratamiento para mantener la vida.

OR  
O

- ☐ B. I want my life to be prolonged and I want life-sustaining treatment to be provided **unless I am in a coma or vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I **do not** want life-sustaining treatment to be provided or continued.

Quiero que se prolongue mi vida y quiero que se me proporcione tratamiento para mantener la vida, **a menos que esté en un estado de coma o vegetativo** en el cual mi médico crea razonablemente que es irreversible. Una vez que mi médico haya concluido razonablemente que seguiré inconsciente por el resto de mi vida, **no** quiero que se me proporcione ni continúe con el tratamiento para mantener la vida.

OR  
O

- ☐ C. I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of procedures.

Quiero que mi vida se prolongue hasta el máximo posible sin tomar en cuenta mi condición, las posibilidades que tenga de recuperación o el costo de los procedimientos.

**AND/OR  
Y/O**

- ☐ D. I specifically express the following desires concerning life-sustaining treatment.  
Específicamente, expreso los siguientes deseos relacionados con el tratamiento para mantener la vida.

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## 17. My Choices Regarding Contribution of Anatomical Gift

### Mis elecciones respecto a las contribuciones con donaciones de anatomía

*If either statement reflects your desires, sign the line next to the statement. You do not have to sign either statement. If you do not wish to sign either statement, your agent (if you have one) and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.*

*Si alguna de las declaraciones refleja sus deseos, firme la línea junto a la declaración. No tiene que firmar ninguna. Si no desea firmar ninguna, su agente (si lo tiene) y su familia tendrán la autoridad de donar todo su cuerpo o parte del mismo, de acuerdo con la Ley uniforme de donación anatómica.*

- ☐ I **do** want to make a gift under the Uniform Anatomical Gift Act, effective upon my death, of:

**Quiero** hacer una donación de acuerdo con la Ley uniforme de donación anatómica, vigente al momento de mi muerte, de:

\_\_\_\_\_  
(Signature)  
(Firma)

- ☐ Any needed organs or parts; or  
Los órganos o partes que se necesiten, o

- ☐ The parts or organs listed:  
Las partes u órganos indicados:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ I **do not** want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to do so.

**No** quiero hacer una donación según la Ley uniforme de donación anatómica, ni quiero que mi agente o mi familia lo haga.

\_\_\_\_\_  
(Signature)  
(Firma)



## 18. My Instructions Regarding Autopsy Mis instrucciones respecto a una autopsia

*If either statement reflects your desires, sign the line next to the statement. You **do not** have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to authorize an autopsy.*

*Si alguna de las declaraciones refleja sus deseos, firme la línea junto a la declaración. **No** tiene que firmar ninguna. Si no firma ninguna, su agente (si lo tiene) y su familia podrán autorizar una autopsia.*

☐ I **do** authorize an examination of my body after death to determine the cause of my death.

**Autorizo** que examinen mi cuerpo después de la muerte para determinar la causa de mi muerte.

\_\_\_\_\_  
(Signature)  
(Firma)

☐ I **do not** authorize an examination of my body after death to determine the cause of my death.

**No** autorizo que examinen mi cuerpo después de la muerte para determinar la causa de mi muerte.

\_\_\_\_\_  
(Signature)  
(Firma)

**19. Choices Regarding Disposition of my Remains**  
**Elecciones respecto a la disposición de mis restos**

If either statement reflects your desires, sign the line beneath the statement. You do not have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to direct the disposition of your remains.

Si alguna de las declaraciones refleja sus deseos, firme la línea debajo de la declaración. No tiene que firmar ninguna; si no firma ninguna, su agente (si lo tiene) y su familia podrán dirigir la disposición de sus restos.

☐ I do authorize  
Autorizo a

\_\_\_\_\_  
(name)  
( nombre)

\_\_\_\_\_  
(phone)  
( teléfono)

\_\_\_\_\_  
(address/city/state/zip)  
(dirección/ciudad/estado/código postal)

to direct the disposition of my remains by the following method:  
para dirigir la disposición de mis restos con el siguiente método:

☐ Burial  
Sepultura

☐ Cremation  
Cremación

\_\_\_\_\_  
(signature)  
(firma)

**OR**  
**O**

☐ I have described the way I want my remains disposed of in:  
He descrito la manera en que quiero que dispongan de mis restos en:

☐ A written contract for funeral services with:  
Un contrato por escrito para servicios funerarios con:

\_\_\_\_\_  
(name and phone of mortuary/cemetery)  
(nombre y número de teléfono de la agencia funeraria/cementerio)

\_\_\_\_\_  
(address/city/state/zip)  
(dirección/ciudad/estado/código postal)

☐ My will  
Mi testamento

☐ Other:  
Otra: \_\_\_\_\_

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(signature)  
(firma)

**By signing below, I am executing this advance directive for health care and, by so doing, am revoking any prior durable power of attorney for health care.**

**Al firmar a continuación, estoy poniendo en vigencia esta directiva anticipada para atención de la salud y, al hacerlo, estoy revocando cualquier poder legal duradero para atención de la salud anterior.**

**Effect of copy:** A copy of this form has the same effect as the original.

**Efecto de la copia:** Una copia de este formulario tiene el mismo efecto que el original.

**Signature:** Sign and date the form here in the presence of your witnesses/notary. /

**Firma:** Firme y ponga la fecha aquí en presencia de sus testigos/el notario.

\_\_\_\_\_  
(date)  
( fecha)

\_\_\_\_\_  
(signature)  
(firma)

\_\_\_\_\_  
(address)  
( dirección)

\_\_\_\_\_  
(print your name)  
(nombre en letra de molde)

\_\_\_\_\_  
(city / state)  
(ciudad / estado)

**Statement of witnesses:** I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

**Declaración de los testigos:** Declaro bajo pena de perjurio según las leyes de California (1) que conozco personalmente a la persona que ha firmado o reconocido esta directiva anticipada de atención de la salud, o que la identidad de la persona se me ha comprobado por medio de evidencias convincentes, (2) que la persona firmó o reconoció esta directiva anticipada en mi presencia, (3) que la persona parece tener la mente sana y no estar bajo coacción, fraude, o influencia indebida, (4) que no soy una persona designada como agente por esta directiva anticipada, y (5) que no soy proveedor de atención de la salud de la persona, empleado del proveedor de atención de la salud de la persona, operador de un establecimiento de atención comunitaria, empleado de un operador de un establecimiento de atención comunitaria, operador de un establecimiento de cuidados residenciales para ancianos, ni empleado de un operador de un establecimiento de cuidados residenciales para ancianos.

First Witness  
Primer testigo

Second Witness  
Segundo testigo

\_\_\_\_\_  
(print name)  
(nombre en letra de molde)

\_\_\_\_\_  
(print name)  
( nombre en letra de molde)

\_\_\_\_\_  
(address)  
(dirección)

\_\_\_\_\_  
(address)  
(dirección)

\_\_\_\_\_  
(city / state)  
(ciudad / estado)

\_\_\_\_\_  
(city / state)  
(ciudad / estado)

\_\_\_\_\_  
(signature of witness)  
(firma del testigo)

\_\_\_\_\_  
(signature of witness)  
(firma del testigo)

\_\_\_\_\_  
(date)  
( fecha)

\_\_\_\_\_  
(date)  
(fecha)

**Additional statement of witnesses:** At least one of the above witnesses must also sign the following declaration:

**Declaración de los testigos:** Por lo menos uno de los testigos anteriores también tiene que firmar la siguiente declaración:

I further declare under penalty of perjury under the laws of California, that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Además, declaro bajo pena de perjurio conforme a las leyes de California que no estoy relacionado con la persona que celebra esta directiva anticipada de atención de la salud por parentesco de sangre, por matrimonio ni por adopción, y a mi mejor saber y entender, no tengo derecho a parte alguna del patrimonio de la persona a su muerte según un testamento existente actualmente, ni por una operación legal.

\_\_\_\_\_  
(signature of witness)  
(firma del testigo)

\_\_\_\_\_  
(signature of witness)  
(firma del testigo)

**Special witness requirement:** The following statement is required only if you are a patient in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

**Requisito especial para el testigo:** La siguiente declaración solamente se requiere si es paciente de una instalación de enfermería especializada – una instalación de atención de la salud que proporciona los siguientes servicios básicos: servicios de enfermería especializada y servicios de apoyo a pacientes cuya necesidad principal es la atención de enfermería especializada a largo plazo. El defensor de pacientes o defensor del pueblo tiene que firmar la siguiente declaración:

**Statement of Patient Advocate or Ombudsman**  
**Declaración del defensor del paciente o del defensor del pueblo**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Declaro bajo pena de perjurio conforme a las leyes de California que soy un defensor de pacientes o defensor del pueblo tal como lo designa el Departamento de la Vejez del Estado, y que me presento como testigo, tal como lo requiere la sección 4675 del Código Testamentario.

\_\_\_\_\_  
(date)  
( fecha)

\_\_\_\_\_  
(signature)  
(firma)

\_\_\_\_\_  
(address)  
(dirección)

\_\_\_\_\_  
(print your name)  
( su nombre en letra de molde)

\_\_\_\_\_  
(city / state)  
(ciudad / estado)

**Acknowledgement of Notary Public  
Reconocimiento del notario público**

(State of California / County of \_\_\_\_\_)

(estado de California / Condado de \_\_\_\_\_)

On \_\_\_\_\_, before me, \_\_\_\_\_ (here insert name and title of the officer), personally appeared \_\_\_\_\_ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

El día \_\_\_\_\_, ante mí, \_\_\_\_\_ (inserte aquí el nombre y título del funcionario), se presentó en persona \_\_\_\_\_ a quien conozco personalmente (o me lo ha comprobado con evidencia satisfactoria) como la persona cuyo nombre se suscribe en el presente documento y reconoce ante mí que ha suscrito el mismo.

WITNESS my hand and official seal.  
DOY FE de mi puño y letra, y con mi sello oficial.

Signature:

Firma: \_\_\_\_\_ (Seal)  
(Sello)

**This document is valid only if signed by two witnesses OR acknowledged before a notary public.**

**Este documento solamente es válido si está firmado por dos testigos O reconocido ante un notario público.**





[illegible]

[illegible]