Human Services, Inc.
50 James Buchanan Dr.
Thorndale, PA 19372
P: 610-873-1010 F: 610-873-9307

Intake Contact:
intake@humanservicesinc.org
610-873-1010 x165

Client Registration Packet

Date

Referral Source/Name of Organization (IF APPLICABLE)

Phone #

Contact Information

Client Information

First Name (Mr. Ms. Mrs. Mx.)

Last Name

Phone Number (REQUIRED)

Address

City

State/Zip Code

DOB

Email Address

Race/Ethnicity

Gender – Alias/Other Preference/Pronouns

Social Security Number (REQUIRED)

Emergency Contact Name & Phone Number (REQUIRED)

Insurance Provider (PRIMARY)

Insurance Member ID ((REQUIRED)

Insurance Provider (SECONDARY)

Insurance Member ID

If you are currently uninsured or under insured, are you interested in applying for County Funding, if eligible? (This is NOT a Medicaid Program)

Yes _____ No _____ I Prefer to Self-Pay _____

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Please complete all of the following questions.

Are you experiencing/recently experienced Suicidal (Thought/Plans) Ideation? ☐ Yes ☐ No
Are you experiencing/recently experienced Homicidal (Thought/Plans) Ideation? ☐ Yes ☐ No
Do you hear/see things that other people do not see/hear (Psychotic Episode)? ☐ Yes ☐ No
Do you Self Harm (Cut, Burn, Skin Pick)? ☐ Yes ☐ No
Are you experiencing/recently experienced Domestic Violence? ☐ Yes ☐ No

If you are currently experience a crisis or in an emergent situation please contact the Police Department at 911 or Valley Creek Crisis Center at (610) 280-3270

Do you/have you used Illegal Substances? ☐ Yes ☐ No
Drug of Choice? _____ Last Used? _____
How Often? _____ How Much? _____

Do you drink/have you drunk Alcohol? ☐ Yes ☐ No
Last Used? _____ How Often? _____
How Much? _____
Date of Last Drug & Alcohol Evaluation: _____

Are you currently receiving any of the following services?
☐ Drug & Alcohol Treatment Where: _____
☐ Medication Management Where: _____
☐ Mental Health Services Where: _____
☐ Case Management Services Where: _____

Have you previously received services from Human Services, Inc.? ☐ Yes ☐ No

Have you recently discharged from a hospital for Mental/Behavioral Health? ☐ Yes ☐ No
Name of Facility: _____ Date of Discharge: _____

Per Human Services, Inc. policy, individuals MUST receive medication management in conjunction with Outpatient Therapy Services. Failure to attend regularly scheduled therapy appointments will result in the cancellation of medication review appointments. Individuals MUST provide accurate financial and insurance information, Failure to comply may result in a $300 Charge.
Client Initials: _____

Are there other services that you are interested in receiving from Human Services, Inc.?
☐ Blended Case Management (BCM) ☐ Critical Time Intervention (CTI/Housing)
☐ Psych Rehab (Transitions/Clubhouse) ☐ Dialectical Behavioral Therapy (DBT) Group

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Are you currently on Probation/Parole? ☐ Yes ☐ No

Officer Name: _____

Contact Phone Number _____

Type of Probation/Parole: ☐ County ☐ State ☐ Federal

Are Court Ordered for Treatment Services/Involuntary Outpatient Commitment (IOC)? ☐ Yes ☐ No

Next Court Date: _____

If yes, please check: ☐ Mental Health Evaluation ☐ Anger Management ☐ Retail Theft
☐ Domestic Violence ☐ Sex Offender ☐ IOC

Sentencing Sheet Showing Court Order **Must Be** Provided Prior To Scheduling Initial Intake.

Please note that Human Services Inc. does not participate/testify in court proceedings

Are you involved with Children and Youth Services? ☐ Yes ☐ No

County/State: _____

Caseworker Name & Phone Number: _____

Are you involved with Family Based Services, Wraparound Services or a Partial Hospital Program (PHP) with another agency?

☐ Yes ☐ No

Please Specify: _____

Any MEDICAL concerns or diagnosis, unrelated to Mental Health? ☐ Yes ☐ No

Please Specify: _____

_____

What concerns do you want to address while at Human Services, Inc.? RESPONSE REQUIRED

_____

_____

Please know that we take many factors into scheduling our clients to best fit their needs.
We cannot guarantee that all requests can be met.

Please check your preferences:			☐No Preference
Office:	☐ Thorndale	☐ Oxford	☐ Brandywine
Time of Day:	☐ Morning/Afternoon	☐ Evening (After 5pm)	
Therapist:	☐ Male	☐ Female	
Language:	☐ English	☐ Spanish	☐ Other

If Other, Please Specify: _____

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IF NOT BEING REFERRED BY HOSPITAL/INPATIENT FACILITY, PLEASE CONTINUE TO PAGE 5

Referral Information:
Transfer of Care from Hospital/Inpatient Facility

Client Name: _____ **DOB:** _____

Name of Facility: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

Date admitted: _____ **Discharge Date:** _____

BH/MH Diagnosis(s): _____

Medical Diagnosis(s): _____

Medications being discharged on: _____

Name	Dosing Instructions	Qty given

Please Email/Fax Copy of any Psych Evaluations performed while in your care

This form MUST be fully completed and submitted with completed referral form. Intake appointments will not be scheduled without this information.

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Informed Consent to treat via Telephone or Video during CoVid-19 Restrictions

Human Services, Inc, under the guidance of OMSHAS, is temporarily conducting Outpatient Services via telephone and/or video services due to the precautions surrounding the Covid-19 outbreak. If you choose, you will be scheduled to complete your Intake appointment via telephone or video chat. If you prefer to not participate in this method, you will be scheduled for an Intake appointment after the restrictions are lifted.

If you are interested in receiving Outpatient Therapy services via telephone or video, please answer the following questions

Preferred Method of Contact:

Telephone Number: _____

And/or

Video Method: ☐ ZOOM ☐ Microsoft Teams ☐ Other

Please List Email: _____

You will also receive New Client Forms that will need to be completed and returned to us prior to Initial Intake appointment. These forms can be mailed, emailed or faxed to you. Please indicate how you would like to receive these and provide us the information to do so.

Delivery Method: ☐ Mail ☐ Email ☐ Fax

Additional specific information will be given with your scheduled Initial Intake appointment time.

By signing this form, you acknowledge that participating in teletherapy is only a temporary measure Once restrictions are lifted, you agree to continue Outpatient services in our offices as scheduled.

Print Name: _____ **Signature:** _____ **Date:** _____

I decline tele/video therapy at this time. I am requesting my Outpatient Services Intake appointment be scheduled after restrictions are lifted.

Print Name: _____ **Signature:** _____ **Date:** _____

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Fiscal Forms Consent Acknowledgement for
Receiving Mental Health Services at Human Services, Inc.

By signing this form, I (print name) _____, acknowledge that I am requesting mental health services for myself or for _____ (as his/her legal guardian) at Human Services, Inc.

By checking and signing below, you as the consumer are agreeing that you have read/understand and been given copies of the following documents:

- ☐ I have read and understand the agency's Complaint/Information Form.
- ☐ I have read and understood the agency's Individual Responsibility for Outpatient Services Form.
- ☐ I have read and understand the agency's notice of Individual Financial Responsibility Form.
- ☐ I have read and understand the agency's Civil Rights Compliance Form.
- ☐ I have read and understand agency's Freedom of Choice Notification. I agree that I have entered into treatment voluntarily and have the choice to obtain mental health services from any provider that I choose. I understand that I have input into the development of my treatment plan.
- ☐ I have read and understood the agency? S Notice of Privacy Practices.
- ☐ I have been provided copies of Mental Health Emergency Numbers.
- ☐ I have read and understood the agency's Limited English Proficiency Policy.
- ☐ I have read and understood the agency's Bill of Rights.
- ☐ I have read and understood the agency's Nondiscrimination of Services.
- ☐ I have been provided copies of the Behavioral/Physical Health Resources-Chester County.

I understand that there will be an evaluation process to determine what mental health services will be recommended for me (or for my ward). I understand that I have input into the development of the services plan concerning what services I will receive.

Signature: _____ DOB: _____ Today's Date: _____

☐ **Please check if signing as parent/legal guardian/Power of Attorney.**
Proper documentation must be submitted

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Human Services, Inc.
Voter's Registration Questionnaire

Last Name: _____ **First Name:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ Yes
☐ Yes, but I would like to take the form with me and apply later.
☐ No, I am already registered to vote where I live.
☐ No
☐ I do not wish to check a box. IF YOU DECIDE NOT TO CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you apply to register to vote, the office at which you submit this registration application form will remain confidential. No information relating to preference to register to vote will be used for any purpose other than for voter registration. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

In order to be qualified to register to vote, you must be at least 18 years of age on the day of the next election, you must have be a citizen of the United States for at least one (1) month prior to the next election and have resided in Pennsylvania and the election district where you plan to vote for at least 30 days prior to the next election, and you must not have been confined to a penal institute for a conviction of a felony within the last five (5) years.

If you believe that someone has interfered with your right to register or your application to register to vote, or your right to right to choose your own party preference, you may file a complaint with the Secretary of the Commonwealth, Pennsylvania Department of State, 302 North Office Building, Harrisburg, Pennsylvania 17120 or call the Department of State, toll-free at 1-877-VOTESPA (1-877-868-3772).

Signature: _____ **DOB:** _____ **Today's Date:** _____

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Human Services, Inc.

PLEASE INCLUDE A COPY OF THE FOLLOWING:

ID/DRIVER'S LICENSE

ALL INSURANCE CARDS (FRONT & BACK)

IN-PERSON OR VIA EMAIL AT:

INTAKE@HUMANSERVICESINC.ORG

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INFORMED CONSENT FOR TREATMENT AND INDIVIDUAL RESPONSIBILITY FOR OUTPATIENT SERVICES

I hereby attest that I have voluntarily given my consent for treatment/services or the treatment/services of the minor or person under my legal guardianship mentioned above, to receive services at Human Services, Inc. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the services may be discontinued at any time by either party, however Human Services, Inc. encourages that this decision be discussed with the treating clinician/prescriber in order to facilitate a more appropriate plan for discharge. I understand that there will be an evaluation process in order to recommend the most appropriate mental health services for my recovery or the minor or person under my legal guardianship. I understand that I am an active member of my treatment team and therefore have a partnership in the treatment process.

I further understand that there are Individual responsibilities I must follow in order to continue to receive services, which are outlined below:

If you must cancel an appointment with your therapist or doctor, we ask that you call at least 24 hours prior to your scheduled appointment time. Failure to do so will constitute as "failed appointment".

PLEASE REVIEW THE FOLLOWING APPOINTMENT POLICY so that you are aware of the circumstances under which Human Services, Inc. would close your case due to failed or cancelled appointments.

- If you fail an appointment and do not respond to a therapist's outreach phone call or letter within the requested time frame.
- If you demonstrate a pattern of failed or cancelled appointments, your therapist will discuss this with you, review this policy with you, and will inform you if your case is at risk of being closed.
- If you have not been active in any outpatient services for over 90 days, then your case will be closed.
- If you fail your scheduled Psychiatric Evaluation, you will not be rescheduled until you meet with your therapist for a minimum of two sessions. There may be delays with obtaining a rescheduled appointment with the prescriber. If you fail a second Psychiatric Evaluation, then you will NOT be rescheduled.
- Failure to follow through with a Medical Assistance application or failure to pay your assessed fee will result in case closure or in services being suspended until these obligations are met.
- Noncompliance with the prescriber's treatment recommendations or misuse of medication may also result in case closure.

Human Services, Inc.

Other factors that may result in closure from the agency:

- Person served indicates they are moving out of the area suddenly.
- Person served decides to get service from another provider.
- Person served leaves Against Medical Advice (AMA).
- Person served is requesting medications or services that are not appropriate for their symptoms, diagnosis, or treatment.
- Persons served are misusing/abusing/selling medication (see also Benzodiazepine policy)
    - If you are taking Opiate pain medication(s), we will not prescribe any Benzodiazepines but will work with you to safely taper off of these medications.
    - If a prescriber does not feel there is sufficient medical necessity for Stimulants they will not be prescribed and clients will work with the prescriber to develop an appropriate tapering plan.
    - If the Prescriber has concerns about any of the medications you may be prescribed they have the right to request a urine screening (UDS) or an oral swab before providing any Controlled Substances. A routine UDS/swab may also be required for ongoing prescriptions. If a client refuses to complete a UDS/swab at the request of the provider, the Prescriber has the right to discontinue prescribing medications and may initiate discharge from the agency (see discharge policy). Clients are allowed to request a second opinion from our facility but the policy remains in effect for that prescriber as well. If a client refuses and the prescribers recommend discharge from the agency, staff will offer resources and support to locate another provider and will prescribe the medically appropriate medications within our policy until client can be transferred or no longer needs supports/services from the agency.

If your case is closed or if your therapist sends a letter to you forewarning of potential closure, you will be provided with a list of other Mental Health Providers in Chester County that you may contact if you wish to pursue services elsewhere.

Human Services Inc. is committed to providing quality services to all individuals who seek treatment with the agency. In order to best serve you, we ask for your involvement and commitment to your treatment and recovery. As a best practice, Human Services, Inc. does not provide Medication Management as a stand-alone service unless the client has successfully completed treatment and it is the recommendation of the entire treatment team. Client must be active in meeting the goals of their recovery plan in order to remain on medication management and can be required to re-engage in services at any time should the team, including you, feel that services would be beneficial.

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Following your intake, you will be given an appointment to meet with your therapist. When you meet with your therapist, you will work together to write your goals for your recovery. This treatment plan is your stated commitment to participate in treatment. Your active participation in therapy is a stepping stone to your recovery. Scheduling an evaluation with a prescriber for possible medication services will be addressed at your first therapy appointment. It is very important that you keep your scheduled appointment times with your therapist and prescriber, especially if you are receiving medications, as missed appointments could result in a delay in receiving prescriptions. Without your investment in therapy, Human Services Inc. will not be able to continue to serve you.

Human Services, Inc.

FINACIAL RESPONSIBILITY FORM

Welcome to Human Services, Inc.! Knowing that you have a choice regarding a provider, we are grateful that you chose Human Services Inc. to provide your counseling services. Hopefully we will meet and exceed your expectations for your recovery. If is our privilege to serve those in our care.

Please read and sign this form to acknowledge your understanding of your individual financial responsibility for services.

FINANCIAL RESPONSIBILITIES:

1. You (or your guardian) are ultimately responsible to insure payment is made at the time of service.
2. Human Services, Inc. will bill your insurance, however, you are responsible to know your insurance policy coverage and benefits. You are responsible to provide the correct and most current insurance information to the receptionist and/or billing department.
3. Payment of copays, coinsurance, deductibles, liability, and any treatment not covered by your insurance plan is your (or guardian's) responsibility.
4. Copay's are due at the time of service
5. Coinsurance, deductibles, and non-covered services are due 30 days from the receipt of billing statement.
6. If payment is returned by bank you are responsible for additional bank charge of $35.00
7. Individuals receiving County funding will be required to provide all required documents for liability determination in order to receive this funding. This information can be requested annually, or if a change of income or insurance has occurred.
8. Liability amounts apply to the following services: Outpatient, Blended Case Management, Resource Coordination, Transitions, and Clubhouse
9. It is the policy of Human Services Inc. that staff are not to testify or provide assessments for custody cases, legal cases, law suits, sentencing hearings, or any other information that may be in conflict with our confidentiality as it relates to the client. If a staff is compelled by a Judge to testify then the client will be issued a bill to include travel, staff fees (per agency hourly rate), and any legal fees incurred in response to any subpoena received.

I have read the above policy regarding my financial responsibility to Human Services, Inc. I understand that services will be submitted to my insurance carrier for payment, any unpaid balance will become my (or my guardian's) responsibility.

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CIVIL RIGHTS COMPLIANCE CLIENT AWARENESS

In accordance with applicable Federal and State Civil Rights Laws and regulatory requirements, you as a client of this agency have the right:

1) To be provided services at this agency and to be referred for services at other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, limited English proficiency (LEP), age or actual/perceived gender identity, gender expression, or sexual orientation.

2) To file a complaint of discrimination if you feel you have been discriminated against on the basis of you race, color, religious creed, disability, ancestry, national origin, limited English proficiency (LEP), age or sex.

Written complaints of discrimination may be filed with any of the following:

Elizabeth Higgins, President/CEO
Human Services, Inc.
50 James Buchanan Drive
Thorndale, PA 19372

American with Disabilities Act
Director, Governor's Office
Room 238 Main Capital
Harrisburg, PS 17120

Department of Public Welfare
Bureau of Equal Opportunity
Room 225, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

U.S. Department of Health & Human Services
Office of Civil Rights
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106

PA Human Relation Commission
Philadelphia Regional Office
110 North 8th Street, Suite 501
Philadelphia, PA 19107

You will not be penalized for submitting complaints to any of the above listed agencies.

Human Services, Inc.

FREEDOM OF CHOICE

There are several Public Mental Health agencies in Chester County which provide a range of Mental Health Services. As a resident of Chester County, you have the freedom to choose the provider from whom you will receive your services.

Individuals are entitled to obtain mental health services from the provider agency of their choice. No provider agency is to restrict the freedom of choice of the individual or parent (if child is under 14 years of age) of needed services at agencies where the needed services are available.

Below is a partial list of agencies, aside from Human Services, Inc that provide mental health services (OUTPATIENT AND CASE MANAGEMENT) in the area:

Creative Health Services
11 Robinson Street
Pottstown, PA 19464
610-326-2767

Holcomb Behavioral Health
835 Springdale Drive Suite 100
Exton, PA 19341
(610) 363-1488

Fellowship Health Resources
723 Wheatland Street, Suite 1A
Phoenixville, PA 19460
610-415-9301

Holcomb Behavioral Health
920 E. Baltimore Pike, Suite 20
Kennett Square, PA 19348
(610)388-7400 (Adults & Children)

Community Services of Devereux
1041 West Bridge Street
Phoenixville, PA 19460
610-933-8110
(Children's services)

Creative Health
701 S. Main Street
Phoenixville, PA 19460
610-933-8880
(Substance abuse services)

Child Guidance Resource Center
744 E. Lancaster Ave. Suite 420
Coatesville, PA 19320
(484) 454-8735 (Children)

Community Services of Devereaux
1041 West Bridge Street Suites 1 and 2
Phoenixville, PA 19460
(610) 933-8110 (Children)

You may contact the Chester County Office of Mental Health for further information about additional area services.

Chester County: 610-344-6265

Crisis Services in Chester County: 610-280-3270 or 610-918-2100 or 877-918-2100

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to you.

- Get an electronic or paper copy of your medical record
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you (Ask us for the request form and assistance)
  - We will provide you with a copy if requested per our Records/Release policy.
  - The request will usually be completed within 30 days after form submission.
  - We do charge for copies and invoices must be paid prior to release of information, unless being sent directly to Social Security or another provider.
- Ask us to correct your medical record
  - You can ask us to correct health information about you that you think is incorrect or incomplete.
  - We may say no to your request, but we will notify you within 60 days the reason why and make a note of the information change you requested.
- Request confidential communications
  - You can asks us to contact you in a specific way (ie: home phone, office phone, cell phone, portal) or to send mail to a different address
  - We will accommodate all reasonable requests
- Ask us to limit what we use or share
  - You can ask us not to use or share certain health information for treatment, payment, or our operations
  - We are not required to agree to your request, and we may say no if it could affect your care.
  - If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurance.
  - We will say yes to requests unless a law requires us to share that information.
- Get a list of those with whom we've shared information
  - You can ask for a list of the times we've shared your health information for six years prior to the date you ask. We can provide who we shared it with and why.
  - We will include all disclosures except for those about treatment, payment and healthcare operations, and other certain disclosures (such as any you asked us to make)

Human Services, Inc.

  - We will provide one accounting year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice.
  - You can ask for a paper copy of this notice at any time.
  - If you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.
- Choose someone else to act for you
  - If you have given someone power of attorney or if someone is your legal guardian, that person can exercise you rights and make choices about your health information.
  - We will make sure the person has the authority and can act for you before we take any action
- File a complaint if you feel your rights are violated
  - You can complain if you feel we have violated your rights by contacting us using the information on the provided
  - You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave. S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
  - We will not retaliate against you for filing a complaint.

YOUR CHOICES: For health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

- In these cases you have both the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - If you are not able to tell us your preference, for example if you are unconscious, we go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety.
- In these cases we *never* share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes.

OUR USES AND DISCLOSURES: How else can we use or share your health information? We are allowed for required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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- Help with public health and safety issues: We can share health information about you for certain situations.
  - Preventing diseases
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a threat to anyone's health or safety
- Do Research: we can use or share your information for health research
- Comply with the law:
  - We will share information about you if state or federal laws require it
  - We will share with the Department of Health and Human Services if it wants to see that were are complying with the federal privacy laws.
- We will share health information to work with the coroner, medical examiner, or funeral director when an individual is deceased
- We can use or share health information about you to address the following requests:
  - Worker's compensation
  - Law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services.
  - Other government requests as required
- Respond to lawsuits or legal actions
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena
  - We will never share any substance abuse treatment records without your written permission
  - We will never share nay HIV information without your written permission.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing.
  - If you tell us we can, you may change your mind at any time.
  - If you change your mind, you must let us know in writing.
- Changes to the terms of this notice
  - We can change the terms of this notice and changes will apply to all information we have about you

Human Services, Inc.

  - The new notice will be available upon request in all of our office sites
- For more information or to report a problem: If you have any questions or would like additional information, you may contact the agency's privacy officer Adam Brandt at 610-873-1010 ext 130 or visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Information on Advanced Directive in Pennsylvania

A Psychiatric Advance Directive (PAD) is a legal document that documents a person's preferences for future mental health treatment, and allows appointments of a health proxy to interpret those preferences during a crisis. PAD's may be drafted when a person is well enough to consider preferences for future mental health treatment. PAD's are used when a person becomes unable to make decisions during a mental health crisis.

If you would like additional information on obtaining an advanced directive you can find the forms as well as the Pennsylvania Statues using the lists listed below.

Pennsylvania Forms: A Mental Health Care Declaration Form; A Mental Health Power of Attorney Form, A combined Mental Health Declaration and Power of Attorney Form

https://www.nrc-pad.org/states/pennsylvania-forms/

Pennsylvania Statutes Title 20

https://www.nrc-pad.org/images/stories/PDFs/pennsylvaniaj.pdf

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MENTAL HEALTH EMERGENCY NUMBERS

If you find the safety of yourself or others is at risk due to a Mental Health emergency, you are advised to take the following steps:

- At any time if there is an **immediate** threat to safety, **CALL 911** for assistance.
- During office hours, call your therapist or case manager. If your therapist or case manager is not available, ask the front desk staff to connect you to a Supervisor.
- After office hours contact ***Valley Creek Crisis at (610) 280-3270 or The Consumer-Run Warm Line:* 1-866-846-2722**

HUMAN SERVICES INC's OFFICE LOCATIONS

Thorndale Office
Main Office
50 James Buchanan Dr Thorndale Pa 19372
610-873-1010

Brandywine Office
Huston Center
255 Reeceville Rd Coatesville Pa 19320
610-380-9982

Oxford Office
2217 Baltimore Pike Oxford Pa 19363
610-998-1807

Human Services, Inc.

BILL OF RIGHTS

YOU HAVE A RIGHT TO BE TREATED WITH DIGNITY AND RESPECT

YOU SHALL RETAIN ALL CIVIL RIGHTS THAT HAVE NOT BEEN SPECIFICALLY CURTAILED BY ORDER OF COURT

1. You have the right to unrestricted and private communication inside and outside this facility including the following rights:

a. To a peaceful assembly and to join with other patients to organize a body of or participate in patient government when patient government has been determined to be feasible by the facility.

b. To be assisted by any advocate of your choice in the assertion of your rights and to see a lawyer in private at any time.

c. To make complaints and to have your complaints heard and adjudicated promptly.

d. To receive visitors of your own choice at reasonable hours unless your treatment team has determined in advance that a visitor or visitors would seriously interfere with your or others' treatment or welfare.

e. To receive and send unopened letters and to have outgoing letters stamped and mailed. Incoming mail may be examined for good reason in your presence for contraband. Contraband means specific property which entails a threat to your health and welfare or to the hospital community.

f. To have access to telephone designated for patient use.

2. You have the right to practice the religion of your choice or to abstain from religious practices.

3. You have the right to keep and to use personal possessions, unless it has been determined that specific personal property is contraband. The reasons for imposing any limitation and its scope must be clearly defined, recorded and explained to you. You have the right to sell any personal article you made and keep the proceeds from its sale.

4. You have the right to handle your personal affairs including making contracts, holding a driver's license or professional license, marrying, or obtaining a divorce and writing a will.

5. You have the right to participate in the development and review of your treatment plan.

6. You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish the treatment goals.

7. You have the right to be discharged from the facility as soon as you no longer need care and treatment.

8. You have the right not to be subjected to any harsh or unusual treatment.

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Human Services, Inc.

9. If you have been involuntarily committed in accordance with civil court proceedings, and you are not receiving treatment, and you are not dangerous to yourself or others, and you can survive safely in the community, you have the right to be discharged from the facility.

10. You have a right to be paid for any work you do which benefits the operation and maintenance of the facility in accordance with existing Federal wage and hour regulations.

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Human Services, Inc.

SUBJECT: Nondiscrimination in Services

TO: Persons Receiving Services

FROM: Elizabeth Higgins, MSW, LCSW, ACSW, CCTP
President/CEO

Admissions, to the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or actual or perceived sexual orientation, actual or perceived gender identify, and/or actual or perceived gender expression.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

Human Services, Inc.
50 James Buchanan Drive
Thorndale, PA 19372

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

PA Human Relations Commission
Philadelphia Regional Office
110 N. 8th Street
Suite 501
Philadelphia, PA. 19107

U.S. Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA. 19106-911

Commonwealth of Pennsylvania
DHS Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA. 19107

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POLICY AND PROCEDURES FOR COMMUNICATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY

POLICY:

Human Services, Inc. will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of *Human Services, Inc.* is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, consent to treatment forms, Civils Rights Compliance, freedom of choice, individual responsibility form, privacy practices, emergency information, and financial and insurance benefit forms, All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

Human Services, Inc. will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

Human Services, Inc. will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTEPRETER

Supervisors is/are responsible for:

(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff

(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language.

Human Services, Inc.

Chester County
Behavioral / Physical Health Resources

Advocacy Resources
Chester County NAMI Referral Helpline
610.430.0177

NAMI Keystone Pennsylvania
888.264.7972 / info@namikeystonepa.org

Pennsylvania Mental Health Consumers' Association
4105 Derry Street, Harrisburg, PA 17111
1.800.887.6422

Chester County Assistance Office
100 James Buchanan Drive, Thorndale, PA 19372
610.466.1000 / 610.466.1022 / 1.888.814.4698

Chester County Drug and Alcohol Program
610 Westtown Road, Suite 325, West Chester, PA 19380
610.344.6620 / 1.800.692.1100 ext. 6620 610.344.5233 (TTY)

Chester County HealthChoices Management
Chester County Department of Human Services
601 Westtown Road, Suite 325, West Chester, PA 19380
610.344.6620 / 1.800.692.1100 ext. 6640

Chester County MH/IDD Program
601 Westtown Road, Suite 325, West Chester, PA 19380
610.344.6625

Community Care
Autism Line: 1.866.415.1708
Customer Service: 1.866.622.4228
TTY/TDD (Dial 711): Request 1.833.545.9191
En español: 1.866.229.3187
Provider Services: 1.888.251.2224

Consumer/Family Satisfaction Team
1.800.734.5665

Crisis Services
610.918.2100 / 1.877.918.2100
Warm Line: 1.866.846.2722

Domestic Violence
Crime Victims Center
610.692.7420 / 610.738.8450 (TTY)
Domestic Violence Center
1.888.711.6270 / 610.431.7262 (TTY)

Legal
Pennsylvania Health Law Project
1.800.274.3258 / 1.866.236.6310 (TTY) staff@phlp.org
Disability Rights Pennsylvania
301 Chestnut Street, Suite 300, Harrisburg, PA 17101
1.800.692.7443 / 877.375.7139 (TTY)
drnpa-hgb@drnpa.org

Medical Assistance Transportation Program
Krapf Bus Company: Paratransit Division
610.594.6930 / 1.877.873.8415

PA Enrollment Services
1.800.440.3989 / 1.800.618.4225 (TTY)
www.enrollnow.net

Physical Health Plans
Aetna Better Health
Member Services: 1.866.638.1232
PA Relay: 711

Health Partners Plans
Member Services: 1.800.553.0784
Special Needs: 1.215.991.4370
TTY: 1.877.454.8477

Keystone First
Member Hotline: 1.800.521.6860
Care Coordination, Special Needs Unit: 1.800.573.4100
TTY: 1.800.684.5505

UnitedHealthcare Community Plan
Member Services: 1.800.414.9025
Special Needs: 1.877.844.8844
TTY: 1.888.616.0021

Smoking Cessation
PA Free Quitline: 1.800.784.8669

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Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, each unit in *Human Services, Inc.* will submit documents for translation into frequently-encountered languages to their Supervisor. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) *Human Services, Inc.* will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

Human Services, Inc. will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including the waiting area in each Outpatient Clinic.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, *Human Services, Inc.* will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, *Human Services, Inc.* will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from clients and community organizations.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 610-873-1010.

Spanish
ATENCIÓN: Si usted habla español, los servicios de ayuda de idioma, sin ningún costo, están disponibles para usted. Llamar al 610-873-1010.

Russian
ВНИМАНИЕ: Если Вы говорите на русском языке, Вам предлагаются бесплатные переводческие услуги. Позвоните по номеру 610-873-1010 (телетайп: 610-873-1010

Chinese (Simplified/Mandarin)
注意：如果您讲中文，可向您免费提供语言协助服务。致电 610-873-1010.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 610-873-1010

Arabic
E
ضY مت E٥ ٥Y مح E أغوي ∆ عد Y مس ZY فئهه تـوجد خدم ، E٥ B
أغر ☐ E ألغ ☐ تتطدث H لـو ☐ ه: إذ Γ أك إهت.
:TTY غد B عن E٥ أوص ☐ EBY أمت ☐* [phone number] إتـصا على
ج 610-873-1010

Nepali
ध्यान दिनहोसु :तपाईं नेपाली भाषा बोल्नुधछ भने तपाईं ननिःशल्क भाषा सहायता सेवा प्राधौत ुहु गनन सक्नाधछ 610-873-1010 मा टललफोन गनहोस् ुोुन
llin

Korean
비고: 한국어를 사용하시고 언어 도움 서비스가 필요하시다면 무료로 사용하실 수 있습니다. 610-873-1010

Cambodian (Khmer)
ឈរ្ររួចងចាំ៖ ប ើ ើោកអ្ុំកចិយាយភាសាៀមយរ ើបរាកម្ុៀ

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ជាំōូយមŎōកភាសាេិោយតរគិរៀលž៉កីមាōōដŽ់ដូōេិោកអ្Ŏក។
េិ ូេិមំទូេិរែញើកាō់បŽម 610-873-1010

French
ATTENTION: si vous parlez Français, vous pouvez bénéficier gratuitement des services d' assistance linguistique. Appelez le 610-873-1010

Haitian Creole
ATANSYON: Si you pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 610-873-1010

Portuguese (Brazil)
ATENÇÃO: Caso você fale português do Brasil, você tem serviços assistenciais de idioma gratuitos à sua disposição. Ligue para 610-873-1010

Bengali
মনোযোগ দিন: আপনি যদি বাঙালি ভাষায় কথা বলেন, ভাষা সহায়তা পরিষেবাগুলি বিনামূল্যে আপনার
জন্য উপলব্ধ রয়েছে। 610-873-1010

Albanian
VËMENDJE: Në qoftë se ju flisni shqip, shërbime për asistencën e gjuhës janë në dispozicionin tuaj, pa pagesë. Telefono 610-873-1010

Gujarati
ધ્યાન આપ□: જ□તમેગુ
જરાતી બ□લતા હ□ ત□ ભાષા સહાયતા સેવાઓ તમનેવવના મલ્યે
ઉપલબ્ધ છે. કૉલ કર 610-873-1010

COMPLAINT POLICY:

Human Services, Inc. is committed to quality service provision and achieving a high level of consumer satisfaction. Human Services, Inc. will facilitate positive resolution of complaints by providing a systematic process of review which is reasonable, timely, and thorough, and which protects consumers from retaliation or barriers to service.

DEFINITIONS:

A complaint is a verbal or written expression of concern with the provision of mental health services provided by Human Services, Inc. that the consumer perceives as a problem.

A consumer is a person receiving mental health services, or the parent/guardian of a child under the age of fourteen (14) receiving mental health services.

PROCEDURE:

1. This complaint procedure will be reviewed with the consumer at Intake for any new consumer entering Human Services, Inc. and at least on an annual basis if needed.
2. A copy of Human Services, Inc. complaint policy and procedure will be provided to the consumer at intake. Copies of Chester County Department of Mental Health/Intellectual and Developmental Disabilities (MH/IDD) complaint policy will also be provided. Copies of both policies and procedures will be posted in all waiting rooms.
3. Any consumer, or those helping the consumer, may initiate a complaint orally or in writing, concerning the exercise of their rights or quality of services and treatment at Human Services, Inc. The complaint shall be presented as soon as possible to the program supervisor or program coordinators for review.
4. Every consumer shall have the right to the assistance of an independent person and witness in presenting the complaint. Any consumer, 14 years or older, must provide a signed Release of Information with the provider before the representative can participate in detailed discussion of the complaint.
5. The program supervisor or coordinator receiving the complaint shall investigate the complaint and make every effort to resolve it. Based upon the investigation, a decision shall be rendered in writing as soon as possible, but within 48 hours after the filing of the complaint. Complaints shall be decided by persons not directly involved in the circumstances leading to the complaint.
6. If the consumer remains dissatisfied and wishes to pursue the complaint further, they must contact Chester County MH/IDD or their MCO, to file a formal complaint. The program supervisor or coordinator who has discussed Human Services, Inc's proposed resolution with the consumer will inform the consumer as to whether they should contact Chester County MH/IDD or the Manage Care Organization (Community Care Behavioral Health or another county if applicable) to file a complaint.
7. FORMAL COMPLAINTS for Chester County MH/IDD funded Services:

Human Services, Inc.

a. If a complaint involving a Chester County MH/IDD funded services is not resolved with Human Services, Inc. at the program level, a consumer may contact the MH Complaint Manager at Chester County MH/IDD at 610-344-6265 to lodge a formal complaint. Once the concern is put in writing it will be handled as a formal complaint

b. The formal complaint will follow the MH/IDD complaint process.

8. FORMAL COMPLAINTS for Medical Assistance or HealthChoices funded Services:
   a. If a complaint is about a Medical Assistance or HealthChoices funded services, a consumer may contact the HealthChoices Managed Care Company's Customer Service line at 1-866-622-4228 to register a formal complaint.
   b. The formal complaint will follow the HealthChoices MCO process which can be found in the consumer's member handbook.

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Human Services, Inc.

COMPLAINT FORM

Statement of Principle:

To assure that the rights of all clients are safeguarded and that disputes concerning their rights are resolved promptly and fairly, clients have the right to lodge grievances and appeals when informal methods of resolving disputes are unsuccessful. Every client shall be informed of the grievance and appeals system and shall be encouraged to use it when informal methods of resolving complaints are unsuccessful.

Any client of Human Services, Inc. may initiate a complaint orally or in writing, concerning the exercise of their rights or the quality of services or treatment. Every client has the right to have the assistance of an independent person or witness in making the complaint.

Name of Person Making Complaint: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Name of the individual assisting in completing the complaint: _____

Phone # of individual assisting in completing the complaint: _____

Name of Staff or Program this complaint is about: _____

Describe your complaint (please use as much detail as possible):

What do you believe would be a fair resolution to the complaint (this is not a guarantee that we can meet your resolution but will do everything we can resolve fairly).

Signature of Person with complaint: _____ Date: _____

Signature of Individual helping: _____ Date: _____

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