|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Alameda County**  **Department of Behavioral Health Care Services**  **Mental Health Division** | Beneficiary’s Name: |  | | | |
| Birth Date: |  | Admit Date: | |  |
| ID/Chart #: |  | RU#, if applies: | |  |
| Provider Name: |  | |  | |

**Informing Materials -- Your Rights & Responsibilities**

**Acknowledgement of Receipt**

**Consent for Services**

As described on page one of this packet, your signature below gives your consent to voluntary mental health care services from this provider. If you are a beneficiary’s legal representative, your signature gives that consent.

**Informing Materials**

Your signature also means that the materials marked below were discussed with you in a language or way that you could understand, and that you were given the packet for your records. You may request an explanation and/or copies of the materials again, at any time.

**Initial Notification:** Please mark the boxes below to show which materials were discussed with you at admission or any other time.

* Consent for Services
* Freedom of Choice
* “Guide to Medi-Cal Mental Health Services” (copy available upon request)
* Member Handbook for Alameda County Medi-Cal Recipients Needing Behavioral Health Services (maroon pamphlet - copy available upon request)
* Provider List for Alameda County Behavioral Health Plan (copy available upon request)
* Confidentiality & Privacy
* Advance Directive Information (for age 18+ & when client turns 18)

*Have you ever created an Advance Directive? 􀂅Yes 􀂅No*

*If yes, may we have a copy for our records? 􀂅Yes 􀂅No**If no, may we support you to create one? 􀂅Yes 􀂅No*

* Beneficiary Problem Resolution Information
* Maintaining a Welcoming & Safe Place (not a State-required informing material)
* Notice of Privacy Practices (HIPAA document)

|  |  |
| --- | --- |
| Beneficiary Signature:  (or legal representative, if applicable) | Date: |
| Clinician/Staff Witness Initials: | Date: |

**Annual Notification:** Your provider must remind you each year that the materials listed above are available for your review. Please put your initials and the date in a box below to show when that happens.

|  |  |  |  |
| --- | --- | --- | --- |
| Initials & date: | Initials & date: | Initials & date: | Initials & date: |

Use one box every year (see above) for the ***beneficiary’s*** initials & date (or their legal representative).

***Provider Directions:***

* *Initial Notification: Discuss each relevant item in the packet with the beneficiary (or legal representative) in their preferred language or method of communication. Complete the identifying information box at the top right of this page. Mark the relevant checkboxes to indicate the items discussed/provided. Ask the beneficiary to sign & date in the appropriate box. Provide staff initials & date in the appropriate box. Give the remaining informing materials packet to the beneficiary for their records. File this signature page in the chart.*
* *Annual Notifications: Remind beneficiaries of the availability of all materials for their review, and review any materials, if requested. Obtain the appropriate dated initials in the boxes provided.*

***(The packet in all threshold languages & a detailed instruction sheet are available at*** [***www.acbhcs.org/providers***](http://www.acbhcs.org/providers)***, in the QA tab.)***