Consent to Participate in Services

IDENTIFYING INFORMATION				
NAME	DOB		CASE #	GENDER
ADDRESS				

DATE

TREATMENT AND PARTICIPATION

I/ my ward/ my child agrees to participate in the services/treatment offered by LifeWays. The services may be provided by LifeWays or LifeWays' provider network. I understand that I will be asked to consent to a treatment plan based on my needs. My treatment plan (we also call this an Individual Plan of Service) will be written by my treatment team, and, if I want, will include input from my family, and/or other support professionals who take part in my care.

I understand that additional consents may be necessary for certain treatment options such as psychotropic medications

I understand that all services/treatments will be explained to my satisfaction including their purpose, risks, benefits, and any appropriate alternatives.

RECEIPT

The following items have been explained to me and I have received a copy of the following:

- Welcome to LifeWays Letter
- Your Rights Booklet
- LifeWays Guide To Services
- LifeWays Notice of Privacy Practices
- Information on Grievances, Appeals, and Second Opinions
- Michigan Advance Directive for Mental Health Care Brochure
- 2-1-1 Brochure
- LifeWays Community Mental Health Services Brochure
- Consumer Responsibilities

NOTIFICATION

I understand that LifeWays or LifeWays' Provider Network are required to coordinate my treatment with medical providers who care for my physical health, specifically my primary care provider.

I understand that when a LifeWays or LifeWays' Provider Network employee/provider has been accidentally exposed to my blood and/ or bodily fluids my/ my ward's/ my child's blood may be tested for Hepatitis B and HIV (Aids Virus). I will be told of any positive results unless I/ my ward/ my child cannot be found when the results are received. (in accordance with Michigan Law; PA 488 and LifeWays policy)

I understand that LifeWays or LifeWays' Provider Network is authorized to release non-identifying information on any reportable communicable disease, infection, and/or condition to the Michigan Department of Health and Human Services in accordance with the Michigan Mental Health Code Public Act 258 of 1974, Section 748, Rule 330.1748 Confidentiality.

FOLLOW-UP

I understand LifeWays or LifeWays' Provider Network may contact me for purposes of obtaining follow up information concerning my satisfaction and progress since receiving services. This information is used internally for quality improvement purposes and to determine if services have been effective. All information is protected by LifeWays or LifeWays' Provider Network and its representatives to ensure confidentiality.

VALID

I understand that I may withdraw my consent and participation at any time without penalty.

I understand that I may revoke at any time except to the extent that action has been taken in reliance on it.

This consent shall no longer be valid one year from the date of this form. Any forms signed after the date on this form shall replace this form and be considered the most current consent.

Upon request, I may receive a copy of this consent

SIGNATURES

My signature acknowledges my understanding that I am agreeing to participate in services at LifeWays and/or one of LifeWays network provider agencies.

SIGNATURES

STAFF SIGNATURE / CREDENTIALS

DATE

CONSUMER / PARENT / GUARDIAN SIGNATURE

PRINTED NAME

DATE

LFWLFWCFP000000000

Note: A new consent form must be obtained if: legally competent minor reaches his/her 18th birthday; or c) change of guardianship status.

*Witness is responsible to, in good faith, assure that if the consumer signs, she/he was competent to give informed consent (R330.7003) (R300.6013) (a)-(c) Michigan Department of Community Health emergency rules, or if guardian signed, documentation is on file indicating that the court has empowered the guardian with the authority. If the witness does not feel the consumer is competent, refer to R330.6011 (3)-(4)

Testing for HBV/HIV without consent would not be for routine testing, rather for testing after unexpected staff contact with bodily fluid. 333.5133.10b “The HIV test is performed after a health professional, health facility employee, police officer, or fire fighter, or a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic licensed under section 20950 or 20952 sustains in the health facility, while treating the patient before transport to the health facility, or while transporting the patient to the health facility, a percutaneous, mucous membrane, or open wound exposure to the blood or other body fluids of the patient.”

Tele-mental Health Informed Consent

I, _____, hereby consent to participate in tele-mental health with, _____, as part of my treatment. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to tele-mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate, and a higher level of care required.
6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to reschedule.
7) I understand that my clinician/staff may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my clinician/staff. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of clinician/staff Date:

Recovery Technology 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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and

conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As social workers licensed in this state and as a members of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Recipients Rights Officer.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Recipient Rights Officer at (517) 796-4520

We will not retaliate against you for filing a complaint.

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name_____ Case #_____Date_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Recovery Technology's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Recipient Rights Officer Andra Antczak at (517) 796-4520.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Personal Representative: _____ Date: _____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

☐ Client/Patient Refuses to Acknowledge Receipt

Signature of Staff Person: _____ Date: _____

Consent to Share Behavioral Health Information

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout the form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

SECTION 1: ABOUT YOU

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	DATE SIGNED

SECTION 2: WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

SECTION 2A: SHARING INFORMATION BETWEEN INDIVIDUALS AND ORGANIZATIONS

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

SECTION 2B: SHARING INFORMATION ELECTRONICALLY

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

CHOOSE ONLY ONE OPTION:

- ◯ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a
- ◯ Do not share my information through the organizations listed below.
- ◯ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

- ☐ PCE Systems
- ☐ Michigan Health Information Network

SECTION 3: WHAT INFORMATION YOU WANT TO SHARE

CHOOSE ONE OPTION:

☐ Share **all** of my behavioral health and substance use disorder records. This does not include "psychotherapy notes."

☐ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

SECTION 4: YOUR CONSENT AND SIGNATURE

Read the statements below, then sign and date the form.

By signing this form, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.
- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it after the event or condition listed below. (For example, at the end of my treatment.)

Date, event, or condition:

CONSUMER SIGNATURE	PRINTED NAME	DATE
PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE SIGNATURE	PRINTED NAME	DATE
WITNESS SIGNATURE	PRINTED NAME	DATE

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

SECTION 5: WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self
☐ Parent (Print Name)
☐ Guardian (Print Name)
☐ Authorized Representative (Print Name)

SIGNATURE _____ DATE _____

WITNESS SIGNATURE (IF APPROPRIATE) _____ DATE _____

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

VERBAL WITHDRAW OF CONSENT

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed in Section 1
☐ Parent (Print Name)
☐ Guardian (Print Name)
☐ Authorized Representative (Print Name)

SIGNATURE OF PERSON RECEIVING VERBAL WITHDRAW OF CONSENT _____ DATE _____

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent

Additional Identifiers (Optional)

MEDICAID LAST 4 OF THE SOCIAL SECURITY NUMBER CASE #

Form Copy (Optional, Choose One Option)

☐ The individual in Section 1 **received** a copy of this form.
☐ The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services (MDHHS) as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MDHHS-5515 (12-18) Previous edition obsolete.

HENRY FORD HEALTH℠

AUTHORIZATION TO ACCESS or RELEASE MEDICAL INFORMATION

COGNITIVE PATIENT LABEL

Questions: Contact Medical Records: 313.916.4540
Please mail completed form to: Medical Records 1414 E. Maple Road, Troy, MI 48083 (**Mailing Address ONLY)**
or Medical Records email address: HFHSMedicalRecords@hfhs.org • fax number 313.916.3917
(Please keep in mind that emails sent over the internet may not be secure.)

Patient Information (please print)

Name (First, Middle, Last)		Maiden name or previous names	
Address	City	State	Zip Code
Date of Birth	Phone	E-mail Address if Applicable	

I authorize my records to be sent from:

Henry Ford Health:

- ☐ HF Jackson
- ☐ HF Jackson Specialty Hospital
- ☐ HF Behavioral Health
- ☐ HF Hospital Detroit
- ☐ HF Kingswood Hospital
- ☐ HF Macomb Hospital
- ☐ HF Maplegrove Center
- ☐ HF West Bloomfield Hospital
- ☐ HF Wyandotte Hospital
- ☐ HF Other (Clinic/Medical Center): _____

Other Facility:

Name/Organization			
Address	City	State	Zip Code

I authorize my records to be released to:

Myself: (Select only one option)

- ☐ MyChart patient portal (patient request)
- ☐ E-mail to me at address above
- ☐ Mailed to me at address above
- ☐ On site inspection. (Authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.)
- ☒ Mailed to address below
- ☒ Faxed to number below

Other: Disclose to - complete information below

Name/Organization Recovery Technology			
Address 1200 N. West Ave., Suite 400	City Jackson	State MI	Zip Code 49202
Phone Number 517-780-3336	Fax Number 517-796-4561		

Please complete below if you want to include medical records for these services:

☐ Substance Use Disorder diagnosis and treatment

Purpose: ☐ Continuation of Care ☐ Legal ☐ Personal ☐ Other _____

☐ Psychotherapy Notes

Specific Information Requested:

	Type of Record requested	Date of Service		Type of Record Requested	Date of Service
	Discharge Summary			Outpatient Record	
	Emergency Department			Radiology Report	
	Laboratory Report			Office Note	
	Immunizations			Other:_____	
	Inpatient Record			_____	

By signing this authorization, I hereby authorize Henry Ford Health System to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. Such notes may contain information on: general medical care, psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), as applicable; communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, as applicable; demographic information; and treatment received by other health care providers. Any alcohol and substance use disorder information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized disclosure of these records. Patient access fee may apply for copies. Fees are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269.

I understand that:

- I may revoke (take back) this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released prior to receiving the revocation. Contact Henry Ford Health System Medical Records department. Contact information is available at the top of the form.
- This authorization expires when the patient information is disclosed as permitted in this authorization, or within one (1) year from the date that it is signed unless another expiration date is written here: _____ _____ (describe the date/event/condition upon which authorization will expire, which must be no longer than one year from the date signed)
- My care or treatment will not be conditioned on signing this authorization
- The person(s) to whom information is disclosed under this authorization may possibly redisclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.
- Henry Ford Health System and/or its copying service reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature_____Relationship (if other than patient) _____

Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA. (if legal guardian, Personal Presentative or person of authority under a durable medical power of attorney, a copy of appropriate documentation may be required)

Date_____ Time_____

LifeWays
Community Mental Health

Authorization to Exchange Information between LifeWays CMH and MDHHS (Michigan Department of Health and Human Services)

Instructions on completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) form:

1. All areas should be complete
2. This form must be signed and dated by the patient or guardian.
3. This form can be faxed to 517-796-4532 or returned to the LifeWays Network Benefits Team

Patient First Name:	Patient Last Name:	Date of Birth:

Patient Address (street, city, zip):

Guardian Name: Check if Not Applicable ☐

This authorization will be valid for a period of ONE YEAR From the signed date, unless a lesser time frame is indicated: Alternative Expiration Date:	Authorized provider, LifeWays Community Mental Health, 1200 N. West Ave, Jackson, MI 49202 to exchange the information identified below to and from: Michigan Department of Health and Human Services

I, or my guardian, request that information regarding federal/state program benefit determination and contact information including- but not limited to- first name, last name, phone number, and address be exchanged to LifeWays Community Mental Health for purpose of any state/federal benefits (cash, food, Medical).

I understand that:

1. Protected health information may include information and records protected under federal and state law such as benefit determination and first name, last name, phone number, and address.
2. My treatment, payment or eligibility of benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to LifeWays, Attn: Customer Services, 1200 N. West Ave. Jackson, MI 49202, except to the extent that LifeWays has taken action in reliance to the authorization.
4. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

_____ _____

Signature of Claimant/Consumer, Guardian or Authorized Representative — Date

_____ _____

Printed Name of Claimant/Consumer, Guardian or Authorized Representative — Date

LifeWays Community Mental Health

Financial Determination

IDENTIFYING INFORMATION

NAME	CASE #	
ADDRESS	DOB	GENDER

FINANCIAL DETERMINATION

FUNDING SOURCE	MEDICAID ID #	MI CHILD ID #

Financial Information

Non Taxable Income

DHS SS SSI/SSDI CHILD SUPPORT OTHER

Total Monthly Income
(can be used to calculate Annual Gross Income) _____

Total Annual Adjusted Gross Income _____

Exemptions:

# of Exemptions Claimed on your Federal Taxes _____ x

# of Individuals 65 or older _____ x

# of Individuals qualifying for special exemptions
deaf, blind, ..or totally and permanently disabled _____ x

# of children ages 18 & under claimed as MI exemptions _____ x

# of qualified disabled veterans _____ x

Unemployment Income
unemployment must be minimum 50% of AGI to qualify _____

Calculated Annual Taxable Income
(amount ATP is calculated from unless "Total Annual Taxable Income" is entered) _____

Total Annual Taxable Income
(Line 16-MI Income Tax-only) _____

Total Annual Income _____

Calculated Total Deduction Amount _____

Monthly Max Charge
(sliding scale) _____

FULL FINANCIAL UTILIZED? ☐ Yes ☐ No	ATP ☐ ATP Not Required	IF SO, REASON
EFFECTIVE FROM	EFFECTIVE THRU	FINANCIAL INFORMATION NEXT REVIEW DATE

Name of Person Responsible to Pay Bill

☐ Check here if the patient is responsible for their own charge (Do not fill out fields below if checked)

PERSON RESPONSIBLE TO PAY BILL NAME	RESPONSIBLE PARTY DOB	RESPONSIBLE PARTY SSN

RESPONSIBLE PARTY ADDRESS

RESPONSIBLE PARTY GENDER ☐ Male ☐ Female ☐ Unknown	CLIENT RELATIONSHIP TO RESPONSIBLE PARTY

NOTES

IDENTIFYING INFORMATION		
NAME	CASE #	
ADDRESS	DOB	GENDER

I understand that if I did not provide my Michigan State Income Tax information for the assessing of an ability to pay , LifeWays may confirm my income with the Michigan Department of Treasury.

I also understand that by willfully refusing to provide the relevant financial information needed to determine my ability to pay, or by providing falsified information, or by refusing to sign the Financial Determination form; I therefore agree to pay the full cost of services less any amount reimbursed by my insurance. I further understand that if I receive insurance checks paid directly to me for services rendered by Lifeways and fail to submit those checks to Lifeways or fail to pay for my services, my balance owed may be submitted to a collection agency.

You have the right to appeal the results of the financial determination within thirty (30) calendar days of the determination date. If you wish to do so, please contact LifeWays Customer Services at (517) 780-3332 or 1-866-630-3690.

SIGNATURES

SIGNATURE/CREDENTIALS _____ DATE _____

Assignment of Benefits: I hereby assign all medical / mental health benefits to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to LifeWays. This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I acknowledge that LifeWays will use my personally identifiable information in daily operations pertaining to treatment and administration, including claims to third party as outlined in the Notice of Privacy Practices.

RECOVERY TECHNOLOGY L.L.C.

Primary Physician Coordination of Care Form

Doctor: _____ Date: _____

Address: _____

City/State/Zip: _____

Re: _____ DOB _____

Dear Dr. _____

This is to inform you that the above-named patient has had the following change in treatment:

☐ Hospitalization ☐ Crisis Home Placement ☐ Other: _____

Receiving the following services:

☐ Outpatient Mental Health Therapy
☐ Substance Abuse Therapy
☐ Assertive Community Treatment
☐ Integrated Dual Disorder Treatment
☐ Dialectical Behavior Therapy
☐ Case Management

Request information from you:

☐ Most current lab results
☐ Diagnosis that you are treating
☐ Most recent physical exam results
☐ Immunization Records
☐ Medications being prescribed by you
☐ Other: _____

The Patient's Diagnosis is: _____

_____

_____

_____

☐ THIS PERSON QUALIFIES AS A MEDICALLY INDIGENT INDIVIDUAL AS DEFINED IN SECTION 106 OF THE SOCIAL WELFARE ACT." MCL § 333.26263(K)

THE SOCIAL WELFARE ACT DEFINES A "MEDICALLY INDIGENT INDIVIDUAL" AS "[A]N INDIVIDUAL RECEIVING FAMILY INDEPENDENCE PROGRAM BENEFITS OR AN INDIVIDUAL RECEIVING SUPPLEMENTAL SECURITY INCOME . . ."

MICHIGAN'S MEDICAL RECORDS ACCESS ACT, PROVIDES THAT "A HEALTH CARE PROVIDER, HEALTH FACILITY, OR MEDICAL RECORDS COMPANY SHALL WAIVE ALL FEES FOR A MEDICALLY INDIGENT INDIVIDUAL." MCL § 333.26269(E)(3).

The patient has signed a release allowing further contact between us. Please feel free to contact me for any questions or coordination of care.

Clinician: _____ Phone Number: _____
(please print)

Clinician Signature/Credentials: _____

Choice of Provider

Date: _____

Client Name: _____ **Case #** _____

Outpatient Therapy: _____ ☐ **Not Applicable**

Case Management: _____ ☐ **Not Applicable**

Assertive Community Treatment: _____ ☐ **Not Applicable**

Outpatient Psychiatric Services: _____ ☐ **Not Applicable**

Other: _____

Other: _____

Other: _____

I attest that I have been given a choice of provider for services.

_____ **Date:** _____

Client/Guardian

Service Orientation Checklist

Client Name: _____ Case #: _____

Please check all that apply:

I have chosen the following service(s):

- ☐ Individual Therapy
- ☐ Case Management
- ☐ Anger Management
- ☐ Dialectical Behavior Therapy
- ☐ Assertive Community Treatment
- ☐ Integrated Dual Diagnosis Treatment
- ☐ Psychiatric
- ☐ Other

- ☐ I have been educated on the service I have chosen and had a chance to ask questions.
- ☐ I have been informed that the Internal Recipient Rights Advisor for Recovery Technology is Andra Antczak at 796-4520.
- ☐ I was trained on the emergency preparedness plan (fire, tornados, bomb threats, assaults with weapons, aggressive behaviors and how to use the fire extinguishers and emergency exits.)
- ☐ Self-determination was explained to me and I was given the choice to participate or not.
- ☐ Quality Improvement was explained to me and I was invited to be a member of the Advisory Board Committee (ABC).
- ☐ Clinician discussed with me the importance of keeping appointments and participating in services scheduled. **I understand that if I miss 3 appointments I may be discharged from the service.**
- ☐ Treatment is court ordered and the requirements for follow-up and discharge have been explained to me.

_____ _____ _____ _____

Client Signature Date Witness Date

_____ _____

Guardian Signature Date

Informal Complaint Process

Date: _____

Client Name: _____ Case #: _____

If you have any questions or concerns regarding your services at Recovery Technology, please call one of the following phone numbers for assistance. If you are unhappy with the outcome of your informal complaint, please contact a member of Recover Technology's management team or if referred by LifeWays, you may contact LifeWays Customer Service.

For Recovery Technology:

Clinician's Name:_____	Phone: _____
Recovery Technology Receptionist	517-780-3336
Recovery Technology CEO/Management	517-780-3336
Recovery Technology Recipient Rights Advisor	517-796-4520

If referred by LifeWays:

LifeWays Customer Service	517-780-3332

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Communication and Message Consent Form

Client Name: _____ Case #: _____ Date: _____

We, at RECOVERY TECHNOLOGY LLC, are committed to safeguarding the privacy and confidentiality of your records including the personal information that you provide us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time, it may be necessary or desirable to contact patients by phone **or text**. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

- ☐ I **DO NOT** want to have detailed messages left with another person who could answer my phone.
- ☐ I **DO NOT** want to have detailed messages left on my voicemail.
- ☐ I **DO NOT** want to be texted with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls at my place of employment.

TEXT MESSAGING INFORMATION

How we will use text messaging: We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your text messages may be forwarded to another RECOVERY TECHNOLOGY LLC staff member as necessary for appropriate handling. We will not disclose your text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted use of your health information and your rights regarding privacy matters.

Risk of using text messages: The use of text messages has a few risks that you should consider. These risks include, but are not limited to, the following:

- Texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress a text and send the information to an undesired recipient.
- Employers and on-line services have a right to inspect texts sent through their company systems.
- Texts can be intercepted, altered, forwarded or used without authorization or detection.
- Texts can be used as evidence in court.
- Text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

Conditions for the use of text messages:

RECOVERY TECHNOLOGY, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of text information sent and received. You must acknowledge and consent to the following conditions (by signing below):

- **IN A MEDICAL EMERGENCY, DO NOT USE TEXTING, CALL 911.**
- If you have an urgent problem during regular business hours, please call your case manager or outpatient therapist, or 517-780-3336. Urgent messages or needs should be relayed to us by using regular telephone communication.
- You should speak with your case manager or therapist to discuss complex and/or sensitive situations rather than using text messages regarding such situations.

- Text messages may be filed electronically into your medical record.
- Clinical staff will not forward your identifiable texts to outside parties without your written consent, except as authorized by law.
- You should use your best judgment when considering the use of text messages for communication of sensitive medical information. **Clinical staff are not responsible for the content of messages.**
- RECOVERY TECHNOLOGY, LLC is not liable for breaches of confidentiality caused by you or any third party.
- It is your responsibility to follow up with staff if warranted.

I UNDERSTAND THAT STANDARD CELL PHONE RATES AND TEXT MESSAGING RATES WILL APPLY TO ANY MESSAGE RECEIVED FROM RECOVERY TECHNOLOGY. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME. MY REVOCATION OF CONSENT WILL NOT AFFECT MY ABILITY TO OBTAIN FUTURE HEALTH CARE NOR WILL IT CAUSE THE LOSS OF ANY BENEFITS TO WHICH I AM OTHERWISE ENTITLED.

THIS CONSENT DOES NOT EXPIRE UNLESS SPECIFICALLY REVOKED BY THE CLIENT/GUARDIAN.

Client/Guardian Signature: _____

Date

Witness Signature: _____

Date

LIFEWAYS CRISIS PLAN

CONSUMER CHOOSES TO PARTICIPATE IN CRISIS PLANNING

☐ YES ☐ NO IF NO, EXPLAIN WHY _____

HOW DO YOU KNOW WHEN I AM IN CRISIS?

_____

_____

_____

DON'T DO (BLANK) WHEN I AM IN CRISIS:

_____

_____

_____

DON'T TAKE ME TO OR TAKE ME TO (NOTE BOTH AND WHY):

_____

_____

_____

SYMPTOMS, FEELINGS OR TRIGGERS THAT MAY LEAD TO A CRISIS:

☐ WANTING TO HURT MYSELF OR SUICIDAL. WHY/HOW? _____

_____

☐ WANTING TO HURT OTHERS. WHY/HOW? _____

_____

☐ ATTEMPTING SUICIDE. HOW? _____

_____

☐ FEELING NOT HEARD. HOW? _____

_____

☐ BULLYING. HOW? _____

_____

☐ USING DRUGS/ALCOHOL TO COPE. WHY? _____

_____

☐ LOSING TEMPER ☐ FIGHTING WITH OTHER PEOPLE ☐ USING DRUGS OR ALCOHOL

☐ INCREASE OR DECREASE IN SLEEP ☐ NOT EATING FOR SEVERAL DAYS ☐ HEARING VOICES

☐ GAMBLING LOSS. WHAT TYPE? _____

_____

☐ BEING TOUCHED. WHY? _____

_____

☐ CRYING NON-STOP OR OFF/ON. WHY? _____

_____

☐ NOT PAYING MY BILLS ☐ BECOMING PHYSICALLY ILL ☐ FEELING UNSAFE

☐ POTENTIAL LOSS OF HOUSING ☐ CHANGE IN HYGIENE ☐ NOT KEEPING APPOINTMENTS

☐ POTENTIAL LOSS OF CHILDREN/FAMILY. HOW/WHEN? _____

_____

☐ ARGUMENTS. WHAT TYPE? _____

_____

☐ SEEING A PARTICULAR PERSON. WHY? _____

_____

☐ LOUD NOISES ☐ LACK OF PRIVACY ☐ BEING RUDE

☐ TIME OF YEAR ☐ TIME OF DAY ☐ OTHER: _____

IMMEDIATE RISK CONCERNS

ACCESS TO WEAPONS ☐ YES ☐ NO	TYPE OF WEAPONS	CURRENT LOCATION OF WEAPONS	RISK OF HARM PRESENT ☐ YES ☐ NO
ACCESS TO MEDICATIONS/ILLEGAL DRUGS ☐ YES ☐ NO	MEDICATIONS THAT ARE ACCESSIBLE	CURRENT LOCATION OF MEDICATIONS	RISK OF HARM PRESENT ☐ YES ☐ NO
PLAN TO ADDRESS IF CURRENT RISK PRESENT			

SUPPORT SYSTEM THAT CAN HELP BEFORE OR DURING A CRISIS

NAME:	RELATIONSHIP:	CONTACT INFORMATION:	RELEASE OBTAINED
_____	_____	_____	☐ YES ☐ NO

PROFESSIONAL RESOURCES THAT CAN HELP

PRIMARY CASE HOLDER	PHONE NUMBER
LIFEWAYS CRISIS-JACKSON	(800) 284-8288; 517-789-1200
LIFEWAYS CRISIS-HILLSDALE	(800)284-8288; 517-439-2641
LIFEWAYS CRISIS R&R – JACKSON – 1200 N. WEST AVE. JACKSON, 49201	LIFEWAYS BUSINESS HOURS

STEPS TO TAKE TO MINIMIZE OR PREVENT MY CRISIS

☐ TALKING WITH MY FAMILY	☐ TALKING WITH MY THERAPIST	☐ TALKING WITH FRIENDS
☐ TIME OUT IN MY ROOM	☐ USE THERAPY/DBT SKILLS	☐ BE AROUND OTHERS
☐ WRAP UP IN A BLANKET	☐ TALKING WITH AN ADULT	☐ BE NEAR MY FAMILY
☐ PUNCH A PILLOW	☐ TALK WITH STAFF ABOUT MY NEEDS	☐ GO TO THE DROP-IN CENTER/SOCIAL PLACE
☐ LIE DOWN WITH A COLD FACE CLOTH	☐ SITTING WITH STAFF	☐ USE A MALE OR FEMALE STAFF AS SUPPORT
☐ TAKE A SHOWER/BATH	☐ WATCH TV	☐ READ (BOOK/PAPER/MAGAZINE)
☐ DO DEEP BREATHING EXERCISE	☐ LISTENING TO MUSIC	☐ WRITE IN A JOURNAL
☐ DRINK A CUP OF WARM TEA	☐ GO FOR A WALK	☐ START ARTWORK
☐ HUGGING A STUFFED ANIMAL	☐ PACE BACK/FORTH	☐ PLAY VIDEO GAMES
☐ GET A HUG	☐ EXERCISE	☐ BOUNCE A BALL
☐ DO CHORES/JOBS	☐ COLORING IN A BOOK/PAPER	☐ MOLDING CLAY
☐ OTHER	☐ DRAW ON MY AREM WITH A RED MARKER	☐ SNAP A RUBBER BAND ON MY WRIST
OTHER		

REMEMBER TO UPDATE DD PROXY MEASURES

Daily Living Activities (©DLA-20): DD/IDD
©W.S. Presmanes, MA, MEd, and R.L. Scott, PhD.

○ **Initial**
○ **Quarterly**
○ **Annual**
○ **Discharge**

Client Name: _____ **Case #**_____

Date: _____

1	2	3	4	5(WNL)	6(WNL)	7(WNL)
None of the time, Pervasive, continuous intervention required. Dysfunctional. **Disabling impairment.**	Almost never. Not functional. Dependent. **Severe impairment.**	Occasionally. Functioning depends on continuous support. **Substantial impairment.**	Some of the time. Marginal independence. Low level of continuous support. **Serious impairment.**	A good bit of the time. Independent with moderate routine support. **Moderate problems.**	Most of the time. Independent with intermittent support or follow-up. **Intermittent problems.**	All of the time. Optimal and independent functioning. Strength. **No problems.**

ACTIVITIES	**Examples of Scoring Strengths as WNL Behaviors (Scores of 5, 6, 7)**						
1. Health Practices	Maintains stable weight. Satisfactorily manages moods and anxieties with or without medication (as prescribed. Participates in medical health care.						
2. Housing Stability / Maintenance	Participates and managed stable housing. Organizes personal possessions, cleans, complies with house rules, responsibilities, Cooperates.						
3. Communication	Effectively responds. Listens Gestures. Expresses feelings, anger.						
4. Safety	Avoids routine dangers: places, situations, actions. No routine injuries and could get help in emergency. No AWOL. Manages vision, hearing aids.						
5. Managing Time	With minimum support, self directs major time blocks. Rarely defiant, tardy or absent for activity, work, appointments. Regular sleep and meals.						
6. Managing Money	With minimum support, helps or self-manages personal money. Chooses and purchases clothes, personal items. No thefts.						
7. Nutrition	With minimum support, eats at least 2 nutritious meals, good snacks.						
8. Problem Solving	With minimum support, makes appropriate decisions. Resolves basic questions and problems. Clarifies instructions and expectations.						
9. Family Relationships	Manages routine contact and gets along with family. Has supportive relationships with significant others in place of residence.						
10. Alcohol/Drug Use	Chooses to abstain from (or no access to) cigarettes, alcohol, beer, drugs, high risk mix of prescribed or over the counter substances.						
11. Leisure	Enjoys a hobby or personal choices for leisure activities – sports, books, magazines, arts, hobbies, movies, board games, music, dance.						
12. Community Resources	Attends social or recreational activity outside of home. Mobile with available supports. Shops, eats out, accesses needed services.						
13. Social Network	Gets along with friends, neighbors, co-workers, peers of like age.						
14. Sexuality	Demonstrated respectable, acceptable sexual behavior in public places. No sexually harassing behaviors. No risk of STD's or unwanted pregnancy.						
15. Productivity	Works PT or FT (supported employment), volunteers, homemaker. Learning skills for financial self-support. (Independent FT work for high WNL scores 6,7)						
16. Coping Skills	Has calm responses to stress, depression, troubled moods. Regains self-control.						
17. Behavior Norms	Exhibits control over self-injurious behavior (SIB), attention-seeking, defiant, destructive, violent, nuisance or bizarre, habitual behaviors. Law abiding.						
18. Personal Hygiene	Independently bathes, showers, brushes teeth. Manages routine self-toileting.						
19. Grooming	Independently bathes, showers, brushes teeth. Manages routine self-toileting.						
20. Dress	Independently chooses and wears clean, comfortable fit clothes in good repair (items appropriate for age, weather, stay fastened). Clothing is generally neat and intact.						
	Sum (max 140)	0	0	0	0		
	Est. GAF	0	0	0	0		

☐ **CSM** ☐ **ACT** ☐ **IDDT** ☐ **OPT** ☐ **DBT** Clinician:

RECOVERY TECHNOLOGY L.L.C.

1200 N. West Avenue, Suite 400
Jackson, MI 49202
(517)-780-3336/FAX (517) 796-4561

Business Satisfaction Survey (Use Client Satisfaction Survey for Guardian)

Date: _____

Please specify how you are associated with Recovery Technology: _____

We would like your opinion on how well Recovery Technology is doing in meeting your needs and expectations. Your completed survey can be faxed to the **Attention of Jim DeBruler at 517-796-4561.** All provided information remains confidential. Please check the appropriate response. Thank you for your time and input.

5=Excellent 4=Good 3=Average 2=Below Average 1=Unsatisfactory

	5	4	3	2	1
1. Overall, how satisfied are you with the timeliness in which Recovery Technology responds to you and/or your organization?					
2. How would you rate the services provided by Recovery Technology?					
3. How well do you think Recovery Technology adheres to Person Center Planning?					
4. How hospitable and helpful is the Recovery Technology staff?					
5. Overall, how convenient are Recovery Technology's business of hours?					

	Yes	No	Comment
6. Would you recommend Recovery Technology to a friend?			
7. If your answer to the above question is no, would you like additional information? If so, please provide your contact information.			
8. Are you aware of all the services Recovery Technology has to offer?			
9. Did you know that your input about Recovery Technology is welcomed at any time?			
10. Do you know who you can contact if you are dissatisfied?			

11. In what ways do you think Recovery Technology can improve?

12. Additional Comments:

Client Satisfaction Survey *Use if client has Guardian **Date:** _____

Please specify how you are associated with RECOVERY TECHNOLOGY:

☐ Client ☐ Guardian ☐ Service Provider ☐ Other: _____

Please specify what services are being rated:

☐ CSM/Support Coordination ☐ Outpatient Therapy ☐ ACT/IDDT

☐ Physician Services ☐ Anger Management/BIP

RECOVERY TECHNOLOGY would like to thank you for giving us the opportunity to serve you. Please help us serve you better by taking a couple minutes to tell us about the services that you have received so far. We appreciate your loyalty and want to make sure we meet your expectations. Your completed survey can be returned to our office at the address listed above**.** All information provided remains confidential. Please check the appropriate response. Thank you for your time and input.

If you do not have an answer or are unsure on any statement, please select "Neutral." Thank you.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Neutral
1. I like the services that I receive(d).					
2. I was able to get the services I thought I needed.					
3. Staff helped me obtain the information I needed so that I could take charge of managing my mental health or disability.					
4. I, not staff, decided my treatment goals.					
5. Staff believed that I could grow, change and recover.					
6. Recovery Technology staff is friendly and helpful.					
7. As a direct result of the services I received, I am better able to take care of my needs.					
8. Recovery Technology's staff were sensitive to my cultural/ethnic background (ex., race, religion, language, etc.).					
9. Recovery Technology staff explained my rights to me in a clear and understandable way.					
10. The services Recovery Technology deliver assisted you in managing your life/illness?					

In what ways, do you think Recovery Technology can improve? (Please continue on the back if more space is needed.)