Welcome

Welcome to Pineland Behavioral Health and Developmental Disabilities (BHDD). We're glad you're here. At Pineland BHDD, you'll be supported by a team of compassionate, culturally and linguistically competent professionals dedicated to meeting your behavioral health needs in a respectful, inclusive, and confidential environment.

We encourage you and your family to be active participants in your care. Your voice matters, and your input plays a central role in developing a person-centered treatment plan tailored to your goals.

Need help after hours? Support is available 24/7.
Call 1-800-PINELAND (1-800-746-3526) to speak with a caring professional at any time. You may also call the Georgia Crisis & Access Line at 1-800-715-4225 for immediate assistance with behavioral health crises.
For urgent mental health support nationwide, dial 988 to reach the Suicide & Crisis Lifeline to connect with a trained counselor.

Same-day access is available; no appointment is needed to receive services. If you have questions or specific needs, please contact your program manager. Their name and contact information is provided below.

We're excited to partner with you on your journey and are committed to helping you succeed. If you are ever dissatisfied with your services, please reach out to the program manager. Your feedback is valuable and helps us improve the care we provide. Thank you for choosing Pineland BHDD.

Administrative Office
Cynthia Cone-Dekle, Interim CEO
5 W. Altman St.
Statesboro, GA 30458
Phone: 912-764-6906 / Fax: 912-764-3585

Pineland BHDD Admission Form

Please complete this intake packet accurately. If you need assistance, please notify one of our staff members.

Full Legal Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Age:** _____ **Sex:** □Male □Female

Gender Identity: □ Male □ Female □ Transgender (MTF) □ Genderqueer □ Transgender (FTM)
□ Choose not to disclose □ Other

Sexual Orientation: □ Straight □ Lesbian, Gay (Homosexual) □ Bisexual □ Other □ Choose not to disclose

Marital Status: □ Married/ Remarried □ Single □ Civil Union □ Divorced □ Widow(er) □ Separated

Race/ Ethnicity: □ American Indian □ Asian (Pacific Islander) □ Black (African American) □ Hispanic (Latino/a)
□ White (Caucasian) □ Other

Social Security #: _____ **Maiden Name (if applicable):** _____

Primary Language: _____ **Religion:** _____

Place of Birth: _____ **Highest Level of Education Completed:** _____

Employment Status: □ Full-Time □ Part-Time □ Unemployed **Occupation:** _____

Hours per Week: _____ **Hourly Wage:** _____ **Date Employed:** _____

Reason for referral to Pineland (presenting problems): _____

_____

Do you use nicotine products? □ Yes □ No **If yes, how often?** _____

Mailing Address: _____ **County:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Best way to contact you:** _____

Are you pregnant? □ Yes □ No □ Unsure □ N/A (Male)

If pregnant, when are you due? _____ **Are you breast-feeding now?** □ Yes □ No

Describe your current residence and how long you've lived there (private home, group home, friend's home, etc): _____

Today's Date: _____

How many live in the household, including yourself? _____

What is your housing stability? □ Stably housed □ At risk of homelessness □ Homeless

Are you a veteran? □ Yes □ No **If you have a military disability, please describe:** _____

Branch of Service: _____ **Years of Service:** _____

Do you have any communication needs or preferences? □ Large Print □ Braille □ Sign Language (ASL)

□ Written communication preferred □ Other _____ □ N/A

Describe any physical impairments or issues (health concerns; vision/hearing loss): _____

_____

Please provide identification and insurance cards to members of the staff to upload into the EMR system.

Insurance: _____ **Subscriber Name:** _____

Member ID: _____ **Group Number:** _____

Insurance: _____ **Subscriber Name:** _____

Member ID: _____ **Group Number:** _____

Emergency Contact Name: _____ **Relationship:** _____

Address: _____

Best Phone Number to Contact: _____

Parent/ Guardian Name: _____

Address: _____

Best Phone Number to Contact: _____

Do you receive non-cash benefits? □ No □ Yes; If yes, please select source of non-cash benefits

□ Supplemental Nutrition Assistance Program (SNAP) □ GA Housing Voucher (DBHDD) □ Section 8

□ TANF Child Care Services □ TANF Transportation Services □ Other TANF-Funded Services

□ Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

□ Temporary Rental Assistance □ Other Source: Specify _____

Today's Date: _____

Income: (Combined Family/ Guardian)

Individual Gross Wages:	$
Spouse Gross Wages:	$
Legal Guardian 1's Gross Wages:	$
Legal Guardian 2's Gross Wages:	$
SSI:	$
TANF:	$
V.A. Benefits:	$
Child Support:	$
Alimony:	$
SSDI:	$
Other Regularly Scheduled Payments (Retirement, Trust Fund)	$
Total Monthly Income:	**$**

Allowable Monthly Deductions:

Child Support:	$
Alimony:	$
Monthly Child Care Payments	$
Monthly Medical Expenses in excess of 5% of gross income	$
Total Allowable Deductions	**$**
Adjusted Monthly Income	**$**
Number of Family Members (including Self)	

Based on this information and the attached fee scale, the determined charge(s) for my services are listed below:

Service	**Individual Fee Amount Per Established Period**

Insurance and Billing Authorization

I authorize Pineland BHDD CSB to release any medical or other information necessary to process claims. I authorize benefits to be paid directly to Pineland BHDD CSB. I understand I am financially responsible for any balance not covered by insurance.

Today's Date: _____

I understand that:

- Co-pays are due at the time of check-in.
- I am responsible for deductibles and any charges not covered by my insurance.
- Certain services (e.g., court reports, drug screens) may not be covered by insurance and will be billed directly to me.

My financial status will be reviewed annually or whenever my circumstances change. I agree to notify the agency of changes in insurance, employment, or income. I may request a review of any financial determination by following the agency's appeals process.

Certification and Consent

I confirm that the information I've given is true and reflects my current financial situation. I understand that I'm responsible for paying for any services provided to me or my dependents. Pineland BHDD CSB may ask for more information to help decide what I can afford to pay, and may verify what I've provided. By signing, I give permission for that verification. I also give permission for my insurance payments to go directly to Pineland BHDD CSB. I understand I must pay for anything not covered by insurance. My financial information will be reviewed once a year or if my situation changes. If I disagree with a decision, I can ask for it to be reviewed.

_____ _____

Signature of Individual or Representative | Printed Name of Individual and Date

_____ _____

Signature of Staff Reviewing Form | Printed Name of Staff and Date

Today's Date: _____

Verification Checklist for Lawful Presence

To: The Person Requesting Services

If you do not have any of the Secure and Verifiable documents listed in Attachment A of this policy and you are lawfully present in the United States, please contact staff of the facility where you are seeking services to complete an affidavit of lawful presence.

THIS PART IS COMPLETED BY STAFF

Individual Name: _____

All documents that verify lawful presence in US must be either ORIGINALS or CERTIFIED copies by issuing agency.

Verification of Lawful Presence in U.S. has been provided?	□ Yes	□ No
Copy on file of verification document?	□ Yes	□ No
If verification was not provided, is service required for emergency situation?	□ Yes	□ No

Verification Reviewed by: _____ Date: _____

Today's Date: _____

Authorization for Treatment

I, _____ (print name), am requesting services provided by Pineland BHDD for myself or my child. I am willing to be evaluated by the Pineland BHDD treatment team. I understand that I am at liberty to seek help from another source. I further understand that information contained in my records is confidential and will not be released to anyone or any agency without my signed release of information which authorizes such release unless otherwise mandated by law.

_____ _____

Signature of Individual or Representative | Printed Name of Individual and Date

Authorization for Telehealth Communication

Pineland BHDD attempts to improve and increase efficiency and access to services by utilizing audio, video, and data communications.

By using telemedicine and/or telehealth, I may be able to

"Obtain a sooner appointment
"Obtain prescriptions for medications if required
"See and interact with my clinical care team including reviewing my progress and getting timely answers to my health questions/concerns
"Complete an appointment without having to travel far from my home
"Obtain services quickly when an urgent need arises

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers to share and/or receive individual medical information for the purpose of improving care. Providers may include medical providers, nurses, medical assistants, counselors, case managers, and other healthcare providers who are part of my care team. In addition to myself and the members of my care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth/telemedicine service, and I agree my personal information may be shared with such family members, caregivers, legal representatives or guardians that are participating in telehealth/telemedicine with me. The information may be used for reasons such as but not limited to diagnosis, therapy, follow-up, and/or education.

Telehealth/Telemedicine requires transmission, via Internet or tele-communication devices, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Videos, pictures, text messages, audio and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to

telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to Pineland BHDD sharing of my protected health information with certain third parties as more fully described in Pineland Policy #2726. I understand, agree, and expressly consent to Pineland BHDD obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies. Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team.

I hereby release and hold harmless Pineland BHDD and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service. I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at Pineland BHDD.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit. I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert back to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled. There is no additional cost or fee for services received through the use of telehealth or telemedicine.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions including the use of (check all that apply):

_____ Audio-Visual HIPAA Compliant Telehealth Platforms including but not limited to Zoom, Webex, or Microsoft Teams
_____ Telephonic Interventions
_____ Text messaging
_____ E-mail

Today's Date: _____

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered to my satisfaction. I understand that this informed consent will become a part of my medical record.

_____ _____

Signature of Individual or Representative | Printed Name of Individual and Date

Today's Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective September 23, 2013. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (HIPAA) and provides some additional information about other federal and state confidentiality protections. If you have questions about this Notice please contact the facility where you receive services (your treatment provider or services provider) or DBHDD's Privacy Officer at the address below.

DBHDD is an agency of the State of Georgia responsible for certain programs which deal with medical, mental health, developmental disabilities, addictive disease, and other confidential information. Both federal and state laws establish strict requirements regarding the disclosure of confidential information, and DBHDD must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how DBHDD may use and disclose your "protected health information" for treatment, payment, health care operations, and for certain other purposes. This notice also describes your rights regarding your protected health information. Protected health information is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. DBHDD is required to notify you in the event of a breach of unsecured protected health information about you. DBHDD is also required to provide you this Notice of Privacy Practices, and to abide by its terms. DBHDD may change the terms of this notice at any time. A new notice will be effective for all protected health information that DBHDD maintains at the time of issuance. DBHDD will provide you with any revised Notice of Privacy Practices by posting copies at its facilities, publication on DBHDD's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services.

1. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights. If you have a court-appointed guardian, your guardian may exercise these rights for you; if you are a minor, your parent or court-appointed custodian may exercise these rights for you; your healthcare agent in a valid advance directive may exercise these rights for you if the advance directive so indicates. To exercise any of these rights, you may contact the staff person named in Section 7 at your treatment provider's location, or your treatment provider's HIPAA Coordinator.
    a. You have the right to inspect and copy your protected health information: You may inspect and obtain a copy of protected health information about you for as long as DBHDD maintains the protected health information. This information includes medical and billing records and other records DBHDD uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it may endanger your life or physical safety. If your protected health information was obtained or created in the course of research that includes

treatment, your right to access that protected health information may be restricted while the research is in progress, provided you agreed to this restriction in advance.

b. You have the right to request restriction of your protected health information: You may ask DBHDD not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. DBHDD is not required to agree to a restriction you request, and DBHDD may not prevent disclosures to the Secretary of Health and Human Services or any disclosure that is required by law. If DBHDD believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If DBHDD does agree to the requested restriction, DBHDD may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. DBHDD must agree to a restriction if you request to restrict disclosure of your protected health information to a health plan if:
    i. the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
    ii. the protected health information pertains solely to a health care item or service for which you, or a person other than a health plan on your behalf, have paid DBHDD in full.
c. You have the right to request to receive confidential communications, including billing and payment information, from us by alternative means or at an alternative location: Upon written request, DBHDD will accommodate reasonable requests for alternative means for the communication of confidential information with you, but may condition this accommodation upon your provision of an alternative address or other method of contact, or means of payment. DBHDD will not request an explanation from you as to the basis for the request.
d. You may have the right to request amendment of your protected health information: If DBHDD created your protected health information, you may request an amendment of that information for as long as it is maintained by DBHDD. DBHDD may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial.
e. You have the right to receive an accounting of certain disclosures DBHDD has made of your protected health information: This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures DBHDD made to you: to family members or friends or representatives, as defined in the Georgia Mental Health Code, who are involved in your care; to anyone based on written authorization by you (or by your guardian, parent, or court-appointed custodian or healthcare agent as applicable); or for national security, intelligence or notification purposes. You have the right to receive legally specified information regarding disclosures occurring in the six (6) years before your request, subject to certain exceptions, restrictions and limitations.
f. You have the right to obtain a paper copy of this notice from DBHDD, upon request.

2. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by DBHDD, its administrative and clinical staff and others involved in your care and treatment for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.

a. Treatment: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party such as, for example, a health care professional who is treating you, or whom you have agreed will be your provider upon your discharge, to a jail or corrections facility if you are under criminal charges and discharged to jail or corrections, or to another health care provider such as a specialist or laboratory.
b. Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in obtaining payment; business associates are also required by law to keep your protected health information confidential.
c. Health Care Operations: DBHDD may use or disclose your protected health information to support the business activities of DBHDD, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services; business associates are also required by law to keep your protected health information confidential.

3. Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object: Your protected health information, including clinical records of treatment for mental illness or addictive disease or services relating to developmental disability, is protected by confidentiality under state law. DBHDD is permitted to make certain disclosures described in Section 2 above and in Sections 4 and 5 below, without your authorization or opportunity to object. Other uses and disclosures of your protected health information will be made only with written authorization by you (or your guardian, parent or legal custodian, or healthcare agent as applicable), which may be revoked at any time to the extent that DBHDD has not acted upon the authorization. DBHDD may disclose all or part of your protected health information when authorized in writing. If you are hospitalized, DBHDD may use and disclose certain protected health information to your representative, as that term is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be given a chance to object to certain other disclosures to your representative. Authorization is required for use or disclosure of psychotherapy notes not maintained in your medical record, with certain limitations in forensic cases. Authorization is required for any disclosure of your protected health information for purposes of DBHDD marketing its services. If DBHDD receives a complaint on your behalf, such as from your representative or family member, your protected health information will not be disclosed to that person in response to the complaint without your authorization.
    a. Confidentiality of Alcohol and Drug Abuse Patient Records: The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or

program evaluation. Violation of these federal laws and regulations by the facility, treatment or service provider, or DBHDD, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by you either at a facility or program or against any person who works at a facility or program, or information about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State agency and local law enforcement authorities.

b. AIDS confidential information: AIDS confidential information, including HIV status or testing information, is confidential under state law. Generally, DBHDD will not disclose AIDS confidential information without your authorization. DBHDD may disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. DBHDD may disclose AIDS confidential information in certain circumstances as part of your mental health commitment or by other legal procedures.
c. Other: DBHDD will not sell your protected health information. If DBHDD wishes to use your protected health information for fundraising (for instance, to send you a request for donation to patient benefit funds), we will first request your authorization.

4. Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object: DBHDD may use or disclose your protected health information without your authorization to your court-appointed guardian, if any; to your parent or court-appointed custodian if you are a minor, or to your healthcare agent when applicable; for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law such as by court order; for public health purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to a law enforcement authority or other state agency authorized to receive reports of abuse or neglect; in certain legal proceedings, such as hearings regarding your hospitalization or commitment or to comply with workers' compensation laws; and for certain law enforcement purposes. If you were admitted to a facility involuntarily, notice of your transfer to voluntary status or of your discharge may be given to the healthcare provider or court that referred you for involuntary care. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, an organ or tissue donation organization, and to the legal representative of your estate.
5. Required Uses and Disclosures: Under the law, DBHDD must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine DBHDD's compliance with the requirements of HIPAA regulations at 45 CFR Parts 160 and 164.
6. Practices not followed by DBHDD:
    a. DBHDD does not sell protected health information of any individual.
    b. DBHDD facilities do not maintain directories of admissions. DBHDD does not disclose the fact of your admission to a facility or program unless it is authorized or required by law to do so, or unless you authorize such a disclosure.
7. Complaints and Additional Information: You may complain to DBHDD and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with your DBHDD facility or program, or with your treatment provider or services provider under contract or agreement with DBHDD which maintains your protected health information at telephone 912-764-6906, facsimile 912-489-3058, or by mail to P.O. Box 745

Today's Date: _____

Statesboro, Georgia 30459. You must state the basis for your complaint. Neither the facility, the provider, nor DBHDD will retaliate against you for filing a complaint. You may also obtain additional information about privacy practices from this contact person. You may also contact DBHDD's Privacy Officer by telephone at (404) 657-2282, facsimile (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.240, Atlanta, Georgia, 30303-3142, for further information about the complaint process or about this notice.

Please sign a copy of this Notice of Privacy Practices for your provider's and the Department's records.

I, _____ (print name), have received a copy of this Notice on the date indicated below.

_____ _____

Signature of Individual or Representative Printed Name of Individual and Date

Today's Date: _____

Rights of Individual Served

Your rights as an individual served by Pineland BHDD are protected by Georgia law.

Your rights include:

- The right to receive professional services, supports, care, and treatment in the least restrictive environment that respects your dignity, protects your health and safety and that gives choice without discrimination.

- The right to receive ethical care suited to your needs, emphasizing positive communication and less restrictive interventions. This may include discussion of legal matters such as guardianship, money management, and advance directives, if appropriate.

- The right to be informed of the purpose and process of the assessment and the benefits and risks of your treatment.

- The right to privacy and confidentiality of information, written, spoken, and electronic.

- The right to participate in planning your own program that is sensitive to individual differences and preferences and to receive a copy of this individual plan.

- The right to informed consent or refusal or expression of choice regarding service delivery, release of information, concurrent services, composition of the service delivery team, involvement in research projects with adherence to resource guidelines and ethics, if applicable.

- The right to refuse services, unless a physician, licensed psychologist, licensed clinical social worker, or licensed professional counselor feels that your refusal would be unsafe for you or others. At that time, consent for treatment is not totally voluntary.

- The right to prompt, accessible and confidential services, including emergency services, even if you are unable to pay.

- The right to access pertinent information, review and/or obtain copies of your records, unless the physician or other authorized staff feels it is not in your best interest, within sufficient time to facilitate a decision making process.

- The right to exercise all civil, political, personal, and property rights to which you are entitled as a citizen.

- The right to remain free of physical restraints or time-out procedures, including seclusion, unless such measures are required for protecting your safety or the safety of others. Chemical restraints may never be used.

- The right to be free of physical abuse, sexual abuse, fear-eliciting procedures, and corporal

punishment.

- The right to access free interpretation services as needed.
- The right to remain free of fiduciary (deliberate exploitation of funds or other exploitation), psychological and verbal abuse, neglect including humiliation, threats (overt and implied), exploiting action, and protection from harm, retaliation or coercion.
- The right to have access to self-help, advocacy support services and referral to legal entities for appropriate representation.
- The right to pursue employment, education and religious expression.
- The right, if you receive residential services, to converse privately, to have reasonable access to a telephone, to receive and send mail, to have visitors, and to retain your personal effects and money.
- The right to file a complaint, orally or in writing, if you think any of these rights have been restricted or denied. Complaints should be address and resolved as appropriate in a timely manner. The name, address and phone number of the Representative for Rights of Individuals Served is listed on a poster at every service site.
- The right to a thorough investigation and resolution of alleged infringement of rights.
- The right to receive a written notice of the address and telephone number of that state licensing authority which further explains the responsibilities of licensing the program and investigating client complaints which appear to violate licensing rules.
- The right to obtain a copy of the program's most recent completed report of licensing inspection from the program upon written request. The program is not required to release a report until the program has had the opportunity to file a written plan or correction for the violations as provided for in these rules.

If you want to know more about your rights, a full copy of the Regulations is available to you on request. A summary of the Rights Complaint Process is also available. Your signature indicates that you have read and understand your rights.

_____ _____

Signature of Individual or Representative | Printed Name of Individual and Date

Today's Date: _____

Responsibilities of Individual Served

Pineland seeks to provide a safe and supportive environment for individuals served. Working as a team, we believe successful treatment will lead to a better quality of life. Each individual is a valuable member of the team, and shares responsibility for successful treatment.

I, _____ (print name) , have been informed of certain rights as an individual served at Pineland Mental Health, Developmental Disabilities and Addictive Diseases. I realize that I also have the following responsibilities:

**I am responsible for asking questions if I do not understand something or have any concerns.
**I am responsible for being an active player on the team by helping to plan my goals and giving input into the services I receive.
**I am responsible for following my treatment plan including taking my medication as prescribed by my physician.
**I am responsible for keeping my Case Coordinator informed of my progress and any problems which I am having.
**I am responsible for keeping my appointments and being on time for my appointments. If I cannot keep my appointment, I will notify my Case Coordinator as soon as possible. I understand that if I do not notify my Case Coordinator at least 24 hours in advance, I will be charged for a missed appointment.
**I am responsible for following the rules and guidelines of the program.
**I am responsible for informing Pineland staff of any changes in my financial status, insurance, or other third party coverage.
**I am responsible for paying my share of the services I receive at the time when the services are offered unless I have made other arrangements in advance.
**I am responsible for reporting any complaint, which I might have. If I have a complaint, I understand that I am first to contact my Case Coordinator or his/her supervisor. If I do not feel that appropriate actions have been taken, I am to contact Patricia Donaldson, Chairperson for Rights of Individuals Served, at 1-800-767-8152.

To ensure a safe and supportive environment, the following acts would cause a person's discharge from the program, as well as a clinical review of his/her treatment plan.
**Threats and/or violence toward staff or peers
**Possession of a weapon on Pineland property
**Sexual activity, sexual threat, stalking or harassment
**Use, possession, or sale of alcohol, unauthorized chemicals or mood altering drugs
**Gambling
**Possession or distribution of pornographic or occult material
**Intentionally damaging, destroying or vandalizing Pineland property
**Theft and other criminal activities

I have read and agree to assume the responsibilities listed above.

_____ _____

Today's Date: _____

Signature of Individual or Representative Printed Name of Individual and Date

Orientation Checklist

I have received the following Orientation to Pineland BHDD, including:

1. The Mission, Code of Ethics, programs, services, activities, and expectations of Pineland BHDD.
2. The identification of the person responsible for coordinating my service/treatment and his/her role. That person will also explain rules and regulations and provide me a copy of the Handbook for Individuals Served in Pineland BHDD Programs.
   That staff person is _____.
3. The explanation of confidentiality, rights, responsibilities, and any potential risks for individuals served, complaints, grievance and appeal procedures and any restriction procedures, such as seclusion and restraint, and identification of therapeutic interventions, including sanctions, interventions, and administrative discharge criteria.
4. Explanation of my right to choose for my family to be involved in my care:
   _____ I Consent _____ I Do Not Consent
5. The process for the assessment and development of my person-centered plan, purpose, potential course of treatment/services, motivational incentives that may be used, and my participation in goal development and achievement.
6. Ways that I may provide input into the quality, satisfaction of care & achievement of outcomes.
7. The explanation of fees and Financial Arrangements that include: rates for services provided, considerations for payment, services not covered, and a reasonable projection of time that services will be provided.
8. Transition and discharge criteria (plus follow-up requirements for mandated treatment).
9. Safety review of premises (including evacuation plan), location of fire suppression equipment and first aid kits.
10. Further orientation specific to program where I am receiving services, including rules and information regarding transition criteria and administrative discharges, smoking, possession of weapons and licit and/or illicit drugs, prescription medications brought into the program, hours of operation, access to after-hour services, attitudes and behaviors that may lead to sanctions or loss of rights or privileges, ways to remove sanctions and regain rights and privileges, agency requirements for reporting and/or follow-up for mandated persons served, expectations for legally required appointments, sanctions, or court notifications.
11. If appropriate, education regarding advanced directives.
12. I understand that my photograph will be taken as part of my admission process and will remain part of my medical records.

_____ _____

Signature of Individual or Representative Printed Name of Individual and Date

Today's Date: _____

Adverse Childhood Experience (ACE) Questionnaire

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
2. Did you lose a parent through divorce, abandonment, death, or other reason?	
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
6. Did you live with anyone who went to jail or prison?	
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
9. Did you feel that no one in your family loved you or thought you were special?	
10. Did you experience unwanted sexual contact (such as fondling or oral/ anal/ vaginal intercourse/ penetration)?	
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? _____ Not Much _____ Some _____ A Lot

Today's Date: _____

Patient Health Questionnaire (PHQ-9)

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.				
	(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				
Total Score _____ = 0 + _____ + _____ + _____				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all … Somewhat difficult … Very difficult … Extremely difficult …