AGREEMENT NO. 19-202-A1

**AMENDMENT TO BOARD OF SUPERVISORS**
**AGREEMENT NO. 19-202**

This Amendment to BOS Agreement No. 19-202 is entered into this 10th day of December 2019, by and between the COUNTY OF MENDOCINO, a political subdivision of the State of California, hereinafter referred to as "COUNTY" and **California Psychiatric Transitions**, hereinafter referred to as "CONTRACTOR".

WHEREAS, BOS Agreement No. 19-202 was entered into on July 1, 2019; and

WHEREAS, upon execution of this document by the Chair of the Mendocino County Board of Supervisors and CONTRACTOR, this document will become part of the aforementioned contract and shall be incorporated therein; and

WHEREAS, it is the desire of the CONTRACTOR and the COUNTY to increase the total amount set out in original BOS Agreement No. 19-202, from $75,000 to $375,000; and

WHEREAS, it is the desire of the CONTRACTOR and the COUNTY to include the Diversion Unit, Admission Agreement, Part I, and Main/DBU/Diversion Program, Admission Agreement, Part II, as attachments to original BOS Agreement No. 19-202, and reference these attachments in Exhibit A, Definition of Services; and

WHEREAS, it is the desire of the CONTRACTOR and the COUNTY to update the chart in Exhibit B, Payment Terms.

NOW, THEREFORE, we agree as follows:

1. The total amount set out in original BOS Agreement No. 19-202 will be increased from $75,000 to $375,000.
2. A new page 1 referencing the added Attachment 2 and Attachment 3 is attached herein.
3. The Exhibit A, Definition of Services, set out in original BOS Agreement No. 19-202 has been altered and a new Exhibit A is attached herein.
4. The Exhibit B, Payment Terms, set out in original BOS Agreement No. 19-202 has been altered and a new Exhibit B is attached herein.
5. An Attachment 2, Diversion Unit, Admission Agreement, Part I, has been added and is attached herein.
6. An Attachment 3, Main/DBU/Diversion Program, Admission Agreement, Part II, has been added and is attached herein.

All other terms and conditions of original BOS Agreement No. 19-202 shall remain in full force and effect.

**IN WITNESS WHEREOF**

**DEPARTMENT FISCAL REVIEW:**

By: _____
Jenine Miller, Psy.D., HHSA Assistant Director/
Behavioral Health Director

Date: 10/1/19

Budgeted: ☒ Yes ☐ No
Budget Unit: 4050
Line Item: 86-3162
Org/Object Code: MHAS75
Grant: ☐ Yes ☒ No
Grant No.:

**COUNTY OF MENDOCINO**

By: _____
CARRE BROWN, Chair
BOARD OF SUPERVISORS

Date: DEC 17 2019

**ATTEST:**
CARMEL J. ANGELO, Clerk of said Board

By: _____
Deputy DEC 17 2019

I hereby certify that according to the provisions of Government Code section 25103, delivery of this document has been made.

CARMEL J. ANGELO, Clerk of said Board

By: _____
Deputy DEC 17 2019

**INSURANCE REVIEW:**

By: _____
Risk Management

Date: 10/17/19

**CONTRACTOR/COMPANY NAME**

By: _____
Aaron Stocking, Director

Date: 11.18.19

NAME AND ADDRESS OF CONTRACTOR:

California Psychiatric Transitions, Inc.
PO Box 339
Delhi, CA 95315
209-662-5364; astocking@cptmhrc.com

By signing above, signatory warrants and represents that he/she executed this Agreement in his/her authorized capacity and that by his/her signature on this Agreement, he/she or the entity upon behalf of which he/she acted, executed this Agreement

**COUNTY COUNSEL REVIEW:**

APPROVED AS TO FORM:

KATHARINE L. ELLIOTT,
County Counsel

By: _____
Deputy

Date: 10/3/19

**EXECUTIVE OFFICE/FISCAL REVIEW:**

By: _____
Deputy CEO

Date: 10/17/19

**Signatory Authority: $0-25,000 Department;** $25,001- 50,000 Purchasing Agent; $50,001+ Board of Supervisors
**Exception to Bid Process Required/Completed** ☒ 20-43
**Mendocino County Business License: Valid** ☐
**Exempt Pursuant to MCC Section:** _____

**COUNTY OF MENDOCINO**
**STANDARD SERVICES AGREEMENT**

This Agreement is by and between the COUNTY OF MENDOCINO, hereinafter referred to as the "COUNTY", and **California Psychiatric Transitions, Inc.**, hereinafter referred to as the "CONTRACTOR".

**WITNESSETH**

WHEREAS, pursuant to Government Code Section 31000, COUNTY may retain independent contractors to perform special services to or for COUNTY or any department thereof; and,

WHEREAS, COUNTY desires to obtain CONTRACTOR for its secure residential treatment services to Mendocino County Behavioral Health and Recovery Services, Lanterman-Petris-Short clients; and,

WHEREAS, CONTRACTOR is willing to provide such services on the terms and conditions set forth in this AGREEMENT and is willing to provide same to COUNTY.

NOW, THEREFORE it is agreed that COUNTY does hereby retain CONTRACTOR to provide the services described in Exhibit "A", and CONTRACTOR accepts such engagement, on the General Terms and Conditions hereinafter specified in this Agreement, the Additional Provisions attached hereto, and the following described exhibits, all of which are incorporated into this Agreement by this reference:

| | |
|---|---|
| Exhibit A | Definition of Services |
| Exhibit B | Payment Terms |
| Exhibit C | Insurance Requirements |
| Exhibit D | Assurance of Compliance with Nondiscrimination in State and Federally Assisted Programs |
| Appendix A | Certification Regarding Debarment, Suspension, and Other Responsibility Matters -- Lower Tier Covered Transactions |
| Addendum A | Business Associate Agreement |
| Attachment 1 | Invoice |
| Attachment 2 | Diversion Unit, Admission Agreement, Part I |
| Attachment 3 | Main/DBU/Diversion Program, Admission Agreement, Part II |

The term of this Agreement shall be from July 1, 2019 (the "Effective Date"), and shall continue through June 30, 2020.

The compensation payable to CONTRACTOR hereunder shall not exceed Three Hundred Seventy-Five Thousand Dollars ($375,000) for the term of this Agreement.

## EXHIBIT A

DEFINITION OF SERVICES

This is a fee for service contract with no minimum beds reserved. All services provided will be in accordance with the following description of services. All referrals will come from or be approved by the Mendocino County Behavioral Health and Recovery Services (BHRS) Director or designee for reimbursement.

CONTRACTOR shall provide the following services:

A. Programs:

1. Psychosocial rehabilitation programs in secured residential settings with a focus on brief lengths of stay.

    a. Recovery-Focused programs
    b. Independent Living Skills Training
    c. Behavioral Intervention
    d. Vocational/Prevocational Training
    e. Self-advocacy/Peer Counseling
    f. Case Management
    g. Psychiatric Medication Management

2. Residential/nonresidential and transitional services in unlocked independent settings.

    a. Extensive Life Skills Training
    b. Peer Counseling
    c. Wellness Recovery Action
    d. Planning
    e. Case Management
    f. Behavioral Self-Management
    g. Neurobehavioral Services
    h. Dementia/Alzheimer's Care
    i. Community Residential
    j. Treatment Systems
    k. Restoration to Competency

B. Services provided to individual patients will be dependent upon the patient's specific needs. The Facility shall have the capability of providing all of the following services:

1. Self–Help Skills Training. This shall include, but is not limited to:

    a. Personal Care and Use of Medication
    b. Money Management
    c. Use of Public Transportation
    d. Use of Community Resources
    e. Behavior Control and Impulse Control
    f. Frustration Tolerance
    g. Mental Health Education
    h. Physical Fitness

2. Behavior Intervention Training. This shall include, but is not limited to:

    a. Behavior Modification Modalities
    b. Re-motivation Therapy
    c. Patient Government Activities
    d. Group Counseling
    e. Individual Counseling

3. Interpersonal Relationships. This shall include, but is not limited to:

    a. Social Counseling
    b. Education and Recreational Therapy
    c. Social Activities such as Outings, Dances, etc.

4. Prevocational Preparation Services. This shall include, but is not limited to:

    a. Homemaking
    b. Work Activity
    c. Vocational Counseling

5. Pre-Release Planning

6. Out-of-Home Placement

C. A minimum average of twenty-seven (27) hours per week of direct group or individual program services will be provided for each patient.

D. In conjunction with the Mendocino County BHRS Director or designee, CONTRACTOR shall reassess each COUNTY patient at least every four (4) months to determine current level of functioning and individual program needs. These records will be sent to COUNTY Quality Assurance for review.

E. CONTRACTOR shall provide COUNTY with clinical and medical records for conserved clients for concurrent and/or post review as needed.

F. CONTRACTOR shall notify COUNTY within one (1) business day if level of care for a client is changed.

G. CONTRACTOR shall provide a status report for clients placed for competency restoration (1370's) within ninety (90) days of placement, then at six (6) month intervals, and/or when the client is restored to competency.

H. CONTRACTOR agrees to provide two (2) Lanterman-Petris-Short (LPS) Conservatorship Declarations, if the client is a conservatee. The Declarations, which will be completed by two (2) physicians or licensed psychologists who have a doctoral degree in psychology and at least five (5) years of post-graduate experience in the diagnosis and treatment of emotional and mental disorders, will certify whether the conservatee is still gravely disabled as a result of a mental disorder. Declarations are to be completed at least annually and up to every six (6) months and forwarded to the COUNTY. In the instance that CONTRACTOR must utilize a psychiatrist or psychologist that is not employed with the CONTRACTOR, the CONTRACTOR will accept responsibility for the cost of the assessment, except when authorized in writing, and in advance by the Mendocino County BHRS Director or designee.

I. CONTRACTOR shall communicate with COUNTY upon receipt of third party requests or demands to assess and evaluate individuals for treatment. Such access to clients requires approval of BHRS Director or designee.

J. In carrying out the Scope of Work contained in this Exhibit A, CONTRACTOR shall comply with all requirements to the satisfaction of the COUNTY, in the sole discretion of the COUNTY. For any finding of CONTRACTOR's non-compliance with the requirements contained in the Exhibit A, COUNTY shall within ten (10) working days of discovery of non-compliance notify CONTRACTOR of the requirement in writing. CONTRACTOR shall provide a written response to COUNTY within five (5) working days of receipt of this written notification. If the non-compliance issue has not been resolved through response from CONTRACTOR, COUNTY shall notify CONTRACTOR in writing that this non-compliance issue has not been resolved. COUNTY may withhold monthly payment until such time as COUNTY determines

the non-compliance issue has been resolved. Should COUNTY determine that CONTRACTOR's non-compliance has not been addressed to the satisfaction of COUNTY for a period of thirty (30) days from the date of first Notice, and due to the fact that it is impracticable to determine the actual damages sustained by CONTRACTOR's failure to properly and timely address non-compliance, COUNTY may additionally require a payment from CONTRACTOR in the amount of fifteen percent (15%) of the monthly amount payable to CONTRACTOR for each month following the thirty (30) day time period that CONTRACTOR's non-compliance continues. The parties agree this fifteen percent payment shall constitute liquidated damages and is not a penalty. CONTRACTOR's failure to meet compliance requirements, as determined by COUNTY, may lead to termination of this contract by the COUNTY with a forty-five (45) day written notice.

K. CONTRACTOR shall maintain compliance with California Code of Regulations Title 9, MHP contract, California Code of Regulations Title 42, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, state and federal laws, and other Mendocino County MHP requirements for client confidentiality and record security.

L. Prior to terminating this Agreement, CONTRACTOR shall give at least forty-five (45) days written notice of termination to COUNTY.

M. COUNTY shall fill and sign the Diversion Unit, Admission Agreement, Part 1 (Attachment 2), and the Main/DBU/Diversion Program, Admission Agreement, Part II (Attachment 3) as applicable, upon admission of clients from Mendocino County.

[END OF DEFINITION OF SERVICES]

**EXHIBIT B**

PAYMENT TERMS

COUNTY will pay CONTRACTOR as per the following instructions:

| | |
|---|---|
| MHRC (Mental Health Rehabilitation Center) | |
| Level 1 | $400/Day |
| 1:1 Monitoring | $40.00/Hour |
| DBU (Disruptive Behavior Unit) | |
| Level 1 | $850/Day |
| 1:1 Monitoring | $40.00/Hour |
| DIVERSION | |
| Level 1 | $575/Day |
| Level 2 | $475/Day |
| 1:1 Monitoring | $40.00/Hour |

A. CONTRACTOR will bill COUNTY on a monthly basis on a COUNTY approved invoice (Attachment 1).

B. Invoices are due by the tenth ($10^{th}$) of the month following month of services. Invoices not received within thirty (30) days will not be honored.

C. Invoices are to be sent to:

COUNTY OF MENDOCINO
Behavioral Health and Recovery Services
1120 S. Dora Street
Ukiah, CA 95482
Attn: Jenine Miller

The compensation payable to CONTRACTOR hereunder shall not exceed Three Hundred Seventy-Five Thousand Dollars ($375,000) for the term of this Agreement.

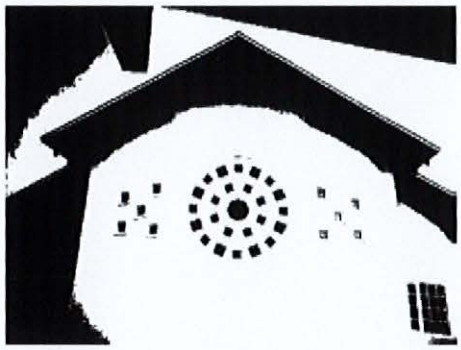
[END OF PAYMENT TERMS]

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

Attachment 2

# CPT MENTAL HEALTH REHABILITATION CENTER

P.O. BOX 339, DELHI, CA 95315
PH (209) 667-9304 FAX (209) 669-3978



# Diversion Unit ADMISSION AGREEMENT

**Part I**

**County Mental Health**

**Date: 00/00/0000**

**THIS ADMISSION AGREEMENT AND THE ACCOMPANYING ADMISSION DOCUMENTATION IS A LEGALLY BINDING CONTRACT. PLEASE READ ALL OF IT AND BE SURE YOU UNDERSTAND ITS TERMS BEFORE SIGNING.**

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

# PAYMENT AGREEMENT

## DAILY RATE

With respect to payment responsibilities,

Placement cost of;

Last, First----000-00-0000-----MM-DD-YYYY shall be reimbursed as follows.

RESIDENT NAME----SOCIAL SECURITY NUMBER----DATE OF BIRTH

County

FUNDING SOURCE (PRIMARY)

N/A

FUNDING SOURCE (SECONDARY) if applicable

Shall reimburse CPT at a rate of $575.00 (FIVE HUNDRED SEVENTY-FIVE DOLLARS) per day.

RATE DECREASE

At no time will a rate be decreased according to an automatic schedule. Requests for a rate decrease must be submitted in writing to the CPT Director. The Treatment Team will then review the request and must support the rate decrease based on but not limited to: the current level status of the resident, medication/treatment compliance, behavior and program progress. The Medical Director and Facility Director must approve the rate decrease. The Facility Director will then contact your agency with a decision. No rate change will be final until the Facility Director authorizes this change in writing. Effective date of reduction will be the 1st of the next month following request approval. If a Resident leaves temporarily, the holding rate for his/her room is the same as the agreed daily rate.

The signature below is of a person(s) who is authorized to enter into for this Payment Agreement.

| √ | √ | √ |
|---|---|---|
| PRIMARY AUTHORIZED PERSON, TITLE (PRINTED) | SIGNATURE | DATE |
| √ | √ | √ |
| SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) If applicable | SIGNATURE | DATE |

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

# PAYMENT AGREEMENT

## ONE ON ONE

In order to maintain some residents at this level of care one-on-one supervision is occasionally indicated. The purpose of this service is to maintain placement and reduce the probability of injury to self or others. In this facility, one-on-one supervision has to be medically indicated and approved by the staff psychiatrist. Unfortunately, such supervision cannot be provided at the basic admission rate for services. An agreement for reimbursement for one-on-one services must be established in order for this facility to be able to provide this service. CPT would explain the resident's current behavior and why one-on-one services would be indicated. One-on-one services will be provided until the need no longer exists.

With respect to payment responsibilities,

One on One supervision cost of;

Last, First----000-00-0000-----MM-DD-YYYY shall be reimbursed as follows.
RESIDENT NAME-----SOCIAL SECURITY NUMBER-----DATE OF BIRTH

**County**

FUNDING SOURCE (PRIMARY)

N/A

FUNDING SOURCE (SECONDARY) if applicable

Shall reimburse CPT at a rate of $40.00 (FORTY DOLLARS) per HOUR, for 1:1 (one on one) supervision services on an "as needed" basis as determined by medical order of the CPT staff psychiatrist.

The signature below is of a person(s) who is authorized to enter into for this Payment Agreement.

| PRIMARY AUTHORIZED PERSON, TITLE (PRINTED) | SIGNATURE | DATE |
|---|---|---|
| | | √ |

| SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) if applicable | SIGNATURE | DATE |
|---|---|---|
| √ | √ | √ |

| RESIDENT NAME----SOCIAL SECURITY NUMBER----DATE OF BIRTH | CPT # |
|---|---|
| **Last, First----000-00-0000-----MM-DD-YYYY** | PENDING |

FILE NAME: ADMISSION MHRC NEW

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

# PAYMENT AGREEMENT

PHARMACY & LABORATORY SERVICES

**THIS PAGE MUST BE COMPLETED AND SIGNED BY AUTHORIZED PERSON(S) *PRIOR TO ADMISSION*.**
**A copy of this page will be sent to the vendors to establish services.**

**COUNTY MENTAL HEALTH** ensures that all medical insurance information (i.e., Medi-Cal or Medicare) for Last, First----000-00-0000-----MM-DD-YYYY is current /active and will be provided to California Psychiatric Transitions prior to admission. ***IT IS THE RESPONSIBILITY OF THE PLACING AGENCY TO PROVIDE UP TO DATE INSURANCE INFORMATION AS IT MAY CHANGE***. If the information for Last, First----000-00-0000-----MM-DD-YYYY, is not active or not available prior to admission,

**COUNTY MENTAL HEALTH**
FUNDING SOURCE (PRIMARY

**N/A**
FUNDING SOURCE (SECONDARY) if applicable

**Will guarantee reimbursement of expenses incurred by:**

- **MID-VALLEY PHARMACY** *#PV0912*
  602 SCENIC DRIVE, MODESTO, CA 95350 PH (209) 552-7600 FAX (209) 552-7638
- **CENTRAL VALLEY DIAGNOSTIC LAB** *#HC0163*
  31 ALEXANDER AVE. MERCED, CA 95348 PH (209)726-3846
- **BIO-REFERENCE LABORATORIES** *#HS0709*
  487 EDWARD H. ROSS DR. ELMWOOD PARK, NJ 07407 PH (800)229-5227
- **DIAGNOSTIC LABORATORIES** ATTN CASH APPLICATIONS
  6400 PINECREST DR. STE. 100 PLANO, TX 75024-2961 PH (877)235-0377

**BILLING INFORMATION** (Please Print)

| | | |
|---|---|---|
| PLACEMENT AGENCY (Responsible Funding Source) | | |
| MAILING ADDRESS (#/Street/Ste. City, State, Zip) | | |
| BILLING CONTACT NAME | PHONE (EXT) | FAX |

**ADDITIONAL CONTACT INFORMATION**

| | | |
|---|---|---|
| CASE MANAGER NAME | PHONE (EXT) | FAX |
| CONSERVATOR NAME | PHONE (EXT) | FAX |

**The signature below is of a person(s) who is authorized to enter into this Payment Agreement.**

| | | |
|---|---|---|
| √ PRIMARY AUTHORIZED PERSON, TITLE (PRINTED) | √ SIGNATURE | √ DATE |
| √ SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) if applicable | √ SIGNATURE | √ DATE |

| RESIDENT NAME----SOCIAL SECURITY NUMBER----DATE OF BIRTH | CPT # |
|---|---|
| **Last, First----000-00-0000-----MM-DD-YYYY** | PENDING |

CALIFORNIA
PSYCHIATRIC
TRANSITIONS

# PAYMENT AGREEMENT

RESPONSIBILITY FOR DAMAGES

**This page MUST be completed and signed by authorized person(s) prior to admission.**

*The resident and/or representative will be billed for any damages to the facility and/or property, caused by the resident, which are not due to normal "wear and tear". Nonpayment of billed damages will be reason for discharge from this facility.*

With respect to payment responsibilities regarding any damages to the facility and/or property caused by:

Last, First----000-00-0000-----MM-DD-YYYY
RESIDENT NAME----SOCIAL SECURITY NUMBER----DATE OF BIRTH

**COUNTY**
FUNDING SOURCE (PRIMARY

**N/A**
FUNDING SOURCE (SECONDARY) if applicable

Will reimburse California Psychiatric Transitions for any damages to the facility and/or property caused by Last, First----000-00-0000-----MM-DD-YYYY

The placement agency will be provided with receipts and/or itemized list of damages, labor and cost of repairs. Supportive documentation may be provided upon request.

**The signature below is of a person(s) who is authorized to enter into this Payment Agreement.**

| √ | √ | √ |
|---|---|---|
| PRIMARY AUTHORIZED PERSON, TITLE (PRINTED) | SIGNATURE | DATE |
| √ | √ | √ |
| SECONDARY AUTHORIZED PERSON, TITLE (PRINTED) if applicable | SIGNATURE | DATE |

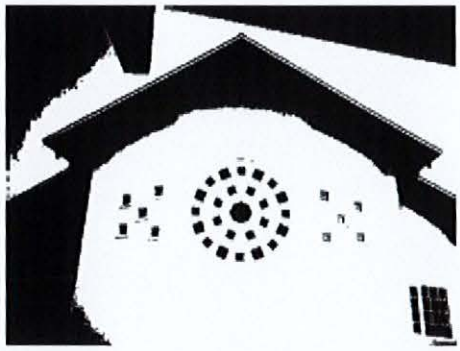
CALIFORNIA
PSYCHIATRIC
TRANSITIONS



RESIDENT INITIALS: _____


## CPT MENTAL HEALTH REHABILITATION CENTER

P.O. BOX 339, DELHI, CA 95315
PH (209) 667-9304 FAX (209) 669-3978

# MAIN / DBU / DIVERSION PROGRAM ADMISSION AGREEMENT

**Part II**

**Regional Center / County Mental Health Agency**

**Date: MM/DD/YYYY**

THIS ADMISSION AGREEMENT AND THE ACCOMPANYING ADMISSION DOCUMENTATION IS A LEGALLY BINDING CONTRACT. PLEASE READ ALL OF IT AND BE SURE YOU UNDERSTAND ITS TERMS BEFORE SIGNING.

RESIDENT INITIALS: _____

# MAIN / DBU / DIVERSION PROGRAM ADMISSION AGREEMENT

**PLEASE NOTE: PLACEMENT IN THIS FACILITY DOES NOT CONSTITUTE A CHANGE OF RESIDENCE FOR THE CONSUMER. THE PLACING COUNTY RETAINS RESIDENCY INCLUDING PSYCHIATRIC MEDI-CAL RESPONSIBILITIES.**

| | | |
|---|---|---|
| **Last, First----000-00-0000-----MM-DD-YYYY** | √ | √ |
| RESIDENT NAME-----SOCIAL SECURITY NUMBER-----DATE OF BIRTH | SIGNATURE | DATE |
| **Aaron Stocking Director, CPT** | √ | √ |
| CALIFORNIA PSYCHIATRIC TRANSITIONS | SIGNATURE | DATE |
| √ | √ | √ |
| CONSERVATOR OR AUTHORIZED REPRESENTATIVE, TITLE | SIGNATURE | DATE |
| √ | √ | √ |
| PLACEMENT AGENCY(S), TITLE | SIGNATURE | DATE |

Basic Services—**General**

(a) CPT shall provide, at a minimum, the following basic services; physician, nursing, pharmaceutical, and dietary services. (In accordance to Title 9, chapter 3.5 and submitted Plan of Operations for the Forensic Diversion Program).

(b) If a service cannot be brought into CPT with regard to the health and welfare of the resident, CPT shall make necessary arrangements for transportation to and from a service location. (Examples; Non-emergency Medical Appointment, Labs or similar services with direct benefit to the resident).

(1) Due to legal status/hold it may be necessary for CPT to employ additional services in order to maintain the safety and security of the resident in question, this cost may be in addition to the daily contractual rate.

(2) In the event emergency services are necessary (911), CPT shall employ additional resources to insure the safety and wellbeing of the resident and staff while in the care of other healthcare providers. This cost may be in addition to the daily contractual rate.

(c) CPT shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated.

(d) Each resident shall be encouraged and assisted to achieve and maintain the highest level of self–care and independence. Every effort shall be made to keep residents active, and out of bed for reasonable periods of time, except when contraindicated by physician's orders.

(e) Each resident shall be provided with good nutrition and with necessary fluids for hydration.

(f) The weight and height of each resident shall be taken and recorded in the resident record upon admission, and the weight shall be taken and recorded once a month thereafter.

(g) Each resident shall be provided visual privacy during treatment and personal care.

(h) Each resident shall be screened for tuberculosis upon admission, unless a tuberculosis screening has been completed within 90 days prior to the date of admission to CPT.

(i) Prior to admission the following labs/tests are required; CBC with differential, VDRL, Lipid Panel with fasting (8) hours, CMP and TSH [all within 6 months and any test deemed necessary based on the safety and welfare of CPT staff and residents].

(j) This facility honors "full code" consisting of first aid, CPR, and 911 notification for every resident.

Basic and any additional services are paid in arrears, and due upon receipt. **Medication, Medical and Psychiatric services, if not covered by insurance shall be paid by the placement agency. All discharges must have a two-week written notice to director**, unless waived by director; placement agency shall be responsible for payment of all days short of two weeks.

## DISCHARGE

Residents discharged from this facility shall (in a planned/scheduled discharge) have all belongings, monies and appropriate medications given to responsible parties (or their representatives) at the time of discharge. In the event that the discharge is not scheduled/not planned, arrangements shall be made to return belongings to the resident's responsible party.

This facility cannot provide any services that can only be provided by law in higher levels of care such as State Psychiatric Hospitals, Health hospitals, Acute Care Psychiatric Health Facilities, serious medical conditions, etc. In addition the following will apply:

- In acute situations (as determined by the MHRC) the county shall make reasonable and timely arrangements for the transfer of the resident to an appropriate level of care.
- The discharge/transfer is necessary for the welfare of the resident and his/her needs cannot be met at this facility
- Based upon a reassessment of the Resident's needs, conducted pursuant to applicable regulations, *California Psychiatric Transitions* shall determine that the facility is not appropriate for the Resident
- The discharge/transfer is appropriate because the resident's health has improved sufficiently so that they no longer need the services of this facility
- The safety of individuals in the facility is endangered by Resident's presence
- The health of individuals in the facility is endangered by Resident's presence
- Payment for services have not been received within (10) days of due date
- The facility is ceasing to operate or its use is being changed
- Reassignment of case managers or placement agencies without prior written approval from this facility
- Failure of the Resident to comply with state or local laws
- Failure of the Resident to comply with written general polices of the facility which are for the purpose of making it possible for Residents to live together.

***Residents admitted to California Psychiatric Transitions – MHRC, shall maintain their respective; LPS, conservatorship, 6500 or any other legal document, status or hold that has met the admissions criteria outlined in the Plan of Operations pursuant to (Title 9 Chapter 3.5). Any change, lapse, alteration, or discontinued condition of the resident's legal status without reasonable prior notification to California Psychiatric Transitions may be grounds for immediate discharge. It is the sole responsibility of the placing agency, county or governing body to notify and update California Psychiatric Transitions, of any changes as to the legal status of the resident. Failure to do so may result in immediate discharge of the resident.***

## VISITING POLICY

Visiting hours are between 11:30am and 2:00pm daily. If any of the Resident's guests fail to abide by the Facility's rules for visitors, the Resident and Responsible Party or Agent agree, upon the Facility's request, to arrange for the prompt removal of such visitors from the Facility.

## NOTICE OF RATE CHANGE

If rates are increased, the Resident or LEGAL REPRESENTATIVE will be given at least 30 days written notice of the change.

*CALIFORNIA PSYCHIATRIC TRANSITIONS* is not responsible for any cash resources, valuables or personal property brought into the facility unless these items are delivered to the Director for safeguarding. **CPT shall not be financially responsible for any artificial or prosthetic devise. {Dentures, contact lenses, hearing aids etc.} [See P&P Artificial & Prosthetic Devise].**

RESIDENT INITIALS: _____

# HOUSE RULES

| | |
|---|---|
| 1 | Residents of California Psychiatric Transitions (CPT) shall not carry, keep or store **any** medication while at CPT. All medications, prescribed and over the counter medications (i.e. cough suppressants, nasal inhalers, pain medications, etc.), will be kept and dispensed by designated facility personnel. All medications must be taken as prescribed by the method prescribed (i.e. as a pill, as a liquid, crushed & mixed with applesauce, by mouth, by intra muscular injection, etc). |
| 2 | Residents are not permitted to smoke inside the center and where "No Smoking" signs are posted. Residents are permitted to smoke only at designated times in the designated areas that are under the periodic observation of CPT staff. Staff will show you where the designated smoking areas are located.<br>NOTE: Article 7. Physical Plant TITLE 9. DIVISION 1 — DEPARTMENT OF MENTAL HEALTH § 787.00. Fire Safety. Authority cited: Sections 5675 and 5768, Welfare and Institu-tions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code. |
| 3 | Any alcohol, stimulants, illicit substances, or "drug related paraphernalia" are prohibited on facility property. The use of alcohol, stimulants or illicit substances is prohibited. |
| 4 | No resident may be in the possession of property belonging to another resident without first obtaining permission from both the owner of the property and the treatment team. |
| 5 | This facility discourages sexual activity among residents in order to protect residents from sexual exploitation. No resident may be in any other resident's room. Resident's cannot have visitors in their assigned rooms without the express permission of the facility director. The director or staff may enter resident's room with or without previous notice. Toilet and shower/bath rooms are limited to one resident at a time. All residents are only allowed to sleep in their assigned beds. |
| 6 | All residents are expected to maintain proper grooming and hygiene. Assistance with routine ADL skills will be provided for those residents requiring such assistance. Shoes or sandals must be worn when outside facility buildings. Eligibility for non-essential service outings shall be partially dependent upon satisfactory completion of ADL's. |
| 7 | All residents and staff are expected to use language and behavior that is neither abusive, threatening nor inappropriate to others. |
| 8 | All visits are to be scheduled. Visiting hours are between the hours of 11:30 AM and 2:00 PM daily. All visitors must sign in our guest book. |
| 9 | Between the hours of dusk to dawn, for protection and safety, all residents must be inside or within a 30 foot perimeter of the residential buildings unless accompanied by staff or if previous arrangements have been made with facility director. All residents on Standing Passes (unsupervised outings into the community) are to sign out prior to leaving on standing passes and sign in upon returning. Destination and duration of the standing pass outings must be clearly stated on the sign out sheet. Residents on standing passes must have met their daily group and ADL requirements prior to being allowed to go on standing passes. Standing passes (unsupervised outings into the community) must be approved by the facility director (or designee). |

RESIDENT INITIALS: _____

| | |
|---|---|
| **10** | All residents are expected to willingly, with minimal prompts, participate in their rehabilitation by active contribution to the development of their treatment plans and in scheduled program activities. |
| **11** | Telephone calls should be limited to reasonable hours and duration. A pay telephone is available to residents. |
| **12** | Mail will be delivered to residents on the day it arrives, after it has been sorted and not during group times. Mail is not delivered on Saturdays, Sundays, and holidays. CPT may cover the postage cost of regular class mail at a rate not to exceed one letter per resident per day. |
| **13** | Residents and staff may not make any purchases for other residents without the prior consent of treatment team. |
| **14** | Residents and staff may not trade, give or sell any items to other residents or staff without prior administrative approval. No perishable food items may be stored in any of the bedrooms. Facility refrigerators may not be used to store resident's personal food or drink items. |
| **15** | All residents funds are to be kept in the resident trust account. Funds can be signed out to residents as appropriate needs arise. |
| **16** | The resident (or representative) shall be billed for any damages to the facility or property, caused by the resident, that is not due to normal "wear and tear". Non payment of billed damages shall be reason for discharge from this facility. |
| **17** | The facility attempts to provide a secure environment by reducing potential stressors such as violent television/video programs, poster, pictures or magazines that promote violence, pornography, military or survivalist items, clothing that promotes the use of illicit drugs or alcohol, etc. |

| RESIDENT SIGNATURE & DATE | CPT STAFF SIGNATURE & DATE. |
|---|---|
| | |
| **PLACEMENT AGENCY SIGNATURE & DATE** | **CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE** |
| | |

**Rules subject to change as deemed appropriate by the facility director.**

***653x**. (a) Any person who telephones the 911 emergency line with the intent to annoy or harass another person is guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000), by imprisonment in a county jail for not more than six months, or by both the fine and imprisonment. Nothing in this section shall apply to telephone calls made in good faith.

(b) An intent to annoy or harass is established by proof of repeated calls over a period of time, however short, that are unreasonable under the circumstances.

(c) Upon conviction of a violation of this section, a person also shall be liable for all reasonable costs incurred by any unnecessary emergency response.

RESIDENT INITIALS: _____

# ACKNOWLEDGEMENT OF AUTHORIZED COMMUNICATION(S)

California Psychiatric Transitions is frequently contacted by outside sources regarding the residents; i.e. relatives, friends, previous placements, etc. In an effort to provide therapeutic support as well as absolute confidentiality regarding, **Last, First----000-00-0000-----MM-DD-YYYY**, please assist us by providing us the name(s), relationship and any pertinent information of individuals/agencies that CPT has permission to speak with regarding this resident. We also ask that you provide any names of individuals/agencies who are NOT okay to speak with.

**RE:** Last, First----000-00-0000-----MM-DD-YYYY
RESIDENT NAME-----SOCIAL SECURITY NUMBER----DATE OF BIRTH

**FROM:** County/Regional Center
RESPONSIBLE PLACING AGENCY

## APPROVED CONTACTS FOR, Last, First----000-00-0000-----MM-DD-YYYY:

| Name (Please Print) | Relationship to CPT Resident | *Comment(s) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Please DO NOT share information with the following contact(s) without further consent:

| Name (Please Print) | Relationship to CPT Resident | *Comment(s) |
|---|---|---|
| | | |
| | | |
| | | |

**The signature(s) below is of a person(s) who can legally authorize contacts.**

√ √ √
CONSERVATOR OR AUTHORIZED REPRESENTATIVE, TITLE (PRINTED) SIGNATURE DATE

√ √ √
CASE MANAGEMENT, TITLE (PRINTED) SIGNATURE DATE

RESIDENT INITIALS: _____

## TRUST FUND AUTHORIZATION

**This page authorizes CPT to deposit resident funds into a CPT resident trust account.**

**1.**

RESIDENT SIGNATURE _____ DATE _____

**2.**

CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE _____ DATE _____

**3.**

CPT STAFF SIGNATURE _____ DATE _____

**4.**

PLACEMENT AGENCY SIGNATURE AND TITLE _____ DATE _____

RESIDENT INITIALS: _____

## INFORMED CONSENT

This document is to provide information to the resident regarding medications and treatment. The resident shall be advised of the expected benefits and potential side effects of any new or added or discontinued medication or treatment. These medications are intended to assist the resident in regaining thought processing abilities and lower acute anxiety and/or agitation. Some medications may require several doses to attain maximum benefits, other medications are immediately effective. Most often, side effects of psychotropic drugs fade during continued treatment. Side effects may or may not include; indigestion, nausea, vomiting, diarrhea, constipation, unsteadiness, dizziness, alteration in blood counts, liver function alteration or skin rash. Some medications affect body weight, can initiate tremors, headache, depression, unusual excitement, or irritability. Every effort is made to gain maximum benefit at the lowest dose possible while minimizing discomfort and side effects to improve the likelihood of long term compliance. All psychotropic, with the exception of Clozaril may cause tardive dyskinesia. As with all medications, there are numerous side effects other than those listed here. In specific cases the doctor will indicate the drug and side effects and counsel the resident and/or authorized legal representative directly.

In the event a change in medication or treatment is necessary an Informed Consent for Medication/Treatment form shall be processed, authorized and signed for each and every event as it occurs.

The undersigned hereby acknowledges and authorizes California Psychiatric Transitions Informed Consent procedures.

**1.**

_____ _____
RESIDENT SIGNATURE DATE

**2.**

_____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

**3.**

_____ _____
CPT STAFF SIGNATURE DATE

**4.**

_____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

RESIDENT INITIALS: _____

## CONSENT/AUTHORIZATION FOR MEDICAL TREATMENT

**With Respect To:** **Last, First----000-00-0000-----MM-DD-YYYY**
RESIDENT NAME-----SOCIAL SECURITY NUMBER-----DATE OF BIRTH

As the Resident, Conservator, Agency Representative or Legal Guardian, I hereby give consent to *California Psychiatric Transitions* to provide medical and dental care as prescribed by a duly licensed physician (MD) or dentist (DDS). I authorize California Psychiatric Transitions to monitor medications and treatments including reviewing lab results and medical progress notes.

Prior to final admission the following Medical/Labs and Testing assessment will be required;

| | |
|---|---|
| Tuberculosis Screening | CBC with differential |
| VDRL | Lipid Panel with fasting (8) hours |
| CMP | TSH |

[All within 6 months and any test deemed necessary based on the safety and welfare of CPT staff and residents].

Financial responsibility and agreement information and/or Letter of Guarantee of payment or Purchase of Services (POS) shall also be required.

THANK YOU

**1.**

_____ _____
RESIDENT SIGNATURE DATE

**2.**

_____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

**3.**

_____ _____
CPT STAFF SIGNATURE DATE

**4.**

_____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

# AUTHORIZATION FOR PHOTOGRAPH / VIDEO TAPE

I, GIVE PERMISSION FOR ***CALIFORNIA PSYCHIATRIC TRANSITIONS*** TO TAKE AND HAVE IN THEIR FILE, PHOTOGRAPHS, AND/OR VIDEO TAPE OF THIS RESIDENT TO BE USED FOR ADMINISTRATIVE IDENTIFICATION PURPOSES.

THANK YOU

1.

RESIDENT SIGNATURE _____ DATE _____

2.

CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE _____ DATE _____

3.

CPT STAFF SIGNATURE _____ DATE _____

4.

PLACEMENT AGENCY SIGNATURE AND TITLE _____ DATE _____

# AUTHORIZATION FOR MEDI-CAL / MEDICARE INFORMATION

**DATE:** _____

**PERMISSION IS HEREBY GRANTED FOR *CALIFORNIA PSYCHIATRIC TRANSITIONS* TO COLLECT ALL INFORMATION PERTAINING TO THE MEDI-CAL COVERAGE REGARDING**

**Last, First----000-00-0000-----MM-DD-YYYY**
RESIDENT NAME-----SOCIAL SECURITY NUMBER-----DATE OF BIRTH

**THANK YOU**

1. _____ _____
RESIDENT SIGNATURE DATE

2. _____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

3. _____ _____
CPT STAFF SIGNATURE DATE

4. _____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

# CONSENT/AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

As the Resident, Conservator, Agency Representative or Legal Guardian, I hereby give consent to ***California Psychiatric Transitions*** to obtain medical information from any health or psychiatric care agency providing service to this person during their residency at ***California Psychiatric Transitions.***

**1.**

_____ _____
RESIDENT SIGNATURE DATE

**2.**

_____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

**3.**

_____ _____
CPT STAFF SIGNATURE DATE

**4.**

_____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE

THE FOLLOWING INFORMATION IS COPIED WORD FOR WORD FROM THE HANDBOOK OF RIGHTS FOR INDIVIDUALS IN MENTAL HEALTH FACILITIES FROM CALIFORNIA OFFICE OF PATIENTS'S RIGHTS APRIL 2004 REVISION.

## RIGHTS FOR INDIVIDUALS IN MENTAL HEALTH FACILITIES HANDBOOK

Admitted Under the Lanterman-Petris-Short Act

### HOW TO REACH YOUR PATIENTS' RIGHTS ADVOCATE

**If you have any questions or would like to make a complaint about a possible violation of your rights, please call the advocacy office listed on the back cover of this handbook.**

Patients' rights law is composed of a complex and evolving system of statutes, regulations, and court decisions. This handbook should be considered a guide, but it may not accurately reflect all the rights available to persons at all times.

The person in charge of the facility in which you are receiving treatment is responsible for ensuring that all your rights in this handbook are protected. You should be informed of your rights in a language and a manner that you can understand.

- On admission to the facility
- When there is a change in your legal status
- When you are transferred to another unit or facility
- At least once a year

If you believe that your rights may have been denied or violated, please contact your patients' rights advocate, even if your situation is not specifically covered in this handbook.

### INTRODUCTION

If you are receiving, either voluntarily or involuntarily, mental health services in one of the facilities listed below, you have the rights outlined in this handbook. Your rights may vary depending on your legal status or the type of facility you reside in. *Your rights may **not** be waived by your parent, guardian, or conservator.*

State Hospital
Acute Psychiatric Hospital
Psychiatric Unit of General Acute Care Hospital
Skilled Nursing Facility/IMD
Licensed Group Home
Adult Residential Facility
Licensed Family Home
Adult Day Care Facility
Psychiatric Health Facility
Mental Health Rehabilitation Center
Community Treatment Facility
23-Hour Treatment Facility

You cannot be asked to give up any of your rights or threatened into giving them up as a condition of admission or for receiving treatment; however, you may not choose not to exercise a specific right.

### ACCESS TO THE PATIENTS' RIGHTS ADVOCATE

You have the right to see a patients' rights advocate who has no clinical or administrative responsibility for your mental health treatment and to receive his or her services. Your advocate's name and telephone number are located on the back cover of this handbook.

You have the right to contact the patients' rights advocate at any time. The facility where you are staying will provide you with assistance to ensure that you can exercise the right. You have the right to communicate with and to receive visits privately from your patients' right advocate or attorney.

### WHAT IF YOU HAVE A COMPLAINT

You have the right to complain about your living conditions, any physical or verbal abuse, any threats or acts of cruelty, or your treatment in the facility without being punished for voicing such complaints.

The patients' right advocate is responsible for investigating and trying to resolve complaints about your rights. If the advocate is unable to help you with your concern, your complaint may be referred, with your permission, to another agency that can assist you.

If you are dissatisfied with the advocate's response to your complaint about your rights, your complaint may be referred to the facility director or to your local mental health director on your request.

### RIGHTS WHILE YOU ARE INVOLUNTARILY DETAINED

The following text provides information about being involuntarily detained.

#### 72-Hour Hold of "5150"

When a person, as a result of a mental disorder, is a danger to himself/herself or others or is gravely disabled, a peace officer, a member of the attending staff, or another professional person designated by the county may with probable cause take the person into custody and place him or her in a facility for a 72-hour treatment and evaluation.

The facility shall require a written application stating the circumstances under which there is a probable cause to believe that a person is, as a result of a mental disorder, a danger to himself/herself or others or is gravely disabled. If the probable cause is based on the statement of a person other than a police officer, a member of the attending staff, or a professional person, this person shall be liable in a civil action for intentionally giving a statement that he or she knows to be false.

If you were brought into a mental health facility against your will because you were considered to be a danger to yourself, a danger to others, or gravely disabled because of a mental disorder, you may be held up to 72 hours for treatment and evaluation unless the person in charge can establish that you need an additional 14 days of mental health treatment (*Welfare and Institutions Code Sections 5150 and 5250*).

**14-Day Certification for Intensive Treatment or "5250"**

If a person is detained for 72 hours under the provisions of Section 5150 of the *Welfare and Institutions Code* and has received an evaluation, he or she may be certified for not more than 14 days of intensive treatment related to a mental disorder or an impairment by chronic alcoholism under the following conditions:

- The professional staff of the facility that provides evaluation services has analyzed the person's condition and has found that the person is a danger to himself/herself or others or is gravely disabled.
- The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis.

If you are held beyond 72 hours, you have the right to remain in the hospital for voluntary treatment. If you do not wish to stay voluntarily treatment. If you do not wish to stay voluntarily, you will automatically be scheduled for a certification review hearing, which will occur at the facility where you are staying within four days of the end of your 72-hour hold. You may be represented at this hearing by a patients' rights advocate or another person of your choice. You can also request to have family members or someone of your choice at the hearing to help explain your circumstances (*Welfare and Institutions Code 5250*). If you want your advocate or facility staff member to telephone someone for you, make this request before the hearing.

*Helpful Hint

If you request a writ of habeas corpus, you give up your right to have a certification hearing. Talk to your advocate for more details about how the writ process works.

**Re-certification for Intensive Treatment of "5260"**

If during the 14-day certification you attempted or threatened to take your own life and if you remain an imminent threat of taking your life, your doctor may place you on an additional 14-day hold, which is known as a re-certification. You have the right to request a writ of habeas corpus. **Please note that no hearing will take place for this hold** (*Welfare and Institutions Code Section 5260*).

**Additional 30-Day Hold or "5270.1"**

In some counties, after you have completed a 14-day period of treatment, you may be held for an additional 30 days if your doctor determines that you remain gravely disabled and you are unwilling to accept voluntary treatment. Another certification hearing will automatically be held. You have the right to have a patients' rights advocate assist you at the hearing. You also have the right to request a writ of habeas corpus at any time during this period and to have a patients' rights advocate or attorney assist you at the hearing (*Welfare and Institutions Code Section 5270.1*).

**Post Certification for Dangerousness or "5300 et. al."**

If sufficient reason exists at the end of the 14-day certification to believe that you are a danger to others because of a mental disorder, the person who is in charge of the facility may petition the court to require you to remain in the facility for further treatment. This treatment is not to exceed 180 days. You have the right to representation by an attorney and to a jury trial (*Welfare and Institutions Code Section 5300 et. al.*).

**Temporary Conservatorship**

If the person in charge of the facility where you are staying believes that you may benefit from the services of a conservator because you remain *gravely disabled*, you may be placed on a temporary conservatorship (T-con) for up to 30 days. At the end of 30 days, a hearing will be held to determine whether you remain gravely disable and whether and whether a one-year conservatorship will be necessary. Your advocate or attorney can assist you with the conservatorship hearing process (*Welfare and Institutions Code Section 5352.1*).

**CONFIDENTIALITY**

Your record is confidential and can be released only to you or people who are involved in providing you with medical or psychiatric services, except under court order, or as provided by law. However, other specific people may be given access to your records whenever you, your guardian, or your conservator gives express consent by signing a form that authorizes the release of information.

You must also be informed of your right to have or to not have other persons notified if you are hospitalized.

**MEDICAL TREATMENT**

While you are staying in a facility, you have the right to prompt medical care and treatment.

*Helpful Hints

- If you don't feel well or are in pain, let your doctor or a treatment staff member know right away.
- If you have any question about your treatment, talk to your doctor or a treatment staff member or ask your advocate to help you.

**RIGHT TO REFUSE TREATMENT**

**Voluntary Patients**

You can refuse any type of medical or mental health treatment, including medications, unless the situation is an emergency (see the "Definitions" section of this handbook for *emergency treatment*).

**Involuntary Patients**

You have the right to refuse medical treatment or treatment with medications (except in an emergency) unless a capacity hearing is held and a hearing officer or a judge finds that you do not have the capacity to consent to or refuse treatment. The advocate or public defender can assist you with this matter.

**Conservatees**

If you are on conservatorship and the judge has granted your conservator power to make mental health treatment decisions, you no longer have the right to consent to or refuse treatment. You should talk with your advocate or attorney for more information. In addition, in some cases, a judge may allow a patient on conservatorship to retain the right to consent to or refuse medical treatment.

**All Patients**

You have the right to refuses to take part in any research project or medical experiment. You also have the right to refuse electroconvulsive treatment (ECT) or any form of convulsive therapy. However, if a court has determined that you lack the capacity to make this decision, then ECT may be given *without* your consent. An advocate or a public defender can assist you with the hearing process (*Welfare and Institutions Code Section 5326.7*).

**MEDICATIONS AND THE INFORMED CONSENT PROCESS**

**Voluntary Patients**

If you are a voluntary adult patient, you have the right to consent to or refuse taking antipsychotic medications (except in an emergency). You may be treated with antipsychotic medications only after the hospital has completed the *informed consent* process.

**Involuntary Patients**

If you are being detained against your will, you have the right to refuse treatment with antipsychotic medications *unless the situation is an emergency or a hearing officer or a judge has determined that you are incapable of making this decision.*

*Helpful Hint

If your medication interferes with your ability to participate in daily activities or has other unpleasant side effects, let your doctor know.

**The Informed Consent Process**

Before you give your consent to take any antipsychotic medication, your doctor must first explain to you the following:

1. The reasons for your taking this medication and the benefits that you can expect
2. Your right to withdraw your consent at any time
3. The type and the amount of medication and how often you must take it
4. The common side effects from taking the medication, the effects that you are most likely to experience, and for how long the doctor believes you will need to take the medication
5. Alternative treatments that are available (if any)
6. The potential long-term side effects of taking the medication

*Helpful Hint

If you are asked to consent to taking medications without being given a full explanation, talk to your advocate.

**CAPACITY HEARING FOR MEDICATIONS**

A capacity hearing, which is also called a Riese Hearing, may be held to determine whether you may or may not refuse treatment with medications. The capacity hearing will be conducted by a hearing officer at the facility where you are receiving treatment or by a judge in court. The hearing officer will determine whether you have the capacity to consent to or refuse medication as a form of treatment.

You have the right to be represented at the capacity hearing by an advocate or by an attorney. Your representative will help you prepare for the hearing and will answer your questions or discuss concerns that you may have about the hearing process.

If you disagree with the capacity hearing decision, you may appeal the decision to a superior court or to a court of appeal. Your patients' rights advocate or attorney can assist you with filing an appeal.

*Helpful Hint

If you have any questions about your right to consent to or refuse medications or about the capacity hearing process, talk to your patients' rights advocate or the public defender.

**RIGHTS THAT CANNOT BE DENIED**

Persons with mental illness have the same legal rights and responsibilities that are guaranteed all other persons by the federal and state constitution and laws unless specifically limited by federal or state laws and regulations (*Welfare and Institutions Code Section 5325.1*).

**The Right to Humane Care**

You have the right to dignity, privacy, and human care. You also have the right to treatment services that promote your potential to function independently. Treatment must be provided in ways that are least restrictive to you.

*Helpful Hints

- If you feel that your treatment is too restrictive, talk to your doctor and find out how your treatment can be changed.
- You can also talk to the patients' rights advocate or file a complaint.

**The Right to Be Free from Abuse or Neglect**

You have the right to be free from abuse, neglect or harm, including unnecessary or excessive physical restraint, isolation, or medication. Medication shall not be used as punishment, for the convenience of staff, as a substitute for treatment, or in quantities that interfere with the treatment program. You also have the right to be free from hazardous procedures.

*Helpful Hint

If you believe that you have suffered abuse or neglect in the facility or feel that your treatment is more restrictive than necessary, talk to your advocate or let a staff member know.

**The Right to Social Activities and Recreation**
You have the right to social interaction and participation in activities within the community or within the facility if you are hospitalized.
You have the right to physical exercise and recreational opportunities.

**The Right to Education**
You have the right to participate in appropriate programs of publically supported education.

**The Right to Religious Freedom and Practice**
You have the right to religious freedom and practice.
*Helpful Hint
Your right to practice your religion cannot be denied by anyone. You may not be pressured in any way to participate in religious practices, and you do not have to accept a visit from a clergyman of any religion unless you want to. As soon as possible after you are admitted to a facility, you should let the staff know whether you have any special religious needs.

**The Right to Be Free from Discrimination**
You have the right to receive mental health services without discrimination on the basis of race, color, religious, sex, national origin, ancestry, age, marital status, physical or mental disability, medical condition, or sexual orientation.
*Helpful Hint
Talk with a staff member or your advocate if you have any concerns about discrimination.

**RIGHTS THAT MAY BE DENIED WITH GOOD CAUSE**
Unless the facility's staff and the doctor have good cause to do so, you cannot be denied any of the following rights:

**Clothing**
You have the right to wear your own clothes (except as prohibited by law in some state hospitals).

**Money**
You have the right to keep and be allowed to spend a reasonable sum or your own money or personal funds for canteen expenses and small purchases.

**Visitors**
You have the right to see visitors each day.
*Helpful Hint
Please check with the facility where you are staying for more details on visiting times and policies.

**Storage Space**
You have the right to have access to storage space for your personal belongings.

**Personal Possessions**
You have the right to keep and use your own personal possessions, including your own toilet articles.

**Telephone**
You have the right to have reasonable access to a telephone both to make and receive confidential calls or to have such calls made for you.
*Helpful Hint
If telephones are not place where you can make private phone calls, ask a facility staff member whether you can have privacy when making your call.

**Mail**
You have the right to receive mail and unopened correspondence.

**Writing Materials**
You have the right to have letter-writing materials, including stamps, made available to you.

**GOOD CAUSE**
*Good cause* for denying any of the rights means that the professional person in charge has a good reason to believe that allowing a specific right would cause:

1. Injury to that person or others; or
2. A serious infringement on the rights of others; or
3. Serious damage to the facility;
   **And** there is no less restrictive way to protect against those occurrences.

Your rights cannot be denied as a condition of admission, a privilege to be earned, a punishment, a convenience to staff, or a part of a treatment program. A denial of a right can be made only by the person authorized by law or regulation to do so, and this denial must be noted in your treatment record. If one of your

rights is going to be denied, a staff member must inform you. Any denial of a right must be reviewed on a regular and ongoing basis. Once good cause no longer exists, your right(s) must be restored.

*Helpful Hint

If you feel that you have had a right unfairly denied or you would like a right restored, you can talk to your advocate or a staff member or file a complaint.

**DEFINITIONS**

**Advocate.** The person mandated by state law to ensure that mental health patients maintain their statutory and constitutional rights.

**Antipsychotic Medication.** Any medication that is customarily prescribe for the treatment of mental disorders, emotional disorders, or both.

**Capacity.** A determination of whether a person is:

- Aware of his or her situation;
- Able to understand the risks, benefits, and alternatives to the proposed treatment; and,
- Able to understand and knowingly and intelligently evaluate information as it concerns giving consent and to otherwise use rational thought processes to participate in treatment decisions.

**Conservator.** A person who is appointed by a court to take care of a patient, his or her property, or both when the patient is considered to be gravely disabled as a result of a mental disorder or an impairment by chronic alcoholism. A conservator may be a public agency representative or a private person. A conservator may make decisions about a patient's treatment, placement, and finances.

**Emergency Treatment.** A situation in which action to impose treatment over a person's objection is immediately necessary for the preservation of life or the preservation of serious bodily harm to the patient or to others and it is impractical to first gain consent from the patient.

**Gravely Disabled.** A person who is unable, by reason of a mental disorder, to provide for his or her own food, clothing, or shelter. A person is not gravely disabled is someone else is 3willing and able to provide these basic necessities.

**Hearing Officer.** A superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer who makes decisions in mental health certification review and capacity hearings.

**Imminent.** About to happen or ready to take place.

**Informed Consent.** A process by which a patient is informed of any antipsychotic medications that have been prescribed to him or her and the patient's consent is obtained. The informed consent form states that the patient was informed about the prescribed medication(s), including the type of medication, the quantity, the benefits or side effects of the medication, and the other forms of treatment that are available. The mental health facility is also require to keep the signed consent form in the patient's record.

**Petition for Writ of Habeas Corpus.** A legal request for release from a facility or an institution that a patient can file himself or herself or with the help of an attorney, an advocate, or a facility staff member. If accepted, the writ will entitle a patient to a hearing in a superior court.

**Probable Cause.** The amount of evidence that justifies issuing a 14-day certification. The mental health facility must establish specific facts that would reasonably lead someone to believe that a person is dangerous to himself, herself, or others or is gravely disabled.

**Merced County Patients' Rights Advocate Address and Telephone Number**

300 E. 15th Street
Merced, CA 95340
(209) 381-6876
(800) 736-5809

**If you are unable to reach your patients' rights advocate you may contact:**

Office of Patients' Rights (916) 575-1610
Office of Human Rights (916) 654-2327

# CPT CONTRABAND LIST

The following is a list of items that are not allowed in the facility, along with items that will be secured with client accessibility during designated times. This safety protocol will be implemented facility wide.

**Restricted Items:**
Illicit Drugs
Glass Products
Pepper Spray
Matches/Lighters
Solid Red or Blue Clothing (Forensic Program)
Compact Glass Mirrors
Loose Tobacco
Electronic Devices with recording capabilities
Cell phones
Alcohol/Alcohol based Products
Knives
Explosives
Weapons
Televisions (Smart type w/ Internet capabilities)
Metal Nail Files
Loose weights/dumb bell style
Fingernail/Toenail Clippers

**Accessible Items that will be secured:**
Nail Polish/Remover
Needles (Arts/Crafts Type)
Hair Curlers
Hair Dryers
Curling Irons/Flat Irons
Access to cash in the amount of $ 25.00
Televisions
Razors

*The accessible items that will be secured may not be restricted absent a showing of good cause, documented in the resident's record and approved by Dr. Hackett and/or Dr. Turpin or their designee.

## DISTRIBUTION OF AGREEMENT

**COMPLETE THE APPROPRIATE SECTION, EITHER SECTION 1 & 2 OR SECTION 3 & 4, DO NOT COMPLETE BOTH**

### SECTION 1 & 2

**Last, First----000-00-0000-----MM-DD-YYYY**

Has received a copy of this completed admission agreement as indicated by signature below.

1.

RESIDENT SIGNATURE _____ DATE _____

2.

CPT STAFF SIGNATURE _____ DATE _____

### SECTION 3 & 4

**Last, First----000-00-0000-----MM-DD-YYYY**

Has chosen not to sign for a copy of this admissions agreement as evidenced by the staff signature and witness signature below.

3.

CPT STAFF SIGNATURE AND TITLE _____ DATE _____

4.

WITNESS _____ DATE _____

# California Psychiatric Transitions

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at a time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information for treatment, payment or healthcare operations, and you may give us written authorization to use or disclose your health information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or anther person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with and opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials; health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

## PATIENT RIGHTS

**Access: You have the right to look at or get copies of your health information, with limited exceptions. (You complete a medical records release form to obtain access to your health information. You may obtain a form by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you a minimum of $30.00 or $2.50 for each page after (12) twelve pages for staff time to locate and copy your health information, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)**

Disclosure Accounting: You have a right to receive a list of instances in which our business associates or we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 15, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Aaron Stocking, Director**
California Psychiatric Transitions
P.O. Box 339
Delhi, CA 95315
Phone: (209) 667-9304
Fax: (209) 669-3978

***CALIFORNIA PSYCHIATRIC TRANSITIONS***
MENTAL HEALTH REHABILITATION CENTER
**P.O. Box 339, Delhi, CA 95315**

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, California Psychiatric Transitions has created this Notice of Privacy Practices. This Notice describes California Psychiatric Transitions' privacy practices and the rights to you, the individual; have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that California Psychiatric Transitions protect the privacy of your PHI that we have received or created.

## Acknowledgement of Receipt of Notice of Privacy Practices

**California Psychiatric Transitions**
**P.O. Box 339**
**Delhi, CA 95315**

I hereby acknowledge that I received a copy of California Psychiatric Transitions' Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of the Notice of Privacy Practices should there be any amendments.

_____ _____
SIGNATURE DATE

**If not signed by the person receiving services, please indicate:**

Relationship:

- ❑ Parent or Guardian of Minor.
- ❑ Legal Authorized Representative or Conservator of an adult receiving services.
- ❑ Beneficiary or personal representative of a person having received services.

Name of person receiving services: **Last, First----000-00-0000-----MM-DD-YYYY**

❑ **REFUSED TO SIGN** **Date:** _____

**ADDENDUM TO THE**
**CALIFORNIA PSYCHIATRIC TRANSITIONS**
**MENTAL HEALTH REHABILITATION CENTER (MHRC)**
**ADMISSION AGREEMENT**

**RE:** Last, First----000-00-0000-----MM-DD-YYYY
RESIDENT NAME-----SOCIAL SECURITY NUMBER----DATE OF BIRTH

**FROM:** County/Regional Center
RESPONSIBLE PLACING AGENCY

WHEREAS, California Psychiatric Transitions Mental Health Rehabilitation Center ("CPT") and _____ ("Placement Agency") entered into that certain written Admission Agreement, dated _____ ("Admission Agreement") for purposes of providing mental health rehabilitation services, including medical monitoring and routine health care, to the aforementioned Resident. The undersigned, being all of the parties to the foregoing Admission Agreement, by their respective signatures hereby acknowledge and agree as follows:

1. Placement Agency Representations and Warranty: The Placement Agency hereby represents and warrants to CPT the following:

   1.1 Placement Agency has shared with CPT all available information about Resident, including relevant social, medical and educational history, behavior problems, court involvement and other specific characteristics of Resident before placement with CPT and shall promptly share additional information to CPT when obtained.

   1.2 Placement Agency has conducted a background check of Resident and has provided written notice to CPT if the Resident has been convicted of a crime other than a minor traffic violation. Placement Agency has provided written notice to CPT if examination of arrest records has determined that there is a possible danger to CPT employees and personnel, CPT patients and/or any third parties located on or surrounding CPT's location.

   1.3 Placement Agency represents and warrants that Resident:

      1.3.1. Has not been registered as a sex offender, as defined by California Penal Code Section 290 et seq;

      1.3.2. Has not been convicted for violating California rape laws as defined under California Penal Code 261 et seq.,

      1.3.3. Has not been convicted for sexual battery under California Penal Code 243.3;

      1.3.4. Has not been convicted for engaging in lewd acts with or involving minors, as defined under California Penal Code 288, California Penal Code 311 and Penal Code 314.

2. Indemnification. Placement Agency shall defend, indemnify and hold CPT, its officers, agents and employees harmless against and from any all claims, suits, losses, damages and liability for damages of every name, kind and description, including attorneys fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to employees, patients/residents, and the public, or damage to property,

which are claimed to or in any way arise out of or are connected with Placement Agency's breach of any of its representations and warranties set forth in this Addendum.

3. Confirmation of Terms. All of the terms, covenants and conditions of the Admission Agreement, including all addendums, attachments and exhibits, except as are herein specifically modified and amended, shall remain in full force and effect, and are hereby adopted and reaffirmed by the parties hereto.

1. _____ _____
RESIDENT SIGNATURE DATE

2. _____ _____
CONSERVATOR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE DATE

3. _____ _____
CPT STAFF SIGNATURE DATE

4. _____ _____
PLACEMENT AGENCY SIGNATURE AND TITLE DATE