MIKID Client Handbook

GUIDE OF SERVICES

Client Name: _____ Provider: _____

Phone Number: _____ Email: _____

Manger: _____ Email: _____

Thank you for deciding on MIKID to be there for you and your child(ren).

Email: phoenix@mikid.org Website: www.mikid.org

Facebook: www.facebook/mikidarizona Toll Free: 1-844-805-2080

Client Name: _____ Provider: _____

MIKID Site: _____ Date: _____

Guardian's Signature: _____

Client's Signature: _____

Please go to website listed below to review your client handbook that contains all information on the second page:

https://www.mikid.org/mikid-client-handbook/

Table of Contents

Patient Rights R9-10-212- Arizona

R9-10-212. Patient Rights

A. An administrator shall ensure that:1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the hospital's premises; 2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and 3. Policies and procedures include: a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that: 1. A patient is treated with dignity, respect, and consideration; 2. A patient is not subjected to: a. Abuse; b. Neglect; c. Exploitation; d. Coercion; e. Manipulation; f. Sexual abuse; g. Sexual assault; h. Seclusion, except as allowed under R9-10-217or R9-10-225;i. Restraint, if not necessary to prevent imminent harm to self or others or as allowed under R9-10-225;j. Retaliation for submitting a complaint to the Department or another entity; or k. Misappropriation of personal and private property by a hospital's medical staff, personnel members, employees, volunteers, or students; and3. A patient or the patient's representative: a. Except in an emergency, either consents to or refuses treatment b. May refuse examination or withdraw consent for treatment before treatment is initiated; c. Is informed of: i. Except in an emergency, alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of the proposed psychotropic medication or surgical procedure; ii. How to obtain a schedule of hospital rates and charges required in A.R.S. § 36-436.01(B); iii. The patient complaint policies and procedures, including the telephone number of hospital personnel to contact about complaints, and the Department's telephone number if the hospital is unable to resolve the patient's complaint; and iv. Except as authorized by the Health Insurance Portability and Accountability Act of 1996, proposed involvement of the patient in research, experimentation, or education, if applicable; d. Except in an emergency, is provided a description of the health care directives policies and procedures: i. If an inpatient, at the time of admission; or ii. If an outpatient: (1) Before any invasive procedure, except phlebotomy for obtaining blood for diagnostic purposes; or (2) If the hospital services include a planned series of treatments, at the start of each series; e. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a hospital for identification and administrative purposes; and f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's: i. medical record, or ii. Financial records.

C. A patient has the following rights: 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis; 2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities; 3. To receive privacy in treatment and care for personal needs;4. To have access to a telephone; 5. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01; 6. To receive a referral to another health care institution if the hospital is not authorized or not able to provide physical health services or behavioral health services needed by the patient; 7. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment; 8. To participate or refuse to participate in research or experimental treatment; and 9. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

Patient's Bill of Rights Sate of Colorado 6 CCR 1011-1 Chap 02-6.104 – PATIENT RIGHTS POLICY

(1) The patient or, where appropriate, patient designated representative has the right to: (a) participate in all decisions involving the patient's care or treatment; (b) be informed about whether the health care entity is participating in teaching programs, and to provide informed consent prior to being included in any clinical trials relating to the patient's care. (c) refuse any drug, test, procedure, or treatment and to be informed of risks and benefits of this action; (d) to care and treatment, in compliance with state statute, that is respectful, recognizes a person's dignity, cultural values and religious beliefs, and provides for personal privacy to the extent possible during the course of treatment; (e) know the names, professional status, and experience of the staff that are providing care or treatment to the patient; (f) receive, upon request: (i) prior to initiation of care or treatment, the estimated average charge to the patient for nonemergent care. (ii) the health care entity's general billing procedures. (iii) an itemized bill that identifies treatment and services by date. (g) give informed consent for all treatment and procedures. (h) register complaints with the health care entity and the Department and to be informed of the procedures for registering complaints including contact information. (i) be free of abuse and neglect. (j) be free of the inappropriate use of restraints. (k) except in emergent situations, patients shall only be accepted for care and services when the facility can meet their identified and reasonable anticipated care, treatment, and service needs. (l) care delivered by the health care entity in accordance with the needs of the patient. (m) confidentiality of medical records. (n) receive care in a safe setting. (o) disclosure as to whether referrals to other providers are entities in which the health care entity has a financial interest. (p) to formulate advance directives and have the health care entity comply with such directives, as applicable and in compliance with applicable state statute. (2) The health care entity shall disclose the policy regarding patient rights prior to treatment or upon admission, where possible. (3) Each health care entity shall post a clear and unambiguous notice in a public location in the health care entity specifying that complaints may be registered with the health care entity, the Department, and with the appropriate oversight board at the Department of Regulatory Agencies (DORA). Upon request, the health care entity shall provide the patient and any interested person with contact information for registering complaints.

Notice of Privacy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice of Privacy ("Notice") please call Medical Records at (602) 253-1240.

MIKID pledge regarding your Protected Health Information (PHI)

MIKID understands that PHI about you is personal. MIKID is committed to protecting this information. MIKID creates a record of care and services you receive at MIKID. We need this record to provide you with quality care and to comply with all federal, state and local regulations. This Notice applies to all medical and behavioral health information generated by MIKID.

This Notice will tell you about the ways in which we may use and disclose Protected Health Information. We also describe your rights and certain obligations we have regarding use and disclosure of PHI.

This applies to the following:

- Any behavioral health care professional authorized to enter information into your PHI record.
- All subcontractors who provide services to MIKID clients.
- All departments and other MIKID clinics will follow the terms of this Notice.
- All MIKID sites and employees will follow the terms of this Notice. In addition, these sites and employees may share medical or behavioral health information with each other for treatment, payment or clinic operations' purposes described in this Notice.

MIKID is required by laws to:

- Make sure all medical or behavioral health information that identifies you is kept confidential.
- Gives you this Notice of MIKID's legal duties and privacy practices with respect to your medical or behavioral health information about you.
- Follow the terms of the Notice that is currently in effect.

How MIKID may use and disclose your PHI

The following categories describe different ways that we use and disclose medical or behavioral health information.

- For Treatment
- For Payment
- For Health Care Operations
- Appointment Reminders
- Treatment Alternatives
- Health-Related Benefits and Services
- Research
- As Required by law
- To Avert a Serious Threat to Health and Safety
- Public Health Responsibilities
- Health Oversight Activities
- Lawsuits and Disputes
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- National Security and Intelligence Activities
- Inmates

Your rights regarding medical information about you

You have the following rights regarding medical information MIKID maintains about you.

- Right to inspect.
- Right to amend.
    - Must be made in writing and include the reason that supports your request.
    - MIKID may deny if information was not created by MIKID, not part of PHI kept by MIKID, information is accurate and complete.
- Right to an accounting of disclosures.
    - Medical or behavioral health information about you disclosed to other agencies.
- Right to request restrictions.
- Right to request confidential communications.
    - How you want MIKID to communicate with you about medical or behavioral health information in a certain way or at a certain location.
- Right to a paper copy of this Notice.

Changes to this Notice

MIKID reserves the right to change this notice. We reserve the right to make a revised or changed notice effective for medical or behavioral health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the MIKID sites. The Notice will contain on the first page, in the bottom right-hand corner, the effective date. In addition, each time you register at or are admitted to the clinic for health care services, we will offer you a copy of the current Notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a written complaint with your local MIKID representatives. Their contact information will be provided to you at intake. If your complaint is not resolved, you can then file a complaint with the MIKID Privacy Officer, Vice President of Programs, or designee, at the MIKID Corporate office.

If MIKID cannot resolve your concerns, you have the right to file a written complaint with the Statewide Behavioral Health and Appeals Coordinator. If the complaint is not resolved there, you can file a complaint with the Secretary of Health and Human Services.

You will not be penalized for filing a complaint

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical or behavioral health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that MIKID is unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Consent To Treat

I hereby grant permission to MIKID, Mentally Ill Kids In Distress, to provide services as may be deemed necessa1y or advisable for the care of _____.
Member Printed Name

I understand that this consent shall remain valid so long as the member is enrolled in the Complete Care Plan or until I withdraw consent. I understand that this information will be reviewed with me yearly.

I understand that all information gathered in the course of services is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law. Examples of such disclosures include situations of an emergency involving a serious: or imminent threat to a person or the public; the reporting of child or adult abuse or neglect; court ordered disclosures; financial claims requirement and audit and program evaluations. I understand that for the purposes of treatment, the member's treatment information may be discussed by other members of the member's Clinical Team and other professionals within the Complete Care Plan system. Additionally, l understands that by signing this consent, I am giving pe1mission for ADHS/DBHS and MEDICAID to access the member's information and records maintained within the Complete Care Plan system and any subcontracted providers concerning the provision of covered services.

I understand that I can request written and verbal information in the language or format that meets my family's needs.

I agree to participate in the treatment planning process regarding the member to the best of my ability. Understand that the length of our involvement in MTKID services is dependent on our family's needs and inclusion of MIKID services on the treatment plan. Also understand that transition planning will be an ongoing part of the planning process to prepare my family for the time when MIKID services come to an end.

ln the event the member becomes a danger to self or others, it may become necessary to place them in a brief Crisis Prevention hold.

Consent To Treat Continued

Parent/Guardian (Print)	Parent/Guardian (Signature)	Date
DCS (Print)	DCS (Signature	Date
MIKID Staff (Print)	MIKID Staff (Signature)	Date

Member's Name: _____ Medicaid ID: _____

How to Get the Best Out of Services

Here are a few guidelines that can help clients while they are in services at Mentally Ill Kids In Distress (MIKID):

♦ Be honest, open-minded, and a willing to look at alternative solutions to current problems.

♦ Be considerate and respectful of others.

♦ Strive to be the best person possible.

♦ Have Pride in self and how it reflects to others.

♦ Cooperate with peers and staff.

♦ Grow in acceptance and humility.

♦ Be consistent in-service attendance.

PSN/Self-Referral Form

Type of Referral: Today's Date: _____

☐ Self-Referral (complete sections A. & B.)

☐ PSN Referral (complete sections A. & C.) **JD # _____**

Section A-General member information:

Member's Name (MEDICAID Name):
_____

DOB: _____ MEDICAID #: _____ ☐ Male
☐ Female

Member lives with: ☐Foster ☐Kinship ☐Other: _____

Address: _____City: _____ Zip: _____

Guardian's Name: _____Phone #: _____

Placement's Name: _____ Phone #: _____

PCP Name, Address, & Phone #: _____

Member's Behavioral Health Home & Office: _____
☐Check if no BHH assigned

Case manager name: _____ Phone #: _____

Case manager email: _____ Fax #: _____

Section B- Self Referral only

☐T1016 Case Management ☐S5110 Family Support ☐S5150 Unskilled Respite
☐T1019 Personal Care ☐H2027 Pre-Job Training ☐H2027HQ Group Pre-Job Training
☐H2025 Ongoing Support to Maintain Emp ☐H2025HQ Group Ongoing Support to Maintain Emp
☐T1013 Interpretive Services ☐H2014 Individual Living Skills ☐H2014HQ Group Living Skills
☐H0038 Individual Peer Support ☐H0038HQ Group Peer Support ☐A0120 Trans-Base
☐S0215 Trans-Mileage ☐H0025 Individual BH Prevention/Ed ☐H0025HQ Group BH Prevention/Ed
☐H0004 Individual Counseling ☐H0004HQ Group Counseling

Please email this form to:
Phoenix: centralazrecords@mikid.org
Northern AZ & Bullhead: nazmedrec@mikid.org
Tucson, Nogales, & Sierra Vista: tucsonmedicalrecords@mikid.org
Yuma, Casa Grande, & La Paz: yumamedicalrecords@mikid.org
**Send to MR dept: ☐ This form ☐MEDICAID Eligibility ☐Consent to Treat ☐ROI (if applicable) **

Section C- PSN Referral only

JD #: _____Date of Removal: _____ Hearing Date: _____

Parent's Name (1): _____MEDICAID # _____

DOB: _____Contact #: _____

Address: _____City: _____ Zip: _____

Contact type: ☐Phone call ☐Text ☐Voicemail Best time to call: ☐Morning ☐Afternoon ☐Evening

Parent's Name (2): _____MEDICAID # _____

DOB: _____Contact #: _____

Address: _____City: _____ Zip: _____

Contact type: ☐Phone call ☐Text ☐Voicemail Best time to call: ☐Morning ☐Afternoon ☐Evening

Attorney Mom: _____ Contact #: _____

Attorney Dad: _____ Contact #: _____

Attorney Member: _____ Contact #: _____

DCS Case Worker: _____ Contact #: _____

Services cannot start until the following documents are received:

Please email this referral form to: annaj@mikid.org with the following documentation.

☐Request for services page ☐Behavioral Health referral page ☐Assessment ☐Service Plan ☐ROI

☐Family Support (S5110) ☐Unskilled Respite (S5150) ☐Case Management (T1016)

Acknowledgement Consent to Treat/ ROI

By signing below, I hereby grant permission to Mentally Ill Kids In Distress, to provide services as may be deemed necessary or advisable for the care of: _____ (Members Name)

Parent signature: _____Date: _____
Verbal Consent Given By (full name & title): _____
_____ Date:_____

MIKID use only

Staff completing the form: _____ Date referral sent: _____
FSP assigned: _____ FSP contact #: _____
FSP email: _____ MIKID Office: _____
CFT date & time:
_____
BHH contact name: _____ Email: _____
☐Declined/not eligible for MIKID services
Send to MR dept: ☐ This form ☐Consent to Treat ☐ROI (if applicable)

Abuse (Physical/Verbal)

For the safety of everyone, verbal and physical violence will not be tolerated.

Anything that could possibly cause or result in physical or emotional harm to self, or another individual, is not allowed. While in services, client(s) will learn how to responsibly to act consideration and not verbally or physically abuse other individuals in the program or the MIKID staff. There is no tolerance for bullying or bully-like behavior. MIKID staff and clients are to demonstrate respect and non-discrimination to race, gender, religion, creed, sexual identity or ethnicity.

The professional staff of MIKID are mandatory reporters of physical and/or sexual abuse.

Activities

MIKID provides a wide variety of activities for clients and families and these activities may include recreational and/or physical activities. MIKID is not responsible for any injuries that might occur going to, participating in, or returning from these activities, and that each client is responsible for any injuries sustained and that any medical bills incurred from any such injury are also the client's responsibility.

Attendance

Consistent attendance at all scheduled activities contained in each client's treatment plan will be of the most beneficial to the success of the outcome desired by client and family. To reach goals, both MIKID staff and client and family are to engage in services agreed upon in treatment plan. If an appointment must be missed, MIKID asks for 24-hour notice of the cancellation either by the client or guardian. This is also the expectations of MIKID staff to the client and family. If a client remains out of services for 30 days (about 4 and a half weeks) or more, the client may be asked to make contact and to be re-established. The client may face termination of services if prior arrangements are not made. Discussion will be to assess needs of services, frequency, and commitment to what has been keeping them out of services before being allowed to return/continue in services.

Attire

Clients and family members are asked to wear clean personal clothing such Jeans, slacks, shorts, dresses, or skirts (with shorts under for children) with an appropriate blouse or shirt may be worn. Clothing and/or accessories that symbolize or advertise inappropriate or suggestive ideas or unhealthy messages are not to be worn. Skintight or revealing clothing, low-cut or tube tops, and halter-tops are considered inappropriate attire. MIKID staff is required to monitor this closely to ensure the safety of all clients, staff, and visitors and have the discretion to ask a client and to change and/or be picked up from facility due to their attire. Client or family members can return to services same day with appropriate attire.

Conduct and Behavior

It is the philosophy of MIKID that clients and their family members be treated with COURTESY and RESPECT by staff, visitors, and other clients. Failure to be respectful of staff, clients and/or their family members, or MIKID facilities may jeopardize continued participation in the program.

MIKID encourages clients not to bring valuables with them while in services. MIKID is not responsible for any personal belongings that are lost or misplaced while at a MIKID facility or while in services.

Code of Conduct Agreement for All Participants

For your information, we expect each participant to conform to these rules of conduct. (Participants who fail to comply with these expectations may be sent home at their parents' expense).

1) Participate with the group and being on time for all gatherings; includes limitations on cellphone use unless there is an imminent need
2) Respect of property: treat indoor spaces appropriately
3) Respect of the efforts of others
4) Respect of other participant's opinions and bodies
5) Respect of staff and other adults
6) Speaking with courtesy/and respect to all; no foul language will be tolerated
7) No possession or use of alcohol, illegal drugs, tobacco, or weapons will be tolerated. Any breaking of the rules will cause in result of immediate dismissal from the premises. (See below SUBSTANCE USE)
8) No offensive or immodest clothing
9) No vape, JU-JU, e-cigarette, aerosols, or any forms of such, etc.
10) Do not leave the event site without permission of an adult supervisor

SUBSTANCE USE: Abstinence from alcohol and unprescribed drugs during your enrollment here is part of your commitment to services. This includes taking medications strictly as directed by your healthcare provider and immediately informing us of any new or modified prescriptions.

I understand that these agreements listed above are meant to make this event the best, safest, and most fun possible for everyone and that if I violate any of them, the Clinical Director will have the authority to determine appropriate consequences up to immediate termination of services at that point. These expectations are for MIKID property such as building and van, etc., as well as in services in the community. I have read and agree to following these standards.

Protected Health Information

MIKID must obtain your written consent before it can disclose protected health information about you. However, federal law permits MIKID to disclose information without your written permission in the following situations:

♦ Pursuant to an agreement with a qualified service organization/business associate.

♦ For research, audit, or evaluations. ♦ As allowed by a court order.

♦ To report a crime committed on MIKID's premises or against MIKID personnel

♦ To medical personnel in a medical emergency. ♦ To appropriate authorities to report suspected child abuse or neglect.

There are times when a client is in a crisis in which confidentiality may be broken to ensure client safety.

Please know that all professional staff of MIKID are mandatory reporters and are required under Arizona law to report all suspected instances of abuse/neglect of minors, developmental, physical, or intellectual and the elderly to the Arizona Department of Human Services.

RELEASE OF INFORMATION

_____	_____	_____
Member's Name	DOB	MEDICAID #

I, _____, authorize _____ to

☐ Release & exchange information/records regarding the above-mentioned member to/with:

MIKID

7816 N 19111 Ave

Phoenix, AZ 85021

602-253-1240

The records to be released and/or exchanged are: All records including confidential Alcohol or Dmg Abuse- related information (as defined in 42 CFR 2.1 et SEQ.), confidential mental health diagnosis/treatment information, confidential HIV related information (as defined in ARS Section 36-661), and confidential communicable disease information (as defined in ARS 36-661), and/or all information related to my contact with the above referenced agency/company including employment performance recommendations. This disclosure is for the purpose of coordination of care.

This consent is subject to revocation at any time except to the extent that the person making the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one (1) year from the date of signature.

_____	_____	_____
Parent/Guardian (Print)	Parent/Guardian (Signature)	Date
_____	_____	_____
DCS (Print)	DCS (Signature)	Date
_____	_____	_____
MIKID Staff (Print)	MIKID Staff (Signature)	Date

RELEASE OF INFORMATION CONTINUED

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, Part II). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

MEDICAID ID:

Member's Name: _____ _____

Authorization to Release Medical Records

Member's Name: _____ Today's Date_____

Date of Birth: _____ Date(s) of Service: _____

□ Photocopy of License

How would you like to receive your requested records?

□ Fax#_____ □ Mail (sent to the address listed below)

□ In person pick-up □ Secure email (to email listed below)

Reason for request:

□ Continuing medical care □ Military □ Insurance □ Social Security/Disability
□ Legal Purposes □ Personal use □ School □ Other_____

Information to be released for accessed:

□ MIKID Monthly Summaries □ MIKID Risk Assessments
□ MIKID Progress Notes □ Other_____

To:

_____ Phone Number: _____

(Doctor, Hospital, Attorney, Self, BHH, etc.)

_____

Address (Street, City, State & Zip Code)

_____

Email Address

I understand that this is a one-time release of medical record(s) to the above entity. By Signing below, I authorize the release of, or request access to the information specified in this document for the above member's name.

Personal or entity requesting records: _____

Signature: _____ Date: _____

Medical Records Use ONLY

MIKID Employee Name: _____ # of pages released: _____

MIKID Employee Signature: _____ Date: _____

healthcurrent

CONSENT TO RELEASE BEHAVIORAL HEALTH & SUBSTANCE ABUSE INFORMATION
(FOR TREATING PROVIDERS)

Patient Name: _____ Date of Birth: _____

By signing this form, I permit all of my past, present and future healthcare providers where I have received behavioral health treatment, including any treatment for substance use disorders, to release my information to Health Current, the statewide health information exchange (HIE), and to the organization listed here:

MIKID - Mentally Ill Kids In Distress	(602) 253-1240		
Name of Healthcare Organization with a Treatment Relationship	Phone Number		
7816 N. 19th Avenue	Phoenix	AZ	85021
Address	City	State	Zip

I am receiving (or will receive) treatment from this organization. The purpose of this disclosure is for:

- My treatment;
- Payment for my treatment (for example, billing insurance companies); and
- Healthcare operations activities (for example, improving the quality of care for patients, managing the care of patients, patient safety activities, and other activities necessary to run a health care organization).

I authorize the disclosure of all my medical information for these purposes, including behavioral health information and substance use disorder information (*e.g.*, drugs and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health, communicable disease-related information, and HIV/AIDS-related information.

I understand that the organization listed above will obtain this information about me through Health Current, the statewide HIE. I understand that if I previously opted out of having my health information shared through the HIE, this form will change that decision. I understand that if I sign this form, I agree to have my health information shared through the HIE. I understand that I can change this decision at any time.

I understand that I may take back or cancel this consent to share my information at any time, except where someone already relied on my consent to release the information. If I want to cancel my consent or if I have questions, I will contact the organization at the contact information listed above. **Unless I cancel this consent earlier, it will automatically terminate <u>one year</u> from the date of my signature.** I understand that my substance use disorder treatment information will continue to be protected by federal law after it is released.

_____ _____
Signature of Patient* Date

_____ _____
Signature of Parent/Guardian *(If Patient is a child under the age of 18)** Date
*Both the child and parent/guardian must consent to disclosure of the child's substance use disorder information, unless the child is married, homeless, or emancipated.

_____ _____
Signature of Patient's Health Care Decision Maker Date
(If Patient has been declared incompetent by a court or is deceased)

Notice to Recipient of Substance Use Disorder Information: 42 CFR part 2 prohibits unauthorized disclosure of these records.

Notice of Confidentiality of Alcohol and Drug Information

- The confidentiality of alcohol and drug abuse member records maintained by MIKID is protected by Federal law and regulation.
- Except under specific circumstances, MIKID may not say to a person outside MIKID that a member attends an alcohol or drug treatment program.
- MIKID also may not disclose any information identifying the member as an alcohol and drug abuser unless:
    1. The member consents in writing;
    2. The disclosure is allowed by a court order;
    3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation purposes.

The violation of Federal laws and regulations governing the disclosure of member information may constitute a crime. Suspected violations may be reported to the appropriate authorities as provided under the regulations.

Federal laws and regulations do not protect any information about a crime committed by a member either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under Arizona law to the appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C 290ee-3 for Federal laws and CFR; Part 2 Federal regulations)

Date: _____

Member Name: _____

Member Signature: _____

Member ID# _____

MIKID Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio, digital or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio, digital or video recordings may be used for, but not limited to, the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos

By signing this release, I understand this permission signifies that photographic, digital, or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs, digital or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio, digital or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release I and release any and all claims against any person or organization utilizing this material.

MIKID Photograph & Video Release Form Continued

Member's Name _____

_____	_____	_____
Parent/Guardian (Print)	Parent/Guardian (Signature)	Date
_____	_____	_____
DCS (Print)	DCS (Signature	Date
_____	_____	_____
MIKID Staff (Print)	MIKID Staff (Signature)	Date

Member's Name _____

MEDICAID ID # _____

MIKID DROP OFF/PICK UP AUTHORIZATION

Member's Name: _____ MEDICAID #_____

I understand that it is my responsibility to ensure I am home when MIKID drops off the member. Should I be unavailable, I authorize MIKID to contact the below emergency contacts:

Name: _____

Relationship to member: _____

Address: _____

Phone Number: _____

Name: _____

Relationship to member: _____

Address: _____

Phone Number: _____

Name: _____

Relationship to member: _____

Address: _____

Phone Number: _____

I, _____(printed guardian name), give MIKID permission to drop off/pick up the member from:

(If different from above list name of an authorized individual's home, school or organization and address below)

_____

_____

_____

MIKID DROP OFF/PICK UP AUTHORIZATION CONTINUED

I can revoke my permission at any time by completing a new Drop Off/Pick Up Authorization form with MIKID staff.

I understand that MIKID will attempt to contact the above-mentioned contacts if I am unavailable during a scheduled drop off. If MIKID is unable to reach myself or emergency contacts, I understand that MIKID may need to contact the local police or DCS.

_____	_____	_____
Parent/Guardian (Print)	Parent/Guardian (Signature)	Date
_____	_____	_____
DCS (Print)	DCS (Signature	Date
_____	_____	_____
MIKID Staff (Print)	MIKID Staff (Signature)	Date

Member's Name: _____ MEDICAID #_____

Grievance Procedure for Clients and Family Members

In the event, while in service, a client feel that their rights have been violated by an action of MIKID staff member or program participant, feel discriminated against, received unequal treatment, or see something that is believed to not be right, please follow the procedure below;

- Inform the provider immediately to find a resolution
- If the situation is not resolved satisfactorily, the client can submit a detailed description of the problem(s) including dates, times, individual(s) involved and contact information to the Program Manager.
- The Program Manager will provide a repose verbally or written within 5 business days.
- If the results are not satisfactory, a review of information will be submitted to the Statewide Director of Program Management and response will be rendered in 5 business days.

Satisfaction Surveys

In an effort to demonstrate continuous growth to improve the delivery of services of MIKID, we would like to know the level of satisfaction with the services being provided to you or your child(ren). Client satisfaction discussions may be given out from time to time by the program manager. Clients and families are strongly encouraged to communicate their satisfaction to the provider and program manager during these discussions.

Discharge Planning

Discharge planning is a joint process between clients and their support team. This may include probation officer, clinical team, family members other than guardian, DCS worker, school staff, etc. with MIKID staff.

Depending on progress in treatment client(s) may be discharged for some of the following reasons;

- The client has successfully accomplished treatment plan goals
- The client has made as much progress and/or gained as much benefit from treatment as they may be able to obtain
- The client or family is not able to or willing to commit to the treatment plan goals and services or the program guidelines.
- The client's behavior is evaluated to be harmful to him/herself or to the rest of his/her peers or community.

EXECUTIVE TEAM

Jeff Kazmierczak, RN, MSN, MBA

Chief Executive Officer

jeffk@mikid.org

Bonnie Kolakowski

Chief Financial Officer

bonniek@mikid.org

Akia Compton, MS, BHT

Vice President of Programs and Operations

akiac@mikid.org

Patrick Winters

Vice President of Marketing and Development

patrickw@mikid.org

Alfonso Gonzales

Director of Human Resources

alfonsog@miki.org

Suma Hodge, MS, LPC, BHP, CCTP

Regional Clinical Director

sumah@mikid.org

Patricia Worthen, LMSW, BHP

Sr. Regional Director of Program Management

pworthern@mikid.org

Heather Fenech, BA

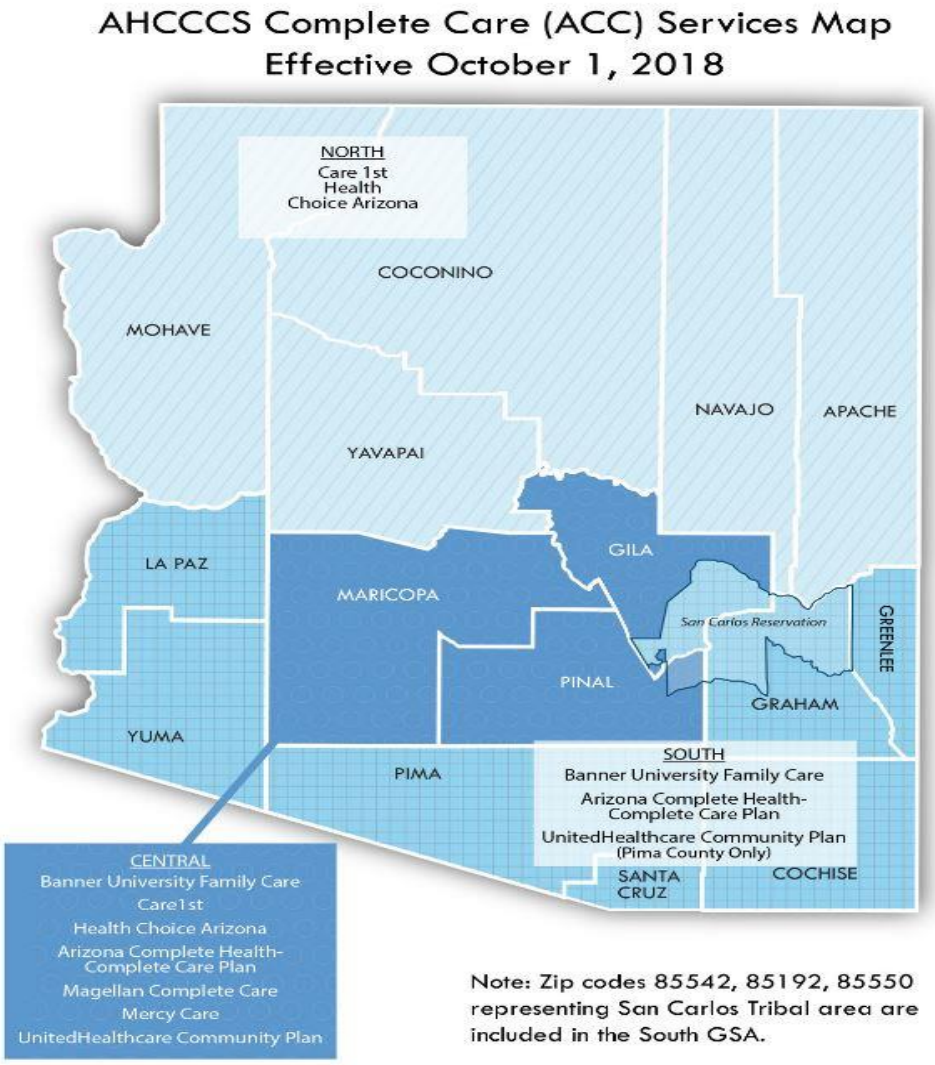
Director of Staff Development

heatherf@mikid.org

Jennifer Diaz

Health Information Systems Manager

jenniferd@mikid.org



included in the South GSA.

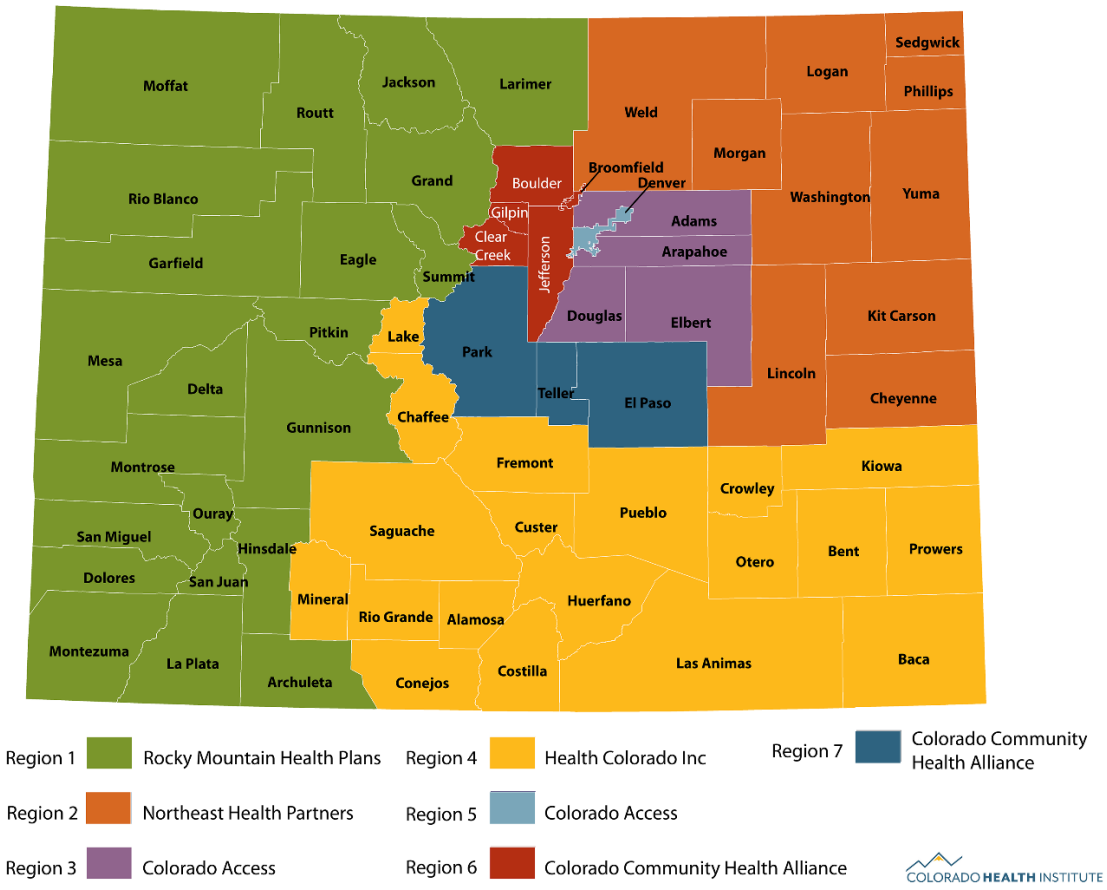
1. **Kingman:** 2615 E Beverly Ave., Kingman, AZ 86409 | PH: 928-753-4354 | FX: 928-543-2277
2. **Bullhead City:** 810 Gemstone Ave., Bullhead City, AZ 86442 | PH: 928-704-9111 | FX: 928-233-7629
3. **Phoenix:** 7816 N 19th Ave., Ste., 100, Phoenix, AZ 85021 | PH: 602-253-1240 | FX: 602-840-3409
4. **Casa Grande:** 901 E Cottonwood Ln., Casa Grande, AZ 85122 | PH: 520-509-6669 | FX: 928-493-3976
5. **Yuma:** 2891 S Pacific Ave., Yuma, AZ 85365 | Phone: 928-344-1983 | Fax: 928-493-3976
6. **Tucson:** 925 E Bilby Rd., Tucson, AZ 85706 | PH: 520-882-0142| FX: 520-882-0124
7. **Nogales:** 1777 N Frank Reed Rd., Off. 1 & 2, Nogales, AZ 85621 | PH: 520-377-2122 | FX: 520-882-0124

Appendix 1-1

Member services for Arizona Health Care Containment Cost System

https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx

Regional Accountable Entity (RAE) Regions in ACC Phase Two



MIKID Colorado Site- Pueblo, CO: 115 E. Riverwalk, Suite 110, Pueblo, CO 81003

Member services for Colorado Health Institute:

https://www.healthfirstcolorado.com/benefits-services/

https://hcpf.colorado.gov/contact-hcpf#Member-Contacts-Anchor-1

Arizona AHCCCS Fee Schedule Site

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

Colorado RAE Fee Schedule Site

https://hcpf.colorado.gov/provider-rates-fee-schedule

https://www.azMedicaid.gov/BehavioralHealth/crisis.html

Crisis Hotlines

Crisis services are available to any Arizona resident, regardless of health insurance coverage. If you or someone you know is experiencing a behavioral health crisis, please call one of these national or local crisis lines:

COVID-19 Crisis Counseling

- Call 2-1-1 for free COVID-19 crisis counseling. www.ResilientArizona.org

National 24-Hour Crisis Hotlines

Phone

- National Suicide Prevention Lifeline: **1-800-273-TALK (8255)**
- National Substance Use and Disorder Issues Referral and Treatment Hotline: **1-800-662-HELP (4357)**

Text

- Text the word "HOME" to 741741

Suicide and Crisis Hotlines by County

- Maricopa County served by Mercy Care: **1-800-631-1314** or **602-222-9444**
- Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties served by Arizona Complete Health - Complete Care Plan: **1-866-495-6735**
- Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties served by Health Choice Arizona: **1-877-756-4090**
- Gila River and Ak-Chin Indian Communities: **1-800-259-3449**
- Salt River Pima Maricopa Indian Community: **1-855-331-6432**
- Tohono O'odham Nation: **1-844-423-8759**

Especially for Teens

- Teen Life Line phone or text: **602-248-TEEN (8336)**

Especially for Veterans

- Veterans Crisis Line: **1-800-273-8255 (press 1)**
- Be Connected: **1-866-4AZ-VETS (429-8387)**

About Arizona's Crisis Services

Arizona has a robust behavioral health crisis services network available to any Arizona resident regardless of health insurance coverage. Services include:

- 24/7/365 crisis telephone lines operated by trained crisis specialists.
- 24/7 mobile teams staffed by behavioral health professionals who travel to the individual experiencing a crisis and provide assessment, stabilization and may triage the individual to a higher level of care, as appropriate.
- Facility-based crisis stabilization centers that offer crisis stabilization and observation, including access to Medication Assisted Treatment.

https://www.healthfirstcolorado.com/benefits-services/#member-handbook

Colorado Crisis Services is the statewide behavioral health crisis response system offering residents mental health, substance use, or emotional crisis help, information and referrals. Its mission is to strengthen Colorado's mental health system by providing Coloradans with greater access to crisis services wherever they are at 24/7/365 regardless of ability to pay.

Call
Connect with someone who will listen, understand, and care.
tel: CALL 1-844-493-8255

Text
Begin a text conversation at any time. We're here to help.
sms: "TALK" to 28255

Walkin Locations

Metro Denver Region
Aurora
Anschutz Medical Campus 2206 Victor Street Aurora, 80045
Wheat Ridge
4643 Wadsworth Blvd. Wheat Ridge, 80033
Denver
4353 E. Colfax Ave Denver, 80220
Boulder
3180 Airport Road Boulder, 80301
Littleton
6509 S. Sante Fe Drive Littleton, 80120

Northeast Region
Greeley
928 12th Street Greeley, 80631
Southeast Region
Colorado Springs
115 S Parkside Drive Colorado Springs, 80910
Pueblo
1310 Chinook Lane Pueblo, 81001
Western Slope Region
Montrose
300 N Cascade Ave. Montrose, 81401

Let others know that there is hope and understanding.
You can change the way the world sees mental health.

Crisis Hotlines

24-Hour Crisis Hotlines – National

1-800-273-TALK (8255) **National Suicide Prevention Lifeline**

Arizona
https://namiarizona.org/crisis-lines/
https://namiarizona.org/information-resources/

Colorado
https://www.namicoloradosprings.org/
https://namibouldercounty.org/resources/boulder-county-mental-health-resources/
chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://leg.colorado.gov/sites/default/files/2020_health_care_resource_book_0.pdf