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| **Department of Public Health, Substance Abuse Prevention and Control**  **Required Language for Admission Agreement in Alignment with R95 Access to Care Expectations (Draft for comment - 9/25/2024)** |
| * Required Language – Noted in **BLUE** * Recommended Language – Noted in **BLACK** text and can be modified or omitted * Comments – Noted in ***ORANGE ITALICS*** text are clarification and are not inclusion in the policy * To include additional agency-specific information not covered in the template, insert a new paragraph directly after the relevant block of required text. * Use agency specific headers / formats in accordance with your policy and procedure standards * This is not an exhaustive admission agreement and any other County or State requirements need to be included in an agency’s final version, including additional guidance that aligns with the intent of the R95 initiative.     *Note: Provider agencies may use “client” or “patient” depending on your standard language* |

**Admission Agreement for Patient Signature:**

The Admission Agreement for [Insert Agency Name] includes important information about your treatment services and how we deliver care. [Optional Text: Our program supports abstinence as a treatment goal and also knows that people are at different stages of readiness when they seek services]. [Optional Text: For this reason, we] We admit people who decided to stop using alcohol and drugs, people who have not decided to stop all use yet but who want services, and people who relapse and still want and can continue receiving services. We teach that substance use disorders (SUD), commonly known as addiction, can be a lifelong health condition and that you decide your treatment and recovery goals. We will encourage you to remain in services even when you are not sure you want to be abstinent or if you relapse, but you still need to follow program rules and participate in your group and individual sessions. We want to make sure that after our discussion you understood these important things about your treatment:

* I know that I am receiving  outpatient, residential,  withdrawal management (detox), and/or  addiction medication services at the following address: [type in prior to patient signing] (check all that apply).
* I know that am going to receive the following services (check all that apply):  individual sessions,  group sessions,  therapy  addiction medications,  case management,  peer support,  recovery support and/or these other services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I know that I need to give written permission before my confidential health information and health records are shared with anybody else, except under limited circumstances such as a medical emergency or a certain court order.
* I know that I decide my own treatment goals and that [Optional Text: even though the program encourages abstinence as a treatment goal] I do not need to agree to stop using all drugs and alcohol before I can receive services. I know that my counselor will work with me to make choices that will help me reach my goals which might mean how to reduce or stop my substance use.
* I know if I take a toxicology test (also known as a “drug test” or “urinalysis”) that I should tell my treatment team before if I will test “positive” and talk about my current recovery because testing is a clinical tool in treatment.
* I know that a relapse or return to substance use does not necessarily mean that I will be discharged but I may receive other consequences or need to enroll in a higher level of care. If I relapse, I know that I can be discharged if I stop participating in treatment services, use on the property, sell drugs to others, and/or do not follow other important program rules such as being violent or intimidating to staff or other clients.
* I know that I can also be discharged due to the following actions, circumstances, or conditions reason not related to a relapse: [insert other reason but they must align with the R95 Initiative].
* I know that readmission is decided on a case-by-case basis with the clinical supervisor and other treatment team members. I know there is no minimum amount of time before I can be readmitted to services.
* I know that I cannot be discriminated against because of my race, color, creed, religion, ancestry, national origin, sex, sexual preference, age, physical or mental disability, marital status, HIV/AIDS status, Hepatitis A/B/C status, political affiliation, use of addiction medications, or ability to pay. I agree to inform a supervisor if I feel I have been discriminated against for these reasons.
* I know that I have the right to free interpreter services if my preferred language is not English and this includes sign language. I know that this program will provide culturally appropriate and trauma-informed services.
* I know that if I am eligible or enrolled in Medi-Cal, that I will not be asked to pay for any of my treatment services unless the State Medi-Cal program told me that I have to pay a share of cost because my income is too high. In these cases, Medi-Cal may require sliding scale payments.
* I know this program encourages me to take my addiction medications such as methadone, buprenorphine, naltrexone, and others as prescribed to stabilize my symptoms and reduce the risk for overdose and death. I know that program staff cannot ask me to stop taking these medications or to reduce my dose, and only a doctor or another qualified clinician can change my prescription.
* I know that I cannot be refused services if I have a medical condition and am able to participate in services. The treatment team will work with my physical health provider(s) to support addressing my medical conditions as necessary.
* I know that I cannot be refused services if I have a mental health diagnosis such as anxiety, depression, bipolar, and schizophrenia if my symptoms do not prevent me from participating in services. I know that this program encourages me to take my mental health medications as prescribed. I know that program staff cannot ask me to stop taking these medications or to reduce my dose, and only a doctor or another qualified clinician can change my prescription. The treatment team will work with my mental health provider(s) to support my mental health treatment and medication adherence as necessary.
* I know the program rules and regulations and why they are needed to support quality care. This includes: [insert agency specific information – it must align with the R95 Initiative].
* I know that the program will prioritize my needs above completion of admission paperwork and that I can take breaks if it is too much for me and if I need to complete documents over multiple sessions.
* I know that I can submit a grievance or complaint to my provider by [insert instructions] and to the Los Angeles County Department of Public Health, Bureau of Substance Abuse Prevention and Control (SAPC) by calling 1-888-742-7900 press 7 Monday through Friday, 8:00 am. through 5:00 p.m. Or, if I cannot hear or speak well, I can call TTY & 711. I can fill out a complaint form or write a letter and send it to: Substance Abuse Prevention and Control, Attn: Complaints and Investigations, 1000 S. Freemont Ave., Bldg. A-9 East, 3rd Floor, Alhambra, California 91803. I may also visit my treating provider and let them know I want to file a grievance [insert DPH instructions].
* I have read and received a copy of the [Insert agency specific information for “Residential” or “Outpatient”] Admission Agreement.
* I know that I may request and receive a copy of my provider’s Admission Policy that describes requirements for program staff.
* I know that I can request a printed copy of the County’s Substance Use Treatment Services Patient Handbook in my preferred language. Available here: http://publichealth.lacounty.gov/sapc/PatientPublic.htm?hl
* I have been shown where the program’s nondiscrimination policies, no-cost access to interpreter services, no-cost services for Medi-Cal eligible or enrolled beneficiaries information is posted.
* I have watched the patient orientation video in my preferred language so I understand more about what services are available to me.

By signing below, I am agreeing that I understand the information above and that I know I can ask questions anytime.

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| Patient/Client Name (Printed) |  | Date |
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| Patient/Client Signature |  |  |
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| Provider/Staff Name (Printed) |  | Date |
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| Provider/Staff Name Signature |  |  |