

**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 directly after the relevant block of required text.
- Use agency specific headers / formats in accordance with your policy and procedure standards. **This specific format (e.g., bullet points vs. check boxes) is not required provided required text is included.**
- 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. Our program supports abstinence as a treatment goal and also knows that people are at different stages of readiness when they seek services. We admit people who have decided to stop using alcohol and drugs, people who have not decided to stop all use yet but who **are interested in help**, and people who relapsed and still want and can continue **participating in services**. **That said, substance use on the premise is not allowed and will result in reasonable consequences**. Further, while [Insert Agency Name] accepts clients wherever they may be on their recovery journey, we do not encourage use off-site **either and support abstinence and recovery**.

Substance use disorders (SUD), **often called** addiction, can be a lifelong health condition and **it is important for clients to have a voice in their** treatment, harm reduction, and recovery goals. We will encourage you to remain in services even **during times** when you are not sure you want to be abstinent or if you relapse. **We will support you in achieving your goals** and need you to follow program rules and **actively** participate in **treatment services (e.g., 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 will receive the following level of care: **[Insert in your agency's template the level of care (e.g., outpatient residential, withdrawal management (detox), addiction medications) that will be provided to the patient. You may**

include check boxes or other formatting approach to better meet your organizational needs].

- I know that I will receive services at the following location(s): [Insert in your agency's template the site address(es) where services will be provided to the patient. You may include check boxes or other formatting approach to better meet your organizational needs].
- I know that the following services are offered individual sessions, group sessions, therapy, addiction medications, care coordination, peer support, and recovery support. [Optional Text: Insert any other services that all patients are eligible to receive].
- 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 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 be open with sharing my recovery experiences, including any return to substance use, with my treatment team. Toxicology/drug testing is a clinical tool in treatment. We will discuss your test results with you.
- I know that a relapse or return to substance use does not necessarily mean that I will automatically be discharged but I may receive other consequences, learning opportunities, or need to enroll in a higher level of care or site. If I relapse, I know that I can be discharged or transferred if I stop participating in treatment services, use substances 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 reasons 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 **and/or file a grievance** if I feel I have been discriminated against for **any of** these reasons.
- I know that I have the right to free interpreter services **at no cost** 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 **but if I prefer, I can ask to be referred to a provider that offers services in my preferred language, as needed**.
- 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 tells 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 **working within their scope of practice** can change my prescription.
- I know that I cannot be refused services **because** I have a medical condition **if I am able to take care of my daily needs and my symptoms do not prevent me from participating 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 **because** 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 **taking my medications as prescribed**.
- 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 the program will prioritize my immediate needs as I start services and that I can take breaks as needed when completing admission paperwork.
- I know that I can submit a grievance or complaint to my treating provider by email, phone, or fax by contacting [insert instructions].
- I know I can also file a complaint or appeal with the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (SAPC):
 - Call (626) 299-4532 to speak to a SAPC employee OR
 - Download the Complaint/Grievance Form in your preferred language on SAPC's Patient Information Webpage (Available Here: <http://publichealth.lacounty.gov/sapc/PatientPublic.htm?hl>) or call for an alternate format (large print, braille, audio) at 1-888-742-7900 press 7:
 - Email it to SAPCMonitoring@ph.lacounty.gov – OR
 - Mail it to Substance Abuse Prevention and Control, Contracts and Compliance, 1000 S. Fremont Ave., Bldg. A-9 East, 3rd Floor, Mailbox 34, Alhambra, California.
- 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 information is publicly posted that describes the program’s non-discrimination policies, how to access no-cost interpreter services, and how to receive no-cost services for Medi-Cal eligible or enrolled beneficiaries [Optional Text: and how to use naloxone for overdose prevention and where to find emergency exits and fire extinguishers].
- 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. [provider can choose “patient” or “client and “provider” or “staff”]

Patient/Client Name (Printed)

Date

Patient/Client Signature

Provider/Staff Name (Printed)

Date

Provider/Staff Name Signature