BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health and Substance Use Disorder Services Organization

Tony Vartan, MSW, LCSW
DIRECTOR

Re: AB1299 Presumptive Transfer to Stanislaus County

Hello Placing Agency Representative,

My name is Teresa-Hang Le, and I am the Presumptive Transfer Single Point of Contact (SPOC) for Behavioral Health and Recovery Services (BHRS) in Stanislaus County.

Per ACL 17-77, in addition to your placing agency's Presumptive Transfer Notification, the forms listed below are vital to ensure timely access to Specialty Mental Health Services. Please note, a separate Release of Information is required for each applicable agency and or caregiver. Please send, or arrange to have sent the following:

- Stanislaus County Authorization for Release of Information (Attached)
- Stanislaus County Consent for Treatment (Attached)
- Most recent mental health records; CANS, mental health assessment, and or treatment plan
- Most recent consent for medication, including the JV-220 a or b and signed JV - 223

Given the nature of out-of-home placements and the intensive needs of these youth; we are seeking to be prompt in our provision of services and are requesting an expedited return of all forms and applicable documents. Please return all documents via the Stanislaus County BHRS AB1299 confidential fax line at 209-558-4245 or encrypted email to presumptivetransfers.stanbhrs.org. Should you have any questions about our process please don't hesitate to contact me directly.

*Save this file and re-open it with **PDF Adobe Acrobat Reader DC** to unlock the PDF fillable features which include the e-signature signing option.

Regards,

Teresa-Hang Le
AB1299 Presumptive Transfer | Single Point of Contact
email: TLe@stanbhrs.org | email: presumptivetransfers@stanbhrs.org
phone: 209-247-8173 | confidential fax: 209-558-4245

Revised 3/6/2024

RETURN Fax Cover Sheet

Presumptive Transfer Notification

To: Teresa-Hang Le, Stanislaus Co. AB1299/ SPOC
Phone Number: 209-247-8173
Fax Number: 209-558-4245

From:
Phone Number:
Fax Number:

Youth's Full Name:			
Youth's Place of Birth:		Youth's Moms First Name:	

Katie A Subclass Eligible

☐ Yes-Attach Documentation
☐ No

Child and Family Team Meeting

Facilitator Contact Information:
Next Scheduled Meeting Date:

STRTP Placement

☐ Yes-Include Interagency Placement Committee (IPC) *Letter of Placement Approval*
☐ No

Is the youth currently receiving Specialty Mental Health Services?

☐ Yes-Please provide CAN's, mental health assessment, and treatment plan
☐ No

Attachments:
Placing Agency AB1299/Presumptive Transfer Notification

- *Stanislaus County Consent for Treatment*
- *Stanislaus County Consent for Telehealth*
- *Stanislaus County Release of Information*
  - *PCP*
  - *School*
  - *Caregiver*
  - *FFA (if applicable)*
  - *Other relevant agencies*
  - *Emergency Contact*
- *Most recent mental health records: CANS, mental health assessment, and treatment plan*
- *JV-220, JV-220 a or b, and signed JV-223*
- *Fee Letter*
- *Medicare and Insurance Authorization*

Start Date: End Date: Client: ID#: DOB:

Consent to Treat

Purpose

I would like services for myself or my child from Stanislaus County BHRS and/or its contracted providers. I understand this document contains information about services that may be provided to me or my child. I understand that I have the right to speak with a provider about the information in this document and ask questions in order to understand this information.

My Rights

I acknowledge I was informed of my/my child's rights as a client and that I was offered the consumer rights document, which contains my/my child's rights as a client.

Privacy Practices

I acknowledge I have been offered a copy of Stanislaus County BHRS and/or its contracted providers' Notice of Privacy Practices, which has information about how my/my child's private health information may be used and disclosed under the law. I understand that in certain circumstances information I share must be disclosed. For example, behavioral health providers are mandated to report if there is a reasonable suspicion of child, elder, or dependent-adult abuse or neglect; if there is a threat to my/my child's physical safety; or if there is a threat to the safety of others.

I understand that if my child is receiving services, in certain cases the provider of those services may not be able to share information with me about those services unless my child permits them to do so.

Services

I understand that the services that may be provided focus on mental health and substance use issues. I am aware my/my child's information and records may be shared between mental health and substance use programs and providers for the purpose of providing treatment, to the extent permitted by law.

Risks and Benefits of Services

I understand behavioral health services may have risks and benefits. I am aware that behavioral health services may involve discussing difficult aspects of my or my child's life and making changes to psychiatric medication I or my child may take and/or substance use treatment. I or my child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I or my child may also experience an increase in the symptoms as I or my child work through issues or as my or my child's medications are being changed and/or added to in the course of treatment.

I am also aware behavioral health services have been shown to have benefits. For example, psychotherapy and/or substance use treatment may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychiatric medication may alleviate symptoms of mental health issues.

I understand there are no certainties about what I or my child will experience as I or my child receive services and how successful services will be. I understand behavioral health services require an investment of time and effort from all involved and openness to what change and success may look like.

Services are Voluntary

I understand participation in behavioral health services is voluntary, except for certain situations where Stanislaus County BHRS and/or its contracted providers is legally required to provide services even if it is involuntary, such as 5150 psychiatric holds or conservatorships.

I understand that even a court orders me to participate in behavioral health services, I can still choose not to participate in services. I am aware that consequences that may arise due to my decision not to participate in court-ordered services that are my responsibility. I understand that I may speak with an attorney, probation officer, and/or Child Welfare Services worker to make the best possible decision regarding participating in court-ordered services.

Eligibility for Services

Eligibility for behavioral health services is determined by a combination of laws, regulations, and local policies. I understand that if an assessment determines that I/my child is no longer eligible for behavioral health services, the reasons will be discussed with me and I will also be provided with a notice of adverse benefit determination (NOABD) that explains these reasons and information on the appeals process. I will then be given referrals to other service providers, as appropriate, that may meet my or my child's needs.

Service Providers

I understand that providers come from different educational and professional backgrounds and have a variety of experience levels and licensure and that providers only provide services that are allowed by law for their specific education, experience, profession, and licensure.

I understand that Stanislaus County BHRS and/or its contracted providers may utilize some unlicensed professionals that are in the process of completing their requirements for clinical licensure but who are authorized by law to provide mental health services under the supervision of a licensed mental health professional. I understand I or my child may receive services from some of these individuals, who will clearly identify themselves, as well as their supervising provider/clinician. I understand I may call the supervising licensed clinician if I have any questions about this arrangement.

Availability of Providers and Crises/Emergencies

I understand providers are generally available during regular county business hours, which are 8am - 5pm, except during county holidays. I understand that some programs have different hours of availability.

For non-urgent matters after-hours, I understand I or my child can leave messages in the provider's confidential voicemail (if they have one available) or with Stanislaus County BHRS and/or its contracted providers after-hours telephone service. For urgent or crisis situations, I or my child can contact: Stanislaus County BHRS Crisis Line at: (888) 210-2515.

For emergencies, I understand my family or I should call 911.

Change of Clinician/Provider

I understand I can request a change of mental health provider at any time by completing a Change of Provider form, which is available at all clinics. I understand requesting a change of provider does not guarantee a change, and there may be significant administrative or treatment issues that may not make the change possible. I understand a supervisor or manager will provide me the reason(s) the change is not possible.

Fees and Billing Medi-Cal, Medicare, and/or Insurance

I understand Stanislaus County BHRS and/or its contracted providers will ask me to provide my financial information on annual basis and this information will be used to calculate service fees that I may be responsible for paying. For substance use treatment services for Drug Medi-Cal Beneficiaries, Drug Medi-Cal funding shall be accepted as payment in full.

I understand any private insurance will be billed by Stanislaus County BHRS and/or its contracted providers before billing Medicare and/or Medi-Cal. I understand I may consult with my private insurance, Medicare social worker, and/or Medi-Cal eligibility worker if I have any questions about my or my child's coverage, deductibles, and co-pays.

Additional Documents for Medi-Cal Clients

I understand the Guide to Medi-Cal Mental Health Services handbook and/or the County Beneficiary Handbook for Substance Use Disorder Services contains details about behavioral health benefits for Medi-Cal beneficiaries.

Complaints and Grievances

I understand I may file a complaint or grievance if I am dissatisfied with the services I or my child receives from Stanislaus County BHRS and its contracted providers. I understand I or my child will not be subjected to any penalty for filing a complaint, grievance, or an appeal. I was offered a copy of the Problem Resolution document, which explains how I can file a complaint, grievance, or appeal.

Complaints to the Licensure Board

I understand that the California Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors, marriage and family therapists, licensed educational psychologists, and clinical social workers. I understand that I may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Informed Consent

By signing, I acknowledge that I understand the information contained in this document and I agree to my receipt, or my child's receipt, of behavioral health services in accordance with the terms described above.

Signature: Date:

Start Date: End Date: Client: ID#: DOB:

Consent For Telehealth

I hereby agree to receive telehealth services from Stanislaus County BHRS and its contracted mental health and substance use disorder providers and agree that this is an acceptable mode of delivering health care related services to me in accordance with the terms of this consent form. I understand and agree to the following statements regarding telehealth:

Telehealth services include the use of video teleconferencing solutions to provide services to a client via electronic interactive audio and video telecommunication from a distant location. Telehealth services are considered face-to-face because the client is visually present. I understand that my provider will not be physically in my presence.

Telehealth services will be provided to me for purposes of evaluation, diagnosis, management, and treatment.

The treating provider performing the examination or treatment will keep a record of the consultation in my electronic healthcare record.

All the information discussed via telehealth is held to the same privacy standards as that of an in-person appointment.

Should I feel for whatever reason telehealth is not a comfortable means of conducting my treatment sessions, I have the right to withdraw consent for telehealth services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

There are risks, benefits, and consequences associated with telehealth, including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

When using my own personal electronic device, Stanislaus County BHRS and/or its contracted providers do not have any control or authority over the protection of my health information that may be stored within my device. I understand that information stored within my device may be at risk, for example, if lost or stolen.

All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. Audio/visual recording may be allowed with a separate written consent. Such recordings are for staff training purposes only, are not part of the medical record, and are destroyed after intended use.

Although my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency, I understand that my provider will be unable to render in-person emergency assistance if I experience a crisis during a telehealth session.

I have a right to access covered services in person. I understand that non-medical transportation benefits are available for in-person visits.

Signature: Date:

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Information

Client Name: Client ID:

DOB: Effective Date:

Program:

General

The Stanislaus County Behavioral Health & Recovery Services abides by all federal and state confidentiality laws including HIPPA (Health Insurance Portability & Accountability Act), and 42 C.F.R. Part 2. By signing this authorization, I acknowledge, accept and agree this information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (43 C.F.R. Part 2) prohibit the recipient from making any further disclose of it without specific written consent of the person to whom it pertains or except as otherwise permitted by SUD's regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Information disclosed under 42 C.F.R. Part 2 cannot be used to criminally investigate or prosecute any client with a SUD except as provided for in 42 C.F.R. Part 2.

Release To/Release From

Name or other specific identification of Person(s) authorized to receive/make the requested use or disclosure:

Organization/Provider Contact **Type:** Release to Obtain From

Release to/from:

Contact type:

Organization:

Name:

Address:

City: **State:**

Zip:

Phone: **Fax number:**

Stanislaus County Behavioral Health and Recovery Services **AUTHORIZATION FOR RELEASE OF INFORMATION** (SCAN)	ALL SYSTEMS OF CARE	NAME: DATE OF BIRTH: MR#:

Purpose of Disclosure

Process insurance/third party claims (Substance Abuse Remittance Only)

Care Coordination

HIE (Health Information Exchange)

Other:

Expiration

If nothing is marked, this authorization will expire one (1) year from date signed.

1 Time Disclosure   6 Months   End of agency treatment

Start date: **End date:**

Information to be used or disclosed

The information that can be disclosed under this authorization includes the following, if available:

ROI Type: MH SUD General

All Records	Acknowledgement of Treatment	Billing &/OR Insurance Information
Intake/Admission Information	Psychological Evolution(s) Reports	Medications Prescribed
Discharge Summary/Plan	Progress Review/Summary	Screening Assessment(s)
AAPS Eligibility Documents	School Records/Reports/IEPs	Medical History, Lab Results, Immunizations Records
Treatment Plan(s)	Progress Notes	Legal Documents

Other:

Records start date: **Records end date:**

Restrictions:

Terms:

- Under state and federal confidentiality provisions only the information specified can be released.
- Stanislaus County Behavioral Health and Recovery Services cannot ensure that the recipient will maintain the confidentiality of the mental health and/or SUD information authorized and released. If the person or organization obtaining this information is not a health care provider, health plan or covered under the federal privacy regulations, the information may no longer be protected by federal privacy laws including 42 C.F.R. Part 2 and could be re-disclosed.
- This authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent action has already been taken.
- Persons or organizations may not re-disclose substance abuse treatment information.
- If not otherwise specified, this authorization will expire in one (1) year from the date of signature, or 90 days of discharge from the agency, whichever is sooner.
- This authorization is voluntary. I have been given the chance to ask questions and receive answers pertaining to this document.
- A list of entities to which my information has been released can be provided by Stanislaus County Behavioral Health & Recovery services.
- A copy of this signed authorization will be considered as valid as the original.

My Rights

- I may refuse this authorization. My refusal will generally not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use of disclosure of.

- I may revoke this authorization at any time with my service provider(s). I may also submit the request to the following address: Behavioral Health & Recovery Services, Medical Records, 800 Scenic Dr. Modesto, CA 95350.
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant of this authorization may be subject to redisclosure by the recipient if allowed or required by law.

By checking these boxes, I agree that I have read, understand and agree to these terms.

NOTICE TO CLIENT:

I understand that signing this form is voluntary and not required to receive services with Stanislaus County Behavioral Health & Recovery Services.

ACCESS TO MY RECORD:

I understand I can request a copy of my record. This request will be reviewed and approved by my therapist. I understand I can also review my records with my therapist by making an appointment. This request can take 30 days to complete, and charges will apply.

<u>Agency Information</u>

Program: **Attention:**

Address:

City: **State:** **Zip:**

Phone:

<u>Other</u>

Copy given to client: Yes Declined a copy **Agency staff:**

ID Verified by: Driver's License Other photo ID Known to agency

Other:

Additional Information

Please note—The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse:

I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

I authorize the release of information relating to HIV/AIDS/Sexually Transmitted Disease/Communicable Disease.

I **PROHIBIT** the release of information relating to HIV/AIDS/Sexually Transmitted Disease/Communicable Disease.

SIGNATURES

Client: **Name:** **Date:**

Parent/Legal Guardian: **Name:** **Date:**

Staff: **Name:** **Date:**

Stanislaus County Behavioral Health and Recovery Services **AUTHORIZATION FOR RELEASE OF INFORMATION** (SCAN)	ALL SYSTEMS OF CARE	NAME: DATE OF BIRTH: MR#:

FULL COST MENTAL HEALTH SERVICES

24-HOUR SERVICE

One Day Room & Board -	$1,287.50
Ancillary Services -	Varies
Professional Fees –	Varies

OUTPATIENT SERVICES

Crisis Intervention	$473.55 per hour
Medication Support	$703.82 per hour
Case Management/Brokerage	$285.35 per hour
Mental Health Services	$379.45 per hour

DAY SERVICES

Day Treatment Intensive	$202.43 Full Day
Day Treatment Intensive	$144.13 Half Day
Day Rehabilitation	$131.24 Full Day

FULL COST SUBSTANCE USE DISORDER SERVICES

OPIOID TREATMENT PROGRAM 21-DAY DETOX

Methadone	$1000
Buprenorphine	$1400
Buprenorphine-Naloxone	$1600

OPIOID TREATMENT PROGRAM MAINTENANCE

Methadone	$600 per month
Buprenorphine	$800 per month
Buprenorphine-Naloxone	$950 per month
Disulfiram	$250 per month
Naloxone 2pk	$175 each

RESIDENTIAL SERVICES

Room and Board	$60 per day
Withdrawal Management	$250 per day
Residential	$150 per day

OUTPATIENT SERVICES

Assessment	$150 per hour
Outpatient/IOP	$150 per hour
Recovery Services	$150 per hour
Case Management	$150 per hour
Physician Consultation	$236 per hour

You will be charged for each service you receive, in accordance to the above amounts, or in accordance to the agreement with your insurance carrier, until you have reached your maximum fee (if applicable). If you have insurance, we will bill them for the total amount of all your services, regardless of the maximum fee (if applicable). You will be responsible for all charges not paid by your insurance company, up to the maximum fee (if applicable).

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INSURANCE COVERAGE INFORMATION

24-Hour Service/Day/Residential Services	Outpatient Services
Your insurance company has quoted your coverage as__________% up to a maximum of $__________ annual/lifetime after you have paid your deductible of $__________. Your co-payment per day is __________.	Your insurance company has quoted your coverage as _______% up to a maximum of ________________annual/lifetime after you have paid your deductible of $__________. Your co-payment per visit is __________.

MAXIMUM FEE INFORMATION

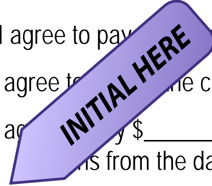
To be considered for a sliding scale adjustment, proof of income, or other financial data is required prior to admission. If the requested information is not supplied, you will not be eligible for this adjustment and you will be billed at full fee.

Mental Health Service: The total cost to you, no matter how many (check one) ___inpatient or ___outpatient services you receive, will not exceed your maximum fee of $________________for the time period____________ to ____________.*

Substance Use Disorder Services: Your Medi-Cal share of cost is _________________.

Your share of cost based on the sliding scale is: _____________% of the total cost of services provided.

MEDI-CAL IS CONSIDERED PAYMENT IN FULL FOR SUBSTANCE USE DISORDER TREATMENT SERVICES, EXCEPT IF THERE IS A "SHARE OF COST"



_____ I agree to pay [obscured]ges for services I receive, up to my maximum fee (if applicable); in full at the time the services are rendered.

_____I agree t[obscured]e charges for service I receive, up to my maximum fee (if applicable), in full within 30 days.

_____I a[obscured]y $_______ each month until paid in full beginning ___________. (We kindly request all balances be paid in full within 6 [obscured]s from the date of service.)

_____If my service is covered by Medi-Cal, Medicare or insurance, I agree to supply any Medi-Cal, Medicare, Insurance cards or information required to bill my insurance. **I understand I am responsible for all charges if I do not comply.**

_____A contracted amount of $__________ to be paid by ______________ to cover the cost of my services. If ______________ does not pay all or part of the contracted fee, I will be responsible for any fee remaining.

PAYMENTS ARE DUE AS AGREED. PLEASE DO NOT WAIT UNTIL YOU RECEIVE A STATEMENT OF YOUR ACCOUNT.
Please note - Accounts over 90 days delinquent may be transferred to a collection agency. If you have questions about your bill, please call the Business Office at (209) 525-5377. Payments can be mailed to: BHRS Business Office, 800 Scenic Dr. Bldg. 4, Modesto, CA 95350

*If your financial situation changes, your maximum fee will be adjusted accordingly, it is your responsibility to notify the clerical staff where you receive services.

NOTE: Fees collected for services received are non-refundable.

SIGN HERE

_______________________________ _______________________________
Client/Guardian Signature Date Staff Witness Date

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES **FEE LETTER** (FILE IN FINANCIAL SECTION)	ALL SOC'S	NAME: ____________________ PROGRAM: ____________________ MR#: ____________________

MEDICARE AND INSURANCE AUTHORIZATION

Client Name:____

Please ask clients with **MEDICARE** to read this release and sign below:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Stanislaus County Behavioral Health and Recovery Services for any services they furnish me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Client Signature_______________________________Date ___________________________

Please ask clients with **INSURANCE** to read this release and sign both spaces indicated below:

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits, otherwise payable to me, to Stanislaus County Behavioral Health and Recovery Services for all services they provided. I understand that I am financially responsible to the Stanislaus County Behavioral Health and Recovery Services for charges not covered by this assignment.

Signature of Insured__________________________________Date____________________

AUTHORIZATION TO RELEASE INFORMATION: I authorize Stanislaus County Behavioral Health and Recovery Services to release to my insurance company any medical information necessary for the processing of a claim. I permit a copy of this authorization to be used in place of the original.

Signature of Insured: ____Date____________
(Client or Parent of Minor)

Distribution: Original to Medical Records   Copy to Client

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES **MEDICARE AND INSURANCE AUTHORIZATION** (FILE IN FINANCIAL SECTION)	ALL SOC'S	NAME: ____________________ PROGRAM: ____________________ MR #: ____________________

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