ECHO DETROIT

ECHO (Enhancing Community Health Outreach)

Service Consent Form

Name: ____ DOB: ___________________________

Agreement to Services: My signature below serves as acknowledgement that I consent to participate in services delivered through the ECHO Detroit Early Intervention program, and specifically provided by trained Certified Peer Recovery Mentors (CPRM). I recognize the short-term, behavioral health outreach services available to me are provided to identify, prevent, and address problematic issues in my life. These issues may be related to substance use, mental health, physical health, housing, employment, relationship challenges, or other concerns that impact my well-being and productivity.

Term of Agreement: Services are FREE and sponsored by the Detroit Wayne Integrated Health Network (DWIHN). My participation is voluntary and, as such, I am free to terminate at any time. However, my lack of attendance and full participation in these services will impact the outcome.

Confidentiality and other Rights: All written, oral information and material disclosed or provided under this Agreement is Confidential and refers to any data or information which would reasonably identify me. Consistent with Federal Confidentiality regulations and HIPPA, the service provider agrees they will not disclose, divulge, or reveal any confidential or Protected Health Information unless authorized by me in writing. Exceptions exist when necessary for internal supervision, billing purposes and duty -to-warn (life and death) situations. This confidentiality agreement will survive indefinitely upon termination of this Agreement, and service.

I have also been given and informed of my right to receive services in a safe, and respectful manner, free from any and all hurt, harm or abuse. I have also been given a copy of the **My Rights** brochure and acknowledge understanding by my initials. Initials____________

Preliminary Recovery Plan Areas of my life that need support:

❑ Substance Use ❑ Mental Health ❑ Medical ❑ Housing ❑ Employment

❑ Legal ❑ Educational ❑ Childcare ❑ Relationship/ Domestic

❑ Other: ____

Recommendations: ❑ agreeable ❑ ambivalent ❑ resistant ❑ refusing

❑ Recovery Support Services ❑ Referral to Treatment ❑ Referral to DWIHN

❑ Self-help / Support Groups ❑ Harm Reduction ________________________________

❑ Other _____________________________________

Signature / Date ____

ECHO Detroit Staff's Signature/ Date ____

SHAR Academy- Recovery Community Center **1851 West Grand Boulevard** **Detroit, MI 48208**
(313) 480-4448 **Fax: (313) 638-1195** www.echodetroit.org

MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

We are committed to maintaining a mutually respectful relationship with our members and providers. The DWIHN Members' Rights and Responsibilities statement is provided to assist you in understanding and exercising your rights while accessing behavioral health care services in Detroit-Wayne County. This statement helps to minimize potential misunderstandings and promote compliance with all applicable statutory and regulatory requirements. Understanding your rights and responsibilities will help you to make informed decisions about your healthcare. These include but are not limited to:

You Have the Right To: Be provided with information about enrollee rights, responsibilities, and protections; Be treated with respect and recognition of your dignity and right to privacy; Be provided with information on the structure and operation of the DWIHN; Receive information about DWIHN, its services, its practitioners and providers and rights and responsibilities; Be provided freedom of choice among network providers; A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage and to freely communicate with your providers and without restriction on any information regarding care; Be informed of the availability of an independent, external review of the UM final determinations; Receive information on available treatment options; Participate in decisions regarding health care, the refusal of treatment and preferences for future treatment decisions; Be made aware of those services that are not covered and may involve cost sharing, if any; Request and receive an itemized statement for each covered service and support you received; Track the status of your claim in the claims process and obtain information over the telephone in one attempt or contact; Receive information on how to obtain benefits from out-of-network providers; Receive information on advance directives; Receive benefits, services and instructional materials in a manner that may be easily understood; Receive information that describes the availability of supports and services and how to access them; Receive information you request and help in the language or format of your choice; Receive interpreter services free-of-charge for non-English languages as needed; Be provided with written materials in alternative formats and information on how to obtain them if you are visually and/or are hearing impaired or have limited reading proficiency; Receive information within a reasonable time after enrollment; Be provided with information on services that are not covered on moral /religious basis; Receive information on how to access 911, emergency, and post-stabilization services as needed; Receive information on how to obtain referrals for specialty care and other benefits that are not provided by the primary care provider; Receive information on how and where to access benefits that are not covered under DWIHN Medicaid contract but may be available under the state health plan, including transportation; Receive information on the grievance, appeal and fair hearing processes; Voice complaints and request appeals regarding care and services provided; Be provided with timely written notice of any significant State and provider network-related changes; Make recommendations regarding the DWIHN member rights and responsibilities.

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DWIHN Your Link to Holistic Healthcare

PROGRESS NOTE

NAME: ______________________________________ DATE: ______________

TIME IN/ OUT: ______________________ CHECK ONE: ❑ DWIHN MEMBER ❑ NON-MEMBER

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NEXT STEPS:

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Signature / Date ____

ECHO Staff- Signature/ Date ____