Clear Form

DEPARTMENT OF HUMAN SERVICES

Behavioral Health Home (BHH) Services Rights, Responsibilities and Consent

Purpose of this form

The purpose of this form is to explain what behavioral health home (BHH) services are, what your responsibilities are if you choose to participate in BHH services and to get your consent to review your eligibility for services. If you choose to participate in the program, your provider will give you a separate form to get your permission to share your protected health information (PHI) with your other medical and service providers. You don't have to give your permission to share your PHI, but if you don't it will affect the services you can get from your BHH services provider.

The goals of behavioral health home services are that an individual:

- Has access to and utilizes routine and preventative health care services
- Has consistent treatment of mental health and other co-occurring health conditions
- Gains knowledge of health conditions and effective treatments and practices self-management of health conditions
- Learns and considers healthy lifestyle routines
- Has access to and uses social and community supports to assist the individual with the individual's goals

Individual Responsibilities

I understand that:

- In order to receive BHH services, a certified BHH services provider must determine if I am eligible for services.
- I must maintain regular communication with my behavioral health home services team, and that this means:
  - I will tell a member of my BHH services team if I go to the emergency room or if I am admitted to the hospital.
  - I will return phone calls, email or other communications from my BHH services team.
- I must work with my BHH services team to identify my health and wellness goals and to complete my health wellness assessment and health action plan.
- I understand that I will not be able to get the following case management or care coordination services at the same time I am getting BHH services:
  - Assertive Community Treatment (ACT)
  - Mental Health Targeted Case Management (MH-TCM)
  - Health Care Home care coordination services

Individual Rights

I understand that I have the following rights:

- BHH services are voluntary. I can stop receiving services at any time.
- If I decide to stop receiving BHH services, I will continue to receive my other health care services covered under Medical Assistance.
- If I am a minor child, my parents or legal guardian might have access to some of my PHI even if I do not give them permission.
- If I have concerns about the BHH services that I am receiving, I can contact DHS at Behavioral.Health.Home.Services@state.mn.us.
- The BHH services provider must tell me in writing if the provider determines that I am ineligible for BHH services. The provider must also tell me the reasons why I am not eligible for BHH services in writing.

Provider Responsibilities

To provide BHH services, a provider must:

- Be enrolled as a Minnesota health care programs provider.
- Meet the certification standards for BHH service providers.
- Assist participants to find answers to questions about the participant's health and wellness.
- Assist participants to obtain available services and supports to meet the participant's health and wellness goals.
- Ensure that the participant's primary care provider and behavioral health provider understand and are working to achieve the participant's health and wellness goals.
- Follow all state and federal laws regarding private health information.

I have discussed this information with the following certified BHH services provider. I understand that by signing this form, I am giving the provider permission to determine if I am eligible for BHH services. If the provider determines that I am eligible for BHH services, I want to participate in the program and I understand my rights and responsibilities.

INDIVIDUAL'S FIRST NAME	MI	LAST NAME		DATE OF BIRTH
SIGNATURE				DATE
NAME (Print)		RELATIONSHIP TO PARTICIPANT		PHONE NUMBER
ADDRESS		CITY	STATE	ZIP CODE

BHH SERVICES PROVIDER			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

800-657-3739

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service. ADA1 (2-18)