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 behavioral health home services and to get your consent to review your eligibility for services. To determine if you are eligible for services, the behavioral health home provider must review your diagnostic assessment. 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 behavioral health home 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, 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 behavioral health home services, a certified BHH provider must conduct a diagnostic assessment, or review my current diagnostic assessment to determine if I am eligible for services.
- I must maintain regular communication with my behavioral health home team, this means:
  - I will tell a member of my BHH 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 team.
- I must work with my behavioral health home 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:

- Behavioral health home services are voluntary. I can stop receiving services at any time.
- If I decide to stop receiving behavioral health home 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 behavioral health home services that I am receiving, I can contact DHS at Behavioral.Health.Homes@state.mn.us.
- The behavioral health home 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 behavioral health home services, a provider must:

- Be enrolled as a Minnesota health care programs provider.
- Meet the certification standards for behavioral health home 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 understands and is 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 certified behavioral health home provider listed below. 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 NAME (Last, First, MI)		DATE OF BIRTH	
PARTICIPANT SIGNATURE		DATE	
NAME (Print)	RELATIONSHIP TO PARTICIPANT	PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

BHH PROVIDER		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

800-657-3739

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

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

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

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.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທີງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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.

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

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