CLIENT RIGHTS AND RESPONSIBILITIES

As a client of **AMITA Health Center for Mental Health**, your rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code. Your right to confidentiality shall be governed by the Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights include but are not limited to the following:

1. You are entitled to have your rights and responsibilities explained to you using a language or method of communication you understand upon commencement of services.
2. You have the right to be provided mental health services and humane care in the least restrictive environment.
3. You have the right to be free from mental, physical, sexual and verbal abuse, neglect, harassment and exploitation.
4. You have the right to have services provided to you following the development of an individualized treatment plan.
5. You and your family and/or guardian, as appropriate, will be informed about the outcomes of care, treatment and services that have been provided including unanticipated outcomes.
6. You have the right, at your own expense, to request the opinion of a consultant.
7. You have the right to request an in-house review of your care, treatment and services.
8. You have the right to be notified in writing of the side-effects of medication if your service includes the administration of psychotropic medication(s).
9. You have the right to be notified of any client rights restriction(s) and to have your parent or guardian notified or any agency designated by you. If any of your client rights are restricted, justification of such rights restriction will be documented in your client record.
10. You have the right to be involved in resolving dilemmas about care, treatment and services. A surrogate decision maker, as allowed by law, will be identified when you cannot make decisions about your care, treatment or service. When you are not able, the legally responsible representative approves care, treatment and service decisions.
11. You have the right to not have services denied, reduced, suspended, or terminated for exercising your rights.
12. You have the right to refuse care, treatment and services, including medication, in accordance with law and regulation.
13. You have the right to request a change in providers.
14. You have the right not to be denied mental health services because of age, gender, sexual orientation, race, religious belief, ethnic origin, marital status, physical or mental disability, or criminal record that is unrelated to present dangerousness.
15. You have the right to reasonable disability accommodations.
16. You have the right to have your cultural, psychosocial, spiritual, and personal values, beliefs, and preference respected.
17. You have the right to formulate Advanced Directives and provide documentation of these to the Center for inclusion in your medical record.
18. You have the right to be provided treatment in a safe setting.
19. You have the right to access, request amendment to, and receive an accounting of disclosures regarding your own clinical/service information as permitted under applicable law.
20. You have the right to exercise citizenship privileges. Client has the right to remain in program unless he/she voluntarily withdraws. Client has right to choose own physician. (TLP/CILA)
21. If you are disoriented or in any state that impairs cognition at the time of entry, you will be informed of these rights at an appropriate time during care, treatment and services.
22. You have the right to be screened for possible referrals for pain management.
23. You have the right to be informed of agency and/or program rules as they pertain to your care, treatment and services.
24. You have the right to receive information about charges for which you will be responsible. Because fees are based on income, if you experience any changes in your financial situation, insurance or third party coverage, you must inform the Center of these changes immediately. You will not be denied service due to the inability to pay. Fee waivers will be determined and approved by the Executive Director.
25. You have the right to contact the Guardianship and Advocacy Commission, Equip for Equality, DHS, DCFS, DMHDD, DOC or Joint Commission. You have the right to be offered staff assistance in contacting these organizations and staff will provide you with the address and telephone number of any of the above agencies you wish to contact. You have the right to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal or unreasonable interruption of care, treatment and services.
26. You have the right to present grievances or to appeal adverse decisions related to your care. You have the right to make such grievances or appeals to the highest level possible in the agency. Grievances should be filed with the Client Advocate. The Client Advocate may be reached at (847) 952-7460 extension 5337 or by mailing a letter to the Client Advocate at 3436 N. Kennicott Ave., Arlington Heights, IL 60004. All grievances will be investigated by the Client Advocate. The resolution of the grievance will be reported to the Executive Director, staff involved in your case, as appropriate, and yourself. You have the right to appeal decisions regarding the grievance up to and including the Executive Director. The Executive Director’s decision on the grievance shall constitute a final administrative decision except when such decisions are reviewable by the agency’s Governing Board, in which case the Governing Board’s decision is final. A record of such grievances and the response to such grievances shall be maintained by the Client Advocate.

27. If you would like to present a grievance to DHS, you may obtain a grievance form and obtain information on how that grievance is reviewed from your local Family Community Resource Center (FCRC). For the office nearest you, please use the DHS Office Locator or call the DHS Help Line toll free at (800) 843-6154 or (800) 447-6404 (TTY), Monday through Friday, 8:00 a.m. to 5:30 p.m., except state holidays.

Guardianship & Advocacy Commission
North Suburban Regional Office
9511 Harrison Avenue, W-335
Des Plaines, Illinois 60016-4264
Phone (847) 294-4264
Fax (847) 294-4263

Equip for Equality
20 N. Michigan Ave, Suite 300
Chicago, Illinois 60602
Voice (800) 537-2632
TTY (800) 610-2779
Fax (312) 541-7544

The Joint Commission
Office of Quality & Patient Safety
One Renaissance Boulevard
Oak Brook Terrace, Illinois 60181
Fax (630) 792-5636
www.jointcommission.org

CLIENT RESPONSIBILITIES

1. You and your family, as appropriate, must provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications and other matters related to your behavioral and physical health.

2. You and your family, as appropriate, must report perceived risks to your care and unexpected changes in your condition.

3. You and your family, as appropriate, must ask questions when you do not understand your care, treatment, and service or what they are expected to do.

4. You and your family, as appropriate, are responsible for following the care, treatment, and service plan developed. Any concerns you have should be expressed to your clinician. We will make every effort to adapt the plan when possible. If adaptations are not appropriate, your clinician will inform you of the consequences and service alternatives to not following the proposed plan of care. (See Right #16)

5. You and your family, as appropriate, are responsible for the outcomes if you do not follow the service plan.

6. You and your family, as appropriate, must follow Alexian Brothers Center for Mental Health rules and be considerate to our staff and property as well as the property of other clients of the agency.

7. You and your family, as appropriate, are responsible for promptly meeting any financial obligation agreed upon with the agency.

8. It is your responsibility to keep scheduled appointments. If you do not receive services for a 4 month period, your case will be closed to the center.

Signatures
I have received a copy of my rights and I have had these rights explained to me in a language or method of communication that I understand.

_________________________  _____________________________
Client Signature (required if 12 or older)   Date

_________________________  _____________________________
Parent/Guardian Signature     Date

As a staff member of AMITA Health Center for Mental Health, I affirm that I have explained these rights to the client in a language or a method of communication he/she understands and believe these rights to have been understood.

_________________________  _____________________________
Staff Signature       Date