Arbor Circle Corporation
PARENT-CHILD ASSISTANCE PROGRAM (PCAP)
Michigan Office of Drug Control Policy

CONSENT TO PARTICIPATE AND RECIPIENT RIGHTS STATEMENT

Thank you for choosing to participate in the Parent-Child Assistance Program (PCAP). The purpose of the program is to offer 3 years of support and services that will help women and their families become healthy and alcohol and drug free.

While you are in PCAP, your case manager will be in touch with you many times a month, including home visits. She will ask about what kinds of goals and needs you have, and develop a plan of care and services that will meet your needs and help you reach your goals. She will review this plan with you every few months. During the program, your case manager will help link you with the community services that are just right for you. She will offer transportation and childcare for some of your important appointments. Based on your needs, she will help you with supplies, activities, and incentives while you are in the program. If you sign release forms to coordinate services with other providers, your case manager will talk with those other service providers (such as DHS, probation, medical) when she needs to.

Your case manager will work with you for 3 years. Here is what you can expect:

- She'll always be truthful with you. She won't lie to you, or for you.
- She won't meet with you if you are high or carrying alcohol or drugs.
- She will be with you through ups and downs. There may be times you are upset with her. It's okay to disagree, but it is important to keep communication open.
- She has other clients and there may be times when she has to cancel an appointment with you because of someone else's emergency.
- Her role is not to always respond to your crises, but to help you move toward reaching your goals.
- She'll be on time, and if you need to cancel you should call her in advance.
- She will let you know ahead of time if she must make a report to Child Protective Services.
- She will have a 3-year working relationship with you, not a 3-year friendship.
- You'll get as much out of the program as you put into it.

Rights:
You have the right to receive fair, non-discriminatory, and uncritical services in accordance with Federal and State requirements. PCAP will not share any information about you outside the agency/contract agency without your written consent, unless mandated by law. You also have the following rights during service:

- The right to respectful services.
- The right to an individualized, written plan of family goals with regular review periods
- The right to refuse service.
- The right to access, upon written request, one's own records.
- The right to referral, as appropriate, to other provider's services at any time, including upon discharge from this program.

As a client, you have the right to be treated with respect and dignity. You will receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, age (18 and above), disability, sexual orientation, and spiritual beliefs. You will not be abused.

In turn, you are responsible for being respectful of the rights of others. You may not bring or use illegal drugs, alcohol, or weapons on PCAP property or in PCAP vehicles. You are expected to not use language and behavior that is threatening to yourself, others, or property.

We will evaluate PCAP to know if the program helps women become healthy and drug free. We would like to interview you when you start PCAP and again when you leave the program. We will ask you questions about your family, your use of drugs and alcohol, your pregnancy history, and your arrest history. The interviews take about 1 hour. Some questions are very personal, such as "Have you worked as a prostitute in the last 3 years, for either drugs or money?" You can skip any question you don't want to answer.

All evaluation forms will use a code number, not your name. Your name and code number will be kept separate from evaluation information. All evaluation information will be kept in locked files. Information we learn from you won't be put into any medical record or given to your other service providers, unless you give us permission in writing. There are some exceptions to the promise of privacy. If you tell us that you may harm yourself or others, we will report it to a mental health worker or the police. If we become aware of child abuse or neglect, we will report it to child protective services. If you need medical help, we may report medical information. If the government audits us, they may see your information.

If you have a complaint that you cannot work out with your case manager, you can call the PCAP supervisor to discuss the problem. You don't have to be in PCAP if you don't want to, and you may leave at any time, unless you were ordered by CPS or the courts. If you would like to leave the program, you can call the PCAP supervisor, Cathy Worthem at 616-456-6571. If you have concerns about the services you receive, please feel free to contact the **Recipient Rights Advisor**: **Beth Bailey** at 616-456-6571, located at 1115 Ball NE, Grand Rapids, MI 49505.

PCAP has been explained to me by ______________________________. I understand that by signing this form, I am agreeing to participate in the PCAP Program. I have also received the **Arbor Circle Notice of Privacy Practices.**

______________________________________ ___________________

Signature of Participant Date

______________________________________ ____________________

Signature of Supervisor Date

Arbor Circle Corporation
Parent Child Assistance Program
AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, authorize ______________________________________ of Arbor Circle PCAP and

____ of ____________________________
_____________,
Name/Title *Agency/Organization*
____ to verbally and/or in writing communicate with and
Address/phone/fax
disclose to one another information regarding the following individual:

____ __________________
____
Name *Date of Birth*
The purpose/need for this release of information is to ___________________________
____

____
____

Client initials each item to be released:
______Name/other identifying information
______Demographic information
______Dates of service
______Bio-psychosocial assessment information
______Diagnosis
______Recommendations for treatment
______Service plan/progress toward goals
______Date of discharge/discharge status/plan
______Employment information
______Education information
______Mental health treatment information
______Substance abuse treatment information
______Alcohol and/or drug test results
______Psychological evaluation
______Psychiatric evaluation
______Medications/medication history and reviews
______Lab work/blood test results
______HIV/AIDS status
______Other:__________________________

Information regarding HIV status or substance abuse treatment must be specifically requested. Such information shall not be released as part of a request for information unless specifically indicated below.

______I give permission for information to be communicated by FAX.

I understand that my records are protected by the:

- Health Insurance Portability and Accountability Act (45 CFR Parts 160 &164),
- Michigan Mental Health Code, Public Act 258 of 1974 as amended, Section 748 (3), and/or

I understand that such information cannot be released without my written consent unless otherwise provided by law. I understand that services will not be conditioned upon the signing of this release. I understand that I may inspect or copy the information to be released. I also understand that, except for action already taken, I may withdraw this authorization at any time by notifying the agency holding my record. Otherwise, this release will expire **one year** from the date signed, on_________. The released information may not be copied, shared, or re-released without explicit authorization by the client.

Signature:____ ____________________

Client *Date*

Signature:____ ____________________

Parent/Legal Guardian/Personal Representative *Relationship to Client* *Date*

Authorization Obtained By: ____ ____________________

Signature of Witness *Date*

***To the recipient**: This information has been disclosed to you from records protected by law. You are prohibited from making any further disclosure of this information without specific written authorization of the person to whom it pertains, or as otherwise permitted by applicable law and regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.*