



**LOWELL COMMUNITY HEALTH CENTER  
SCHOOL-BASED HEALTH CENTERS  
AT LOWELL PUBLIC SCHOOLS**

**CONSENT TO TREATMENT &  
RELEASE OF INFORMATION**

<b>STUDENT</b>	Student Name: _____ Date of Birth: _____ Address: _____ Student Phone: _____ Language Preference: _____ Primary Care Doctor / Clinic: _____ Health Insurance: _____ Subscriber Name: _____ Subscriber Number: _____ Current School: _____ Grade: _____
<b>LEGAL GUARDIAN</b>	Legal Guardian Name: _____ Guardian Phone: _____ Language Preference: _____ Emergency Contact: _____ Relation: _____ Phone: _____

By signing below as the authorized representative<sup>1</sup> (legal guardian or approved minor or adult student), I consent for the student to receive services at Lowell Community Health Center's (CHC) School-Based Health Centers (SBHC). I give permission for a designated health provider to deliver services which may include: Physical Health, Behavioral Health, Vision and Nutrition exams, assessments and screenings, immunizations, and general management of their health care.

The health record of students seen at the SBHC is a confidential record, and is not part of a school record. I understand that confidentiality will be observed due to the nature of this type of record. I also authorize Lowell CHC to release information regarding treatment to third party payers for billing purposes and for any reason required by statues and regulations described in Lowell CHC's Notice of Privacy Practices.

For the purpose of continuity of quality care and when relevant to treatment, I hereby authorize the exchange of information<sup>2</sup> between Lowell Community Health Center and the entities listed below:

<b>Lowell Community Health Center</b>	<b>Lowell Public Schools</b>	<b>Primary Care Doctor</b>	<b>Other:</b> _____
Health History	Attendance & Behavior	Health History	_____
Treatment Progress	Immunizations	Treatment Progress	_____
Substance Use <sup>3</sup>	504 Plan or IEP	Substance Use <sup>3</sup>	_____

<sup>2</sup>Psychotherapy notes, genetic testing, and HIV testing must be requested specifically and separately.

<sup>3</sup>Further disclosure is prohibited without written consent by the student or otherwise permitted by 42 CFR Part 2.

I have read and understand that authorizing the exchange of health information is voluntary and not conditional to receiving treatment. I understand this consent is subject to revocation made in writing at any time, except to the extent that disclosure made in good faith has already occurred. Information released may be subject to re-disclosure by the recipient. This consent and authorization will expire following withdrawal or graduation from Lowell Public Schools.

**Name:** \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Authorized representatives and special considerations regarding consent for minor patients: <https://www.mass.gov/info-details/guide-on-the-disclosure-of-confidential-information-health-care-information#authorized-representatives-and-special-considerations-regarding-consent-for-minor-patients>



## Global Consent for Behavioral Health Services

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

By initialing and signing this form, I am acknowledging receipt, review and understanding of the following consents and policies.



Scan QR Code to view a downloadable copy of these policies.

If you'd rather a physical copy, please request a paper packet.

- \_\_\_\_\_ School-Based BHS Program Philosophy
- \_\_\_\_\_ School-Based Attendance Protocol
- \_\_\_\_\_ Agreement of Confidentiality
- \_\_\_\_\_ Informed Consent Regarding Limitations on Confidential Communications
- \_\_\_\_\_ Client Bill of Rights
- \_\_\_\_\_ BSAS Know your Rights
- \_\_\_\_\_ BSAS Patient & Resident Rights
- \_\_\_\_\_ Complaint/Grievance Procedure
- \_\_\_\_\_ BSAS Admission Medication Standard

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Lowell CHC Employee/Interpreter

\_\_\_\_\_  
Date

Updated 8/2024

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
OFFICE OF MEDICAID (MASSHEALTH)**

**PERMISSION TO GET AND SHARE INFORMATION IN THE MASSHEALTH  
CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) SYSTEM**

Name of MassHealth member (Member) \_\_\_\_\_

Name of behavioral-health assessor (Assessor) \_\_\_\_\_

Name of provider organization (Provider) \_\_\_\_\_

Provider address \_\_\_\_\_

\_\_\_\_\_ (Member) is under the age of 21 and is receiving a behavioral health assessment.

**What is the CANS?**

Behavioral-health providers (providers) use a tool called the Child and Adolescent Needs and Strengths (CANS) to collect behavioral health clinical information about members under 21. For members who are in ongoing treatment, a provider will regularly update the CANS at least every 90 days.

The information collected using the CANS tool (CANS Information) helps providers to do a number of things, such as:

- decide what behavioral health services a member may need
- check over time that behavioral health services are helping the member

**Why MassHealth Wants to Obtain and Share CANS Information**

MassHealth has a computer system that a provider can use to enter CANS Information each time a behavioral health assessment is done or updated. MassHealth wants to use the system to access CANS Information and share it with providers and MassHealth managed care entities (organizations that manage and pay for a member's care) so that such parties can work together to make sure that the behavioral health services offered to the member meet the member's needs. Sharing CANS Information through the system will also help better inform the member's providers of the member's medical history and reduce the overall amount of information that such providers must collect from the member, as further described below.

If you give your permission, the Provider noted above will enter any CANS Information that it collects about the Member into the MassHealth system. Through this system, MassHealth will be able to access such information and make it available to the Provider for future access. MassHealth will also use the

system to give the Provider access to any CANS Information entered by the Member's other providers. This will allow the Provider to update the Member's CANS Information when needed, rather than redoing the whole CANS again. If you agree, MassHealth will also use the system to give the Member's other providers with permission access to the CANS Information entered by the Provider in the CANS system, so they will understand the Member's history and may not need to ask the Member to repeat as much information. Your permission will also allow MassHealth to use the system to give a MassHealth managed-care entity in which the Member is enrolled access to CANS Information collected by the Provider.

### **Your Permission**

By signing below, you give permission for the Provider listed above to:

- enter all of the CANS Information about the Member that it collects into the MassHealth system
- view and copy any CANS Information about the Member that other providers have entered into the MassHealth CANS system

By signing below, you also give permission for MassHealth to use the system to share CANS Information collected by the Provider with:

- the Provider noted on the first page of this form
- the MassHealth managed-care entity in which the Member is enrolled at the time that the CANS is entered into the MassHealth CANS system
- other providers for whom you have given permission

### **Things You Should Know**

**Neither MassHealth nor the Provider may condition treatment, payment, enrollment or eligibility for benefits on whether you sign this form or whether you decide to take back the permission in the future.**

If you give your permission to the activities noted above, the Provider will enter CANS Information about the Member into the MassHealth system, and MassHealth will access such information and share it with the Provider, other providers for whom permission is given and the Member's managed-care entity. Your permission will also allow MassHealth to give the Provider access to CANS Information entered into the system by the Member's other providers. **Note that even if you do not provide your permission, MassHealth and the Provider may still use or disclose CANS Information about the Member as required or permitted by law.**

After CANS Information is shared through the MassHealth system, the organization that shared the information will no longer be able to control how it is used or disclosed. The privacy laws covering CANS Information may be different when MassHealth, providers, or managed care entities hold the information, but each such organization must follow the privacy laws that apply to it when using or disclosing the information.

You may put a permission end date on this form below. If you do not, the permission ends one year from when you sign this form.

You may cancel this permission at any time in writing. The cancellation will prevent the Provider and MassHealth from using the MassHealth system to share CANS Information that is collected after you cancel your permission. Information that has already been made available to MassHealth, managed care entities, the Provider or other authorized providers through the MassHealth system prior to receipt of your cancellation cannot be taken back.

The written cancellation must:

- say who the Member is
- give the Member's birth date
- say who you are
- say if you are the Member, the Member's custodial parent, or explain why you can act for the Member
- say that you are cancelling your permission to enter and share CANS Information online

You must give the written cancellation to the Provider at the address noted on the first page of this form. The Provider must then notify MassHealth by emailing a scanned copy of the written cancellation letter to: CANS-CBHI@MassMail.State.MA.US

### **Your Signature**

**By signing this permission form, you are giving permission for the uses and disclosures of CANS Information about the Member as noted above. You are also saying: that you have read the whole form and signed it willingly; and that you have the right to get a signed copy of the form.**

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Printed name of person signing permission

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Signature of person signing permission

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Date of signing (date permission starts)

### **Disenrollment from Lowell Public Schools**

Date permission ends (If no date is written on this line, permission will end one year from the date of signing.)

Please check the line below saying why you can sign this permission under law.

\_\_\_\_\_ I am the Member. I am 18 years old or older. If I am not 18 years old or older, I can give my permission for other reasons under law.

\_\_\_\_\_ I am the Member's custodial parent.

\_\_\_\_\_ I am able to act for the member to give permission to give out medical information. I have attached a legal document showing why I can do this.

**Reminder to Provider: A signed copy of this form must be given to the Member or caregiver. If the Member or caregiver later cancels this consent, you must e-mail a scanned copy of the cancellation letter to: CANS-CBHI@MassMail.State.MA.US**



**LOWELL COMMUNITY HEALTH CENTER  
SCHOOL-BASED HEALTH CENTERS  
AT LOWELL PUBLIC SCHOOLS**

School-Based  
Behavioral Health Services  
Program Philosophy

## **Program Philosophy**

Lowell Community Health Center's School-Based Health Centers' Behavioral Health Services (LCHC/SBHC/BHS) is designed to provide comprehensive treatment services in a culturally and linguistically competent manner to those affected by mental health and/or the disease of addiction. The BHS philosophy adheres to a stage of change model; treatment is based upon the client's motivational stage. Based on this premise, the team of BHS works co-jointly with each client to identify and treat those identified therapeutic needs. The over-arching goal of the treatment at BHS is foster healthy and adaptive self-choice.

### **Client Commitment:**

1. Attend all scheduled appointments, group and/or individual, on time;
2. Give advanced notice, if an appointment has to be missed;
3. Participate in their treatment planning;

### **Minor Consent to Treatment:**

Mature Minor: If it is determined that it is in the best interest of the student not to notify their guardian and the student is believed to be mature enough and able to give informed consent to treatment, we may accept the minor's consent alone.

Further Information: Baird v. Atty. Gen., 371 Mass. 741 (1977); 104 CMR 25.03

<https://www.mass.gov/doc/104-cmr-25-authority-vision-mission-definitions-and-computation-of-time-0/download>

Substance Use Treatment: A minor 12 or older may consent to treatment for substance use disorder (other than methadone maintenance therapy).

Further Information: G.L. c.112, §12E; 110 CMR 11.08(1)

<https://www.mass.gov/info-details/guide-on-the-disclosure-of-confidential-information-health-care-information#authorized-representatives-and-special-considerations-regarding-consent-for-minor-patients->

### **Payment for Care:**

The Health Center accepts many forms of insurance including MassHealth and private insurance. For those with private insurance, you may receive a bill for co-pays or co-insurance. If you are concerned about being able to afford services, our sliding fee scale may help reduce payments, based on your income. For help applying for the sliding fee scale or insurance, please contact Health Benefits at 978-937-9700 or [healthbenefits@lchealth.org](mailto:healthbenefits@lchealth.org). No one is ever turned away due to inability to pay.

### **Rules for Behavior:**

Intoxicated clients will be assessed within the SBHC by the Behavioral Health Clinician and must be evaluated by the SBHC Nurse Practitioner or the Lowell Public Schools Nurse. Appropriate interventions will be initiated, which may include informing the school administration and the legal guardian, and referral to clinically necessary higher level of care. Failure to follow through with treatment recommendations may result in discharge from treatment pending engagement in required care. Arrangements for alternative transportation will be made for any client who is impaired and is driving.



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School-Based  
Behavioral Health Services  
Program Philosophy

**Reasons for Discharge from Treatment:**

1. Successful completion of treatment. A mutual decision between the client and therapist is reached services are no longer needed.
2. Voluntary termination from the program. Either a transfer or discontinuance of treatment. The client reaches this decision.
3. Discharge from the program due to treatment non-compliance. Clients are expected to attend all of their scheduled appointments unless proper cancellation notice has been given. Discontinuance of services will result for clients who do not adhere to the Attendance Protocol (see attached).
4. Inappropriate Behavior: the following behaviors will result in immediate discharge from BHS outpatient services and will be documented as such within the discharge summary.
  - a. Violence or Potential of engaging in violence towards BHS members and/or other clients.
  - b. Possession or use of a dangerous weapon by a client including any and all objects used as weapons.
  - c. Any criminal behavior on premises that becomes evident to BHS staff.
  - d. Specific verbal or nonverbal threats of committing homicide and/or physical injury toward a staff member or a client (the staff member or client must be specifically identified or named by the threatening client).
  - e. General verbal or nonverbal threats of committing homicide and/or physical injury toward any staff member or client in general (not specifically named) if determined by staff members involved that the client has a serious intent of committing such violence and/or the client will not contract for safety.
  - f. Destruction of agency property and/or personal property belonging to staff or clients.
  - g. Any and all sexually inappropriate behaviors.

**Emergency Instructions:**

If you have an emergency that requires immediate attention please call 911 or go to the nearest emergency room.

If you have an urgent mental health need that is not an emergency, you may call:

- 988 Lifeline at 9-8-8 for people in distress, prevention and crisis resources.
- Vinfen's Lowell Crisis Team at 978-674-6744 for local, in-person support.
- LCHC's On-Call Behavioral Health Clinician at 978-937-9700 for after-hours support.

Updated 8/2024





**LOWELL COMMUNITY HEALTH CENTER  
SCHOOL-BASED HEALTH CENTERS  
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**School-Based  
Behavioral Health Services  
Attendance Protocol**

## **Attendance Protocol**

Lowell Community Health Center's School-Based Health Centers' Behavioral Health Services (LCHC/SBHC/BHS) is committed in supporting you reaching your treatment goal(s) in therapy and medication management if indicated. Due to the overwhelming demand for services, missed appointments reduce our ability to serve others students in need. Therefore, we have implemented the follow guidelines below:

### **For patients who attend therapy at the SBHC:**

In the case that you need to reschedule, please contact your therapist directly by phone/text or in-person at the School-Based Health Center. Appointments are considered a no-show when patients do not provide notice to their therapist or the SBHC ahead of their scheduled appointment start time.

In the case of repeat cancellations or no-shows, we will discuss strategies for increasing consistency. There are situations that due to school nonattendance, a community-based referral may be more appropriate than school-based services.

*After three consecutive no-shows or if we have not met with you for 90 days, your case will automatically be closed. You are welcome to reconnect with services after this point, however, you will need to go through the waitlist before reconnecting.*

### **For patients who receive medication management from the LCHC main clinic:**

If you have not been seen in the last 4 months and have not responded to outreach calls and messages, then your case will be closed, and no med refills will be provided. Once closed; to begin services again it may take a few weeks or months depending on availability of services.

We will make an effort to contact you via phone call/text message or letter when you have missed an appointment. You may call back to reschedule at 978-221-6730.

If we don't hear from you *within 2 weeks* your case will be closed.

Updated 8/2024



**Lowell Community Health Center, Inc.  
Behavioral Health Services**

**Agreement of Confidentiality**

The confidentiality of alcohol and drug abuse client records maintained by this agency is protected by Federal Law and Regulations (see 42 CFR Part 2; 42 USC 290ee-3). All information discussed between the patient and the Treatment Team is confidential. This agency will not disclose information identifying any individual as a patient or identifying any patient as a SUD Diagnosed person. In some specific instances, the following types of disclosures may be made per Federal guidelines:

1. The patient consents in writing;
2. The disclosure is required by a court order;
3. The disclosure is made in the case of a medical emergency to a qualified medical personnel, or;
4. Unidentifiable disclosure may be made to qualified personnel for research, audit, or program evaluation.

Federal Law and regulations do not protect any information either about a crime committed by a client against the agency, against any person who works for the agency, or about any threat to commit such a crime.

Federal Law and Regulations do not protect any information about a suspected child abuse/neglect form being reported under State Law to appropriate State or local authorities. Under Massachusetts's law, addiction during pregnancy is not sufficient for reporting child abuse/neglect.

Violation of the Federal Law and Regulations by any agency is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

If you suspect your rights to confidentiality have been violated, proper procedure is as follows: see the Executive Director of this agency. If you are not satisfied, the appropriate authority is the Department of Public Health, Division of Substance Abuse Services, 150 Tremont Street, Sixth Floor, Boston, Ma 02111; (617) 727-1960.

I have read, signed and verbalized an understanding of the above agreement included in the BHS Global Orientation Package.



**Lowell Community Health Center, Inc  
Behavioral Health Services**

**Informed Consent regarding limitations on  
Confidential Communications**

I understand that information about my treatment and communications with my therapist/treatment team may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission as explained below:

1. If necessary to protect my safety or the safety of others.
  1. If I am clearly dangerous to myself, my therapist/treatment team may take steps to seek involuntary hospitalization. My therapist/treatment team may also contact members of my family or others if necessary to protect my safety.
  2. If I threaten to kill or seriously hurt someone and the therapist/treatment team believe I may carry out my threat, or if I have a known history of physical violence and the therapist/treatment team believe I will attempt to kill or seriously hurt someone, my therapist/treatment team may:
    - Tell any reasonably identified victim;
    - Notify the police; or
    - Arrange for me to be hospitalized.
2. If a judge thinks the therapist/treatment team has important evidence about my ability to provide suitable care or custody in a child custody or adoption case.
3. In court proceedings involving the care and protection of children or to dispense with the need for parental consent for adoption.
4. If the therapist/treatment team believes a child, a handicapped person, or an elderly person in my care is suffering injury as a result of the abuse or neglect.
5. To provide information regarding my diagnosis, prognosis and course of treatment, including the treatment plan, to an insurance company or government agency paying for my care.
6. To create a treatment plan as required with the therapist/treatment team that reflects the goals that I have identified with the therapist.
7. In a legal proceeding where I introduce my mental or emotional condition, or, in the event of my death, in a proceeding where my mental or emotional condition is introduced.
8. If I bring an action against the therapist/treatment team and disclosure is necessary or relevant to a defense.
9. If necessary to use a collection agency or other process to collect amounts I owe for services.
10. If a court issues a "bishop" order giving access to my records to defense counsel in a sexual assault or other criminal case.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect being reported under state law to appropriate state authorities. (See U. S. C. 290dd and 42. 290ee-3 for federal laws and 42 CFR, part 2, for federal regulations.)

I have had the opportunity to discuss this informed consent statement with my therapist/treatment team.

I understand its meaning and consent to receiving services based on this understanding.

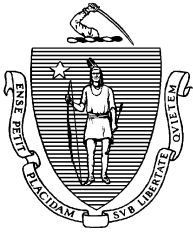


Lowell Community Health Center, Inc.  
Behavioral Health Services

**Client Bill of Rights**

It is the philosophy of Lowell Community Health Center, Inc. to provide the best possible care while recognizing the rights of the individual. **You have:**

1. The right to considerate and respectful care.
2. The right to individual dignity and personal privacy.
3. The right to obtain from your therapist, all current information concerning diagnosis, treatment and prognosis, in a language you can understand. When not clinically indicated, the information should be made available to an appropriate person on your behalf.
4. The right to know the names of clinicians involved in your care.
5. The right to refuse treatment, to the extent provided by law, and to be informed of the consequences of this action.
6. The right to expect reasonable continuity of care.
7. The right to interpreters when language is a barrier.
8. The right to confidentiality of records, to the extent provided by law.
9. The right to request and receive a copy of the bill, or statement or charges, submitted to any third party by this agency for your care.
10. The right to file a grievance report regarding any concern for services rendered.
11. The right for patients who are served by this agency, to be seen for services regardless of the ability to pay. No one will be denied admission based on disability, race, gender, gender identity, creed, ethnic origin, sexual orientation, religion, age or ability to speak English.
12. The right, upon written request (release of records) to review clinical files, with you and your clinician.



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY  
Governor

KIMBERLEY DRISCOLL  
Lieutenant Governor

KATHLEEN E. WALSH  
Secretary

MARGRET R. COOKE  
Commissioner

Tel: 617-624-6000  
[www.mass.gov/dph](http://www.mass.gov/dph)

## Know Your Rights

### Bureau of Substance Addiction Services (BSAS)

You have many rights related to your treatment and care that must be protected by  
Licensed and Approved Programs under **105 CMR 164.079**.

#### Assessments & Referrals:

- After an assessment, a provider may determine that this is not the right service setting for you, and the provider **must** then make a referral to the appropriate service setting and support you through the referral process.

#### Admission:

- You **cannot** be denied admission based **only** on
  - the results of a drug screen or primary substance used;
  - a medication prescribed to you; or
  - if you do not have a current prescription refill on any active medications

#### Re-admission:

- You **cannot** be denied re-admission to a program based **only** on one of the following events:
  - you left treatment against medical advice;
  - you relapsed while in treatment; or
  - you filed a complaint either to the program or to BSAS about any aspect of your treatment.

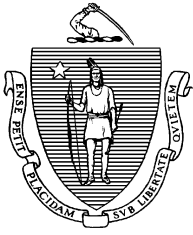
#### Cultural services:

- You have the right to an interpreter and to receive care that is culturally appropriate.

If you think your rights around treatment have been violated, please call the  
**BSAS confidential complaint line at (617) 624-5171**

BSAS Regulation Online:





The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY  
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Lieutenant Governor

KATHLEEN E. WALSH  
Secretary

MARGRET R. COOKE  
Commissioner

Tel: 617-624-6000  
[www.mass.gov/dph](http://www.mass.gov/dph)

## Patients' and Residents' Rights

Bureau of Substance Addiction Service (BSAS) Providers shall guarantee the patient or resident, at a minimum, the following rights:

### Personal Safety:

- freedom from **physical and psychological abuse**;
- freedom from **strip searches and body cavity searches**;
- **control over** bodily appearance; provided, however, on program premises, the
- program may prohibit attire and personal decoration which interfere with treatment;

### Records:

- **access to** the patient or resident record in the presence of the administrator or
- designee, unless there is a determination that access to parts of the record could cause harm to the patient or resident;
- the right to **challenge information** in the patient or resident record by inserting a
- statement of clarification or letter of correction signed by both the clinician and the patient or resident;
- the right to **obtain a copy** of the patient's or resident's records
- the right to have the **confidentiality** of the patient or resident records secured

### Treatment and Consent:

- the **right to terminate treatment** at any time, except in the case of an individual committed to treatment under M.G.L. c. 123, § 35;
- freedom from **coercion**;
- treatment provided on a **nondiscriminatory basis**;
- treatment in a manner **sensitive to individual needs and which promotes dignity and self-respect**

### Fees:

- **full disclosure regarding fee charged** and, in residential rehabilitation programs, any patient or resident benefits to be contributed;

### Grievance:

- the **right to grieve actions** or decisions of the Licensed or Approved Provider regarding the patient's or resident's treatment;
- the **right to contact** the Department, including the BSAS Complaint Line 617-624-5171

### Personal Beliefs and Spirituality:

- freedom to practice **religious faith**;
- the right to **request a referral** to a facility that provides treatment in a manner to which the patient or resident has no religious objection;

### Screening for Substances:

- drug screens conducted in a **manner that preserves the patient's or resident's dignity** and, when the drug screen is by urine sample, accommodate any medically confirmed inability to give urine by providing an alternate effective means of screening such as an oral swab

### Anti-Discrimination

- You are entitled to services regardless of your primary language, cultural background, race, and or ethnicity
- Interpreter services should be accessible through the program at no cost

### Legal Advocacy:

- You have the right to access legal representation and communicate with your attorney while in treatment

BSAS Regulation Online:





**Lowell Community Health Center, INC.  
Behavioral Health Services**

**Complaint/Grievance Procedure**

The client may make a complaint at any time and expect a response and/or resolution in as timely a manner as possible. Patient complaint procedures are as follows:

- 1) Initial communication can be verbal or written and may be reported to the BHS Director or Site Manager. Every effort will be made at the initial time of the complaint to address the issues with the complainant in an attempt to immediately resolve the problem to the client's satisfaction.
- 2) If a solution is found and agreed to by you/your family within 3 working days the complaint is resolved.
- 3) If a complaint cannot be resolved immediately, the Director of BHS or Site Manager verbalizes that the issue will be reviewed/investigated and the client will be notified of the result as soon as the review is complete. Designated staff members are available if a translator is required. The complaint is documented on the standard Event Report form by the BHS Director or Site Manager.
- 4) When a complaint or grievance cannot be resolved to the client's satisfaction, the complaint is referred to the Chief Quality Officer. The CQO will work with the Executive Director to determine who would be appropriate to follow-up with the client making the complaint. Follow-up by phone call and/or letter should be done as soon as possible or within 3 business days.
- 5) If the CQO is not available, the complaint is referred to the Executive Director or Medical Director.
- 6) The completed Event Report form with documented resolution and follow-up is kept for pattern analysis and trending.
- 7) Evaluation of patient complaints are managed through the Patient Satisfaction survey process and through continuous quality improvement activities.
- 8) If you remain unsatisfied with these results the client may contact:  
**The Department of Public Health  
Division of Substance Abuse Services  
250 Washington Street  
Boston, MA 02108**

I have read and understand the above procedure – initial on Global Consent.





**The Commonwealth of Massachusetts**  
Executive Office of Health and Human Services  
Department of Public Health  
250 Washington Street, Boston, MA 02108-4619

**CHARLES D. BAKER**  
Governor

**KARYN E. POLITO**  
Lieutenant Governor

**MARYLOU SUDDERS**  
Secretary

**MONICA BHAREL, MD, MPH**  
Commissioner

Tel: 617-624-6000  
[www.mass.gov/dph](http://www.mass.gov/dph)

## **BSAS Admission Medication Standard**

The Bureau of Substance Addiction Services (BSAS) acknowledges that ensuring the continuation of prescribed medications for clients is imperative to treatment success. This BSAS Admission Medication Standard clarifies appropriate medication requirements for referring and admitting clients to inpatient programs.

1. Referring programs are responsible for ensuring clients' ability to continue prescribed medication(s) as part of their aftercare planning and transition to other levels of care.
2. Receiving programs may not require a designated amount of medication for admission.
3. Programs must accept clients who arrive with medication(s) remaining on current prescription(s), and facilitate the ability to refill such prescription(s).

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4. Programs cannot deny admission of clients that lack current prescription refills and are expected to work with clients to coordinate medication refills.

BSAS continues to support and encourage efforts to improve admission practices and reduce barriers to accessing treatment for substance use disorders. Please note that it is within the scope and authority of BSAS to take action on the status of a license and/or the ability to admit clients when it has been determined that proper care has not been provided. Additionally, contractual actions up to and including termination will be strictly enforced upon substantiation of violations of BSAS policy.