

**MENDOCINO COUNTY HEALTH AND HUMAN SERVICES AGENCY  
BEHAVIORAL HEALTH & RECOVERY SERVICES, MENTAL HEALTH PROGRAM  
APPLICATION FOR SERVICES & CONSENT TO TREATMENT**

I, \_\_\_\_\_, hereby make application to receive care and treatment voluntarily from Mendocino County Behavioral Health & Recovery Services (MCBHR), Mental Health Program. I understand that such care and treatment may consist of an evaluation process, psychotherapy and, in some instances, medication.

If this application is accepted, MCBHR, Mental Health Program is authorized to administer treatment. My consent, however, does not waive my civil rights. I reserve the right to decline treatment. I understand that I have the right to an explanation of treatment to be administered, and that I may voice dissatisfaction through the Patients' Rights Advocate established by MCBHR, Mental Health Program at (707) 463-4614.

I further understand that my records are confidential and will not be released to outside individuals or agencies without my expressed written consent. However, I realize that information may be released without authorization under the following circumstances:

1. To qualified professions in order to provide services to me.
2. Upon the filing of a conservatorship.
3. To make a claim for medical assistance or insurance on my behalf.
4. Upon the receipt of a legitimate subpoena or court order.
5. A threat is made to a federal or state official or their families.
6. In the event of a valid medical emergency.
7. If there is evidence that child abuse has occurred.
8. When a physical threat against another person requires disclosure.

I understand and agree that I was offered free language assistance and have a right to it at any time during my treatment.

I understand and agree to the above conditions in order for treatment to be received.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client/Parent/Conservator/Guardian)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Witness/Staff)

Consent must be signed by the client, parent or nearest relative available or guardian if the client is a minor or physically or mentally incompetent. Complete the following if client does not sign:

_____	_____
Reason Client is unable to Sign	Date
_____	_____
Parent or Relative or Guardian Signature	Relationship

**NOTE TO STAFF:** At time of signing this document client should also sign HIPAA receipt and UMDAP.  
New Client: Original Opening Paperwork (Treatment Consent, HIPAA Receipt, UMDAP, Periodic Update & Facesheet) will be forwarded to business services for chart assignment.  
Annual Update: UMDAP will be forwarded to business services for data entry. Treatment Consent and HIPAA will be filed in chart.

**MENDOCINO COUNTY BEHAVIORAL HEALTH & RECOVERY SERVICES  
(MENTAL HEALTH PROGRAM)  
ACKNOWLEDGMENT OF RECEIPT  
NOTICE OF PRIVACY PRACTICES AND OTHER INFORMATION**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the Mendocino County Behavioral Health & Recovery Services, Mental Health Department. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and your rights to your medical file and other important information. Please read Notice of Privacy Practices in full.

In addition to receiving our Notice of Privacy Practices, you are also being provided with the following information:

- ♦ MHP Provider List
  - ♦ Guide to Medi-Cal Mental Health Services Booklet
  - ♦ Mental Health Plan Members Brochure
  - ♦ Your Right to Make Decisions About Medical Treatment (Advance Directive) Brochure
  - ♦ Grievance and Appeal Process Brochure
  - ♦ Request for Change of Provider Brochure
  - ♦ Request for a Second Opinion Brochure
  - ♦ Patients' Rights Advocacy
  - ♦ Medi-Cal Notice of Privacy Booklet
- ♦ Mendocino County Mental Health Plan (MHP) offers free Language Line Interpreter assistance and TTY/TDD services for beneficiaries requesting or accessing services. These services may be requested at any Mental Health Plan Provider site or by calling 1-800-555-5906.

If you have any questions about any of the above information, please contact:

Mendocino County Behavioral Health & Recovery Services  
Mental Health Program  
1120 South Dora Street  
Ukiah, CA 95482  
(707) 472-2300 FAX: (707) 472-2306

**Acknowledgment of Receipt:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client/Parent/Conservator/Guardian)

**Inability to Obtain Acknowledgment:** Describe the efforts made to obtain Acknowledgment and the reasons why it was not obtained:

\_\_\_\_\_

Signature of Provider Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at [www.co.mendocino.ca.us/mh](http://www.co.mendocino.ca.us/mh) or contacting our reception office in Ukiah at 472-2300.