Iowa Department of Human Services

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June 28, 2013

GENERAL LETTER NO. 3-A-AP-5

ISSUED BY: Division of Mental Health and Disability Services

SUBJECT: Employees' Manual, Title 3, Chapter A, Appendix, ***MENTAL HEALTH INSTITUTES APPENDIX***, Title page, revised; Contents (page 1), revised; pages 1, 2, 4, and 6, revised; and the following forms:

470-0420	*Application for Voluntary Admission – MHI*, revised
470-0423	*Application for Voluntary Admission – Substance Abuse Treatment*, revised
470-0430	*Authorization to Release Information for Assignment of Insurance Benefits*, revised
470-4161	*DHS MHI Admission Core Data*, revised
470-4495	*Hospital Procedures in the Event of Unauthorized Departures*, revised

Summary

This chapter is revised to:

- Update language declaring the county of legal settlement and processing dispute resolutions on form 470-0420, *Application for Voluntary Admission – MHI*.
- Update form 470-0423, *Application for Voluntary Admission – Substance Abuse Treatment*, to reflect the Department's branding.
- Change the name of form 470-0430 from *Authorization to Release Information for Legal Settlement and Assignment of Insurance Benefits*, to *Authorization to Release Information for Assignment of Insurance Benefits*. The instructions have been revised to remove references to legal settlement.
- Update the instructions to reflect availability of form 470-4161, *DHS MHI Admission Core Data*. The form has been revised to reflect the Department's branding.
- Update form 470-4495, *Hospital Procedures in the Event of Unauthorized Departures*. Unauthorized departures are now reported to the Division of Mental Health and Disability Services' division administrator.

Effective Date

July 1, 2013

Material Superseded

This material replaces the following pages from Employees' Manual, Title 3, Chapter A, Appendix:

Page	Date
Title page	May 15, 2009
Contents (page 1)	May 15, 2009
1	May 14, 2010
2	May 15, 2009
470-0420	4/10
470-0423	4/10
4	May 15, 2009
470-0430	5/09
6	May 15, 2009
470-4161	5/09
470-4495	5/09

Additional Information

Refer questions about this general letter to the division administrator for mental health and disability services.

MENTAL HEALTH INSTITUTES

APPENDIX

Iowa Department of Human Services

Page

Application for Voluntary Admission – MHI, Form 470-0420

Purpose

Form 470-0420 is used to make application for voluntary admission to a mental health institute and to assure that:

- The application has been approved through the central point of coordination process or designated regional administrator, and
- County of residence has been determined or the process for determination is implemented.

Source

Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed from the sample in the manual as needed.

The county central point of coordination or designated regional administrator may print the form as above or request copies of the form from the mental health institute.

Completion

Section A of the form is completed in all voluntary applicants, or by the individual's parent, guardian, or legal representative. For private pay and minor applicants, only this section of the form needs to be completed.

Section B of the form is completed when the individual or those financially responsible for the individual are unable to pay for the care and the cost of care will be paid in whole or in part at public expense. The adult individual who is seeking admission or the individual's guardian or legal representative completes Section B. Then application submitted to the individual's county of residence's central point of coordination or designated regional administrator.

Section C of the form, when section B has been completed, is completed through the applicant's county of residence's central point of coordination process or designated regional administrator.

Section D of the form is completed by the division administrator for mental health and disability services or the division administrator's designee when approval as a state case is requested.

Distribution	The mental health institute receives and retains the original in the individual's record. A copy of the completed application is provided to the applicant and, when the application is through a central point of coordination the central point of coordination or designated regional administrator may retain a copy.
Data	When the central point of coordination or designated regional administrator determines that the individual's county of residence is in a county or that the individual is a state case, documentation to support the determination shall be attached. If county of residence is determined to be in dispute, the central point of coordination or designated regional administrator shall include information showing that the dispute resolution process has been initiated.

Iowa Department of Human Services

Application for Voluntary Admission – MHI

Section A

I, the undersigned, desire to enter the mental health institute as a voluntary patient for observation, diagnosis, care, and treatment for mental illness.

If admitted, I agree to abide by the rules and regulations of the mental health institute and to give written notice if I decide to leave the mental health institute against the advice of the medical staff.

If, after a diagnostic evaluation and after being informed of the findings that I am or may be suffering from a condition requiring care and treatment and I am admitted as a patient, I hereby voluntarily consent to such care and treatment based on a standard reasonable course of treatment as indicated by sound medical practice including laboratory and x-ray procedures, as determined by the medical staff in consultation with me.

I also understand that there are further courses of treatment available for me for which my further consent, or that of my parent, guardian, or legal representative, shall be required.

Signature of Patient	Date

Witness	Parent, Guardian, or Legal Representative

Section B

To the County Point of Central Coordination, I, , by my signature above, hereby make application for voluntary admission to the mental health institute under sections 229.2 and 229.42, Code of Iowa. I declare that my county of residence is County.

Section C

This application has been made through the County Point of Central Coordination process and the voluntary admission is ☐ denied ☐ approved.

☐ The applicant is a resident of the above declared county.

☐ The applicant's declared county is in dispute and the dispute resolution process in Iowa Code section 331.394, subsection 5, will be implemented.

CPC Administrator	Date

Section D

This application is for the admission of an individual determined to be a state case.

☐ Approved ☐ Denied

Administrator, Mental Health and Disability Services Division	Date

Iowa Department of Human Services

Application for Voluntary Admission – Substance Abuse Treatment

I, the undersigned, desire to enter the mental health institute as a voluntary patient for observation, diagnosis, care, and treatment for substance abuse.

If admitted, I agree to abide by the rules and regulations of the mental health institute and to give written notice if I decide to leave the mental health institute against the advice of the medical staff.

If, after a diagnostic evaluation and after being informed of the findings that I am or may be suffering from a condition requiring care and treatment and I am admitted as a patient, I hereby voluntarily consent to such care and treatment based on a standard reasonable course of treatment as indicated by sound medical practice including laboratory and x-ray procedures, as determined by the medical staff in consultation with me.

I also understand that there are further courses of treatment available for me for which my further consent, or that of my parent, guardian, or legal representative shall be required.

Signature of Patient	Date

Witness	Parent, Guardian, or Legal Representative

This application is for the admission of an individual determined to be a state case.

☐ Approved ☐ Denied

Administrator, Division of Mental Health and Disability Services	Date

Admitted for:

☐ Alcoholism ☐ Substance abuse

Confidential Patient Information
Unauthorized release of this information is prohibited by law.

Authorization to Release Information for Assignment of Insurance Benefits, Form 470-0430

Purpose	Form 470-0430 is used to obtain consent from the individual to obtain necessary information for the assignment of insurance benefits.
Source	Complete this form on line using the template in the public state-approved mental health forms folder on Outlook. Supplies of the form may also be printed or photocopied from the sample in the manual as needed.
Completion	The form is completed at the time of admission by the individual seeking admission or the individual's parent, guardian, or legal representative.
Distribution	The mental health institute receives and retains the original in the individual's record. A copy of the completed application is provided to the applicant.
Data	The form contains the date of completion and the signature of the individual, or the individual's parent, guardian, or legal representative and the employee witnessing the signature.

Iowa Department of Human Services

Authorization to Release Information for Assignment of Insurance Benefits

TO: The Superintendent of the Mental Health Institute, , Iowa.

This is your full and sufficient authority to release my name and any other confidential information needed to obtain reimbursement for the cost of my care and treatment from any third party payers or funding sources. (This includes MAGELLAN.)

I hereby assign to the Mental Health Institute and the state of Iowa any and all insurance benefits due me to cover the cost of my care in the institute.

Dated this day of , 20

THIS CONSENT EXPIRES ONE YEAR FROM ABOVE DATE

Witness	Signature of individual, parent, guardian, or legal representative
	If not the individual, your relationship to patient

The information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

MENTAL HEALTH INSTITUTE	STAMP PATIENT IDENTIFICATION IN SPACE BELOW
AUTHORIZATION TO RELEASE INFORMATION FOR ASSIGNMENT OF INSURANCE BENEFITS	

DHS MHI Admission Core Data, Form 470-4161

Purpose	Form 470-4161 is used for collecting pertinent information concerning an individual admitted to state mental health institute or state resource center.
Source	This form is generated by the AVATAR medical records system. The form may also be completed on line using the template in the public state-approved mental health forms folder on Outlook.
Completion	The form is completed by the institution employees for all admissions whose cost of care is payable in whole or in part by the state or a county.
Distribution	The institution retains the original in the individual's record. A copy of the completed form is sent by facsimile or other electronic means to the county of residence by the end of the next working day after the day of admission.
Data	The form contains identifying and background information concerning the individual admitted.

Iowa Department of Human Services

For Internal Use Only

DHS MHI Admission Core Data

Confidential Information

Name	Institution ID
Social Security Number	Admit Date/Time /
County of Residence	Facility Chart #

A. General Information

Institution		Patient Phone	
State ID		Sex/Gender	
Admission Type		Marital Status	Veteran
Alias Name		Religion	
Birthdate	Age	Employment Status	
Birthplace		Highest Grade Completed	
Citizenship	Race	Occupation	

B. Hospital Assignment

Physician	Program Code	Unit
Social Worker	Counselor	

C. Legal Status

Legal Status	Prescreened
Effective Date	Court Case #
Contact Person	Hold Order
Committing County	Hold For

D. Authorization

Consent to Release Information Completed To	
Voluntary App Signature	Tx Consent Signature
Co-Signature Required	Co-Signature Obtained

Name	Institution ID
Social Security Number	Admit Date/Time /
County of Residence	Facility Chart #

E. Background Information

Admitting From	
Accompanied By	Living Arrangement
Source of Admission	

F. Payment Source

Guarantor

G. Resource People

H. Patient's Information Issued

Advanced Directives	
Client Rights Received	Smoking Policy Received
Visitors	

I. CPC Notified

How Notified

J. Additional Comments

Treatment History at this Facility	
Number of Admissions	Last Discharge Date

Name	Institution ID
Social Security Number	Admit Date/Time /
County of Residence	Facility Chart #

Response Sheet for Residence

(Please FAX this sheet to state facility within three business days.)

☐ Accept

☐ Disputed
The dispute resolution process in Iowa Code section 331.394, subsection 5, will be implemented.

Address Information

Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No
Address	County	Facility ☐ Yes ☐ No

Note This is not a determination of funding.
This is not a Notice of Decision.

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Hospital Procedures in the Event of Unauthorized Departures

As a voluntary patient, you have the right to request your discharge by submitting a written notice to the Superintendent or Chief Medical Officer. You will then be discharged immediately except when the Superintendent, Chief Medical Officer, or attending physician intends to institute judicial procedures.

If, as a voluntary patient, you leave this hospital without going through the proper discharge procedure, this hospital will then proceed as follows:

If you are found to be unaccountably absent from the ward or assigned therapy, and cannot be immediately located, unauthorized departure (departure without prior authorization) will be assumed. Ward personnel will immediately notify the charge nurse, attending physician, and/or the physician on call. Before instituting any further procedures, hospital personnel will make a thorough search of the wards, building, and grounds. If you are not located, the following actions will be instituted:

1. The responsible physician will probably call your nearest relatives (or correspondents listed) notifying them of the unauthorized departure and outlining the proposed steps they should take (return if you are agreeable, involuntary hospitalization, temporary home visit, discharge, etc.).

2. At the discretion of the hospital staff, law enforcement officials may be informed of the unauthorized departure, if this is considered to be in your best interest. Protected health information will be released according to HIPAA guidelines as outlined in the hospital's Notice of Privacy Practice.

3. In case of a court hold or legal request to notify law enforcement authority, such persons will be notified of the unauthorized departure.

4. Your unauthorized departure will be reported to the division administrator of the Division of Mental Health and Disability Services.

Date	Signature of Patient
Witness	Guardian