

**FAMILY SUPPORT SERVICES OF NORTH IDAHO**

**CLIENT/AGENCY SERVICE AGREEMENT**

A representative of Family Support Services of North Idaho has explained the following to me in detail:

\_\_\_\_\_ I may refuse or terminate services at any time during the course of treatment.

\_\_\_\_\_ I have the right to be treated respectfully and to have my questions/concerns addressed in a timely manner.

\_\_\_\_\_ I have the right to receive services at the times that are convenient for me/my family.

\_\_\_\_\_ I was made aware there are other agencies that provide similar services and was offered a list of these agencies.

\_\_\_\_\_ I have the right to appeal the decision of the Mental Health Authority (MHA). If I have questions, I can contact the Medicaid office @ 208-364-1813. I can also call this number in the event of a grievance with the agency.

\_\_\_\_\_ I have been given the phone numbers and address of both local and state authorities in the event of an appeal or to raise concerns regarding my treatment or that of a child in my care.

\_\_\_\_\_ I have been made aware that I have the right to legal services, support in the event I have a grievance.

\_\_\_\_\_ I understand I can access emergency services in the event of a crisis by contacting the agency office at 769-4222 between the hours of 8:30am-5:00pm, or by calling the 24-hour pager number @ 765-0678.

I have received and reviewed the following documents:

\_\_\_\_\_ The Consumer Bill of Rights/Participant Rights

\_\_\_\_\_ The Client Grievance Policy

By signing below, I acknowledge the above indicated issues have been explained in full and that I wish to select Family Support Services of North Idaho as my treatment provider.

Name \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_