HIGH PLAINS MENTAL HEALTH CENTER
Patient Information - Adult

Name: ______________________________ Age:_____ Date of Birth:______________

Address: ______________________________ Phone: (H)____________ (W) ______________

City, State, Zip______________________________ (Cell) _______________

May we correspond by mail, telephone and voicemail (if applicable) at the above HOME address and phone number? ☐Yes ☐No
May we correspond by telephone and voicemail (if applicable) at the above WORK address and phone number? ☐Yes ☐No
May we correspond by mail, telephone and voicemail (if applicable) at the above CELL phone number? ☐Yes ☐No

If not, where may we contact you? The home address listed above will be used for all correspondence unless an alternate address and phone is given below:
Address ______________________________ Phone ________________
______________________________ Whose address & phone is this?__________________

GENDER
☐Male
☐Female
☐Transgender Male to Female
☐Transgender Female to Male

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latino

MARITAL STATUS
☐ Never Married
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

RACE
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other

ELIGIBILITY FOR SSI OR SSDI
☐ Not Applicable
☐ Eligible and Receiving Payment
☐ Eligible but not Receiving Payment
☐ Potentially Eligible
☐ Determined to be Ineligible by Review and Decision
☐ Determination Decision on Appeal

MILITARY STATUS ☐ No Service ☐ Active Duty ☐ Reserves ☐ National Guard Are you currently serving? ☐ Yes ☐ No

BRANCH (Check all that apply) ☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Coast Guard

TOBACCO USE ☐ Never Used ☐ Have Used/Not Current User ☐ Occasional User ☐ Regular User ☐ Use Smokeless Tobacco

PRIMARY LANGUAGE ____

RELIGIOUS/SPIRITUAL AFFILIATION ____________________________________

What is your occupation?____

Highest grade level completed:____

Recent History of Present Situation

Who referred you to us?____

Please describe the problems you are concerned about:

____

____

____

How long has this been troubling you?____

Did you have any psychological/emotional problems growing up? ☐Yes ☐No If yes, explain:

____

____

Family history of mental illness? ☐Yes ☐No (e.g. depression, schizophrenia, etc)

If yes, please explain:____

____

Family history of substance abuse? ☐ Yes ☐ No

If yes, explain:____

____

Have you experienced any current or past abuse and/or neglect? (Victim or Perpetrator) ☐ Yes ☐ No
If yes, please explain:____

____

Have you experienced any current or past problems with alcohol or other substance use? ☐ Yes ☐ No

If yes, please explain:____

____

Current medications:____

____

Current medical conditions____

____

Please list all **PREVIOUS** (Mental health and/or Substance Abuse) treatment you have received (including all High Plains MHC facilities):

Facility	Location (City, State)	Type of Care (Inpatient, Outpatient, Substance Use)	Dates (if known)

Please list all drug allergies and adverse reactions you have had to medications:

Name of Drug:	Type of Adverse Reaction:

Name of Primary Care Physician: ____

In emergency, who can we notify? Name ____________________ Relationship ________________
Street Address ____________________ Home Phone ________________
City ________________State ______Zip __________ Business Phone ______________

Form Completed by:____________________________________ Date:________________

For Office Use Only:
Reviewed By: ____________________ Initials for additions:__________ Date: ________________

High Plains Mental Health Center
Adult Entry Client Status Report

Name: ___________________________________ DOB: ___________________________________

Current Educational Status:

_____ Attending College (1-6 hours)
_____ Attending College (7 or more hours)
_____ Attending Vocational school or apprenticeship, vocational program, (CNA training)
_____ Basic Educational skills
_____ Working on English as a second language
_____ Working on GED
_____ No educational participation
_____ Other (specify: ____________________________________)
_____ Pre-Educational explorations
_____ Avocational Educational involvement

Current Vocational Status:

_____ No Vocational Activity
_____ Prevocational Activity
_____ Screening & Evaluation of vocational interests & abilities
_____ Active Job Search
_____ Participating in a Sheltered work program/sheltered employment
_____ Employed in Transitional Employment
_____ Participating in ongoing volunteer activity
_____ Any person who remains home to take care of children or others
_____ Any job or set of jobs requiring LESS than 30 hours per week
_____ Any jobs or set of jobs requiring MORE than 30 hours per week
_____ Other (Specify: ____________________________________)
_____ Retired

Current Residential Arrangement:

_____ Nursing Home
_____ NFMH
_____ Group Home
_____ Boarding Home
_____ Lives w/ relatives – DEPENDENT
_____ Lives w/ relatives – INDEPENDENT
_____ Supervised Housing Program
_____ Independent Living
_____ Other (Specify: _____________________________________)
_____ Precariously Housed
_____ Homeless

Form Completed by:____________________________________ Date:______________________

HIGH PLAINS MENTAL HEALTH CENTER

PATIENT SERVICES AND CONSENT FOR TREATMENT AND EVALUATION

THE FOLLOWING SERVICES ARE AVAILABLE (BASED ON MEDICAL NECESSITY) THROUGH HIGH PLAINS MENTAL HEALTH CENTER

Diagnostic Evaluation	Individual Counseling	Conjoint/Marital Counseling
Family Counseling	Group Counseling	Psychiatric Assessment
Medication Services	Attendant Care	Community Psychiatric Support Treatment
Crisis Intervention	Crisis Stabilization	Psychosocial Rehabilitation – Ind or Group
Targeted Case Management	Respite Care	Screening/Concurrent Utilization Review
Competency to Stand Trial Evaluation	Psychological Testing/Evaluation	Parent Support & Training – Ind or Group
Independent Living Skill Building	Peer Support – Ind or Group	Professional Resource Family Care
Substance Use Assessment	Individual Substance Use Counseling	Group Substance Use Counseling

Language interpretation services are available as required when identified by patient and/or High Plains staff.

CONSENT FOR SERVICES AT HIGH PLAINS MENTAL HEALTH CENTER

Identified Patient: ________________________________ DOB:_________________________

Knowing my rights and the services available:

ADULT SEEKING SERVICES (Check box and sign below):

☐ I hereby consent to receive treatment or an evaluation at High Plains Mental Health Center.

☐ I am the legal guardian of the above named Identified Patient, who is 18 or older, and I hereby give my permission for him/her to receive treatment or an evaluation at High Plains Mental Health Center. (You must provide HPMHC the appropriate court document.)

CHILD SEEKING SERVICES (Check box and sign below) :

☐ I am the parent or legal guardian of the above named Identified Patient, who is under age 18, and I hereby give my permission for him/her to receive treatment or an evaluation at High Plains Mental Health Center.

IN THE MATTER OF DIVORCE OR OTHER LEGAL ORDERS OF CUSTODY: **(Check One)**

☐ I share joint custody of this child with: Name____

Address____

City, State Zip ____

(A letter will be sent to the second parent notifying them of the request for services and an invitation to participate in services.)

☐ I have sole custody of this child.

MINOR CONSENTING FOR HIS/HER OWN SERVICES (Check box and sign below):

☐ I am 14-17 years of age and hereby consent to receive treatment or an evaluation at High Plains Mental Health Center. I understand that, per KSA 59-29b49, I must authorize High Plains Mental Health Center to notify my parent or legal guardian that I have sought services.

Initial and Date on each line below. Please use the full date on each line: MM/DD/YY

_____ __/__/___I have received a copy and verbal explanation of and understand the **Rights and Responsibilities** brochure.

_____ __/__/___I have received a copy and verbal explanation of the Notice of Information and Privacy Practices, and I consent to the use and disclosure of protected health information as described in the **Notice of Information and Privacy Practices**.

_____ __/__/___I have received a copy and verbal explanation of and understand the Grievance Procedure as outlined in the **Rights and Responsibilities** brochure and the Notice of Information Privacy Practices.

SIGN HERE: ____ Relationship: ______________________ Date: ________________

Printed Name of Person Authorized to Sign ____

Internal Use Only:

The above signed has stated that (s)he/they has/have an understanding of their rights and meet the signature requirements. Per K.S.A. 59-2949, I have determined that (s)he/they has/have the capacity to make the decision for treatment.

Therapist: ____ Date: ____________________

HIGH PLAINS MENTAL HEALTH CENTER
TREATMENT PLAN SIGNATURE PAGE

Patient Name: ____ Date of Birth:______________________

My signature below indicates that the treatment plan dated _________________has been discussed with me and that I have been involved in developing it.

____ _________________________
Signature of Patient or Representative Date

HIGH PLAINS MENTAL HEALTH CENTER
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Information Requested From

Name ______________________________

Address ______________________________

____

City ____________ State ____________ Zip ____________

Telephone Number ______________________________

Release Information To:

High Plains Mental Health Center Attn: Medical Records 208 E 7th Street Hays, KS 67601 Ph (785) 628-2871 Fax (785) 628-0330

I hereby authorize the disclosure of information checked below from the records of:

Name: ____________________ DOB: ____________ SSN (last 4 digits): ________

Dates of Treatment: ______________________________

The type and amount of information to be used or disclosed is as follows:

- ☐ Entry/Admission Report
- ☐ Discharge Report
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Other ____________
- ☐ All of my Substance Use Disorder Records
- ☐ Verbal or Written Progress Reports/Consultations
- ☐ Medical History, Lab Results, X-Ray
- ☐ Medications
- ☐ School Records/Reports
- ☐ Behavioral Reports
- ☐ Disciplinary Reports
- ☐ Special Education Placement
- ☐ Information concerning IEP

It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Payment ☐ Legal ☐ Other (specify) ____________

* I understand my records may include information regarding alcohol or drug treatment, HIV testing, HIV status, or AIDS.
* I understand I may revoke this authorization verbally or in writing at any time except for any information that has already been sent. Unless I revoke it earlier, this authorization will automatically expire one year from date of signature unless otherwise specified. (Specific date or event may not exceed one year):______________________________
* I understand that information used or disclosed to any entity other than a health plan or health care provider may no longer be protected by federal privacy laws.
* I understand that High Plains Mental Health Center will not condition treatment on my signing this authorization.

Signature of Patient ____________________ Date ____________

Signature of Legal Representative ____________________ Date ____________

Printed Name of Signee ____________________ Relationship ____________

Signature of Witness ____________________ Date ____________

* Notice To Whomever Records are Disclosed: These records are protected by Federal Regulations (42 C.F.R. Part 2) and Kansas Statutes. Any further disclose of this information is PROHIBITED.

HIGH PLAINS MENTAL HEALTH CENTER
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Information Requested From:

High Plains Mental Health Center Attn: Medical Records 208 E 7th Street Hays, KS 67601 Ph (785) 628-2871 Fax (785) 628-0330

Release Information To:

Name ______________________________

Address ______________________________

____

City ____________________ State ____________ Zip ____________

Telephone Number ______________________________

I hereby authorize the disclosure of information checked below from the records of:

Name: ____________________ DOB: ____________ SSN (last 4 digits): ________

The type and amount of information I authorize the release of is as follows: (Please check all that apply)

- ☐ Entry/Admission Report
- ☐ Psychological Evaluation
- ☐ All of my Substance Use Disorder Records
- ☐ Verbal or written reports of progress and case consultation
- ☐ Verbal or written notes/reports re: Medication Evals/Reviews
- ☐ A letter of notification of the date of my admission into and discharge from services.
- ☐ Discharge Report
- ☐ Other (specify) ____________________

All of the records authorized above may be released unless actual dates of treatment are specified here: ____________

* I understand my records may include information regarding alcohol or drug treatment, HIV testing, HIV status, or AIDS.
* I understand that this information will be used for the purpose of continuity of care between my physician and High Plains Mental Health Center. Patient information is FAXED only when the transfer of information is critical.
* I understand I may revoke this authorization verbally or in writing at any time except for any information that has already been sent. Unless I revoke it earlier, this authorization will automatically expire one year from date of signature unless otherwise specified. (Specific date or event may not exceed one year):______________________________
* I understand that information used or disclosed to any entity other than a health plan or health care provider may no longer be protected by federal privacy laws.
* I understand that High Plains Mental Health Center will not condition treatment on my signing this authorization.

Signature of Patient ______________________________ Date ____________

Signature of Legal Representative ______________________________ Date ____________

Printed Name of Signee ______________________________ Relationship ____________

Declination to Release Information

Please check one:
- ☐ I am currently not being followed by any physician for medical reasons.
- ☐ Do not release any information to my physician.

Signature of Patient ______________________________ Date ____________

Signature of Legal Representative ______________________________ Date ____________

* Notice To Whomever Records are Disclosed: These records are protected by Federal Regulations (42 C.F.R. Part 2) and Kansas Statutes. Any further disclose of this information is PROHIBITED.

HIGH PLAINS MENTAL HEALTH CENTER
FEE AND PAYMENT AGREEMENT
INSURANCE AUTHORIZATION AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Patient Name ______________________________DOB ___________Soc. Sec. #* _________________ Entry Date __________
Patient Address ________________________________ City _______________________ State __________ Zip _____________
Responsible Person _______________________________Relationship____________ DOB ________ Soc. Sec. #*____________
Mailing Address ________________________________City _______________________ State __________ Zip ____________
Cell Phone ___________________________Home Phone ______________________Work Phone________________________
Please list any payers including but not limited to **Insurance, Medicaid, EAPs**. List name of policy holder and DOB if other than patient.
Payer Name ____ Policy Holder Name and DOB ___________________________
Payer Name ____ Policy Holder Name and DOB ___________________________
Payer Name ____ Policy Holder Name and DOB ___________________________

I request that payment be made on my behalf to High Plains Mental Health Center for services provided, under the medical direction of Center physicians, during the treatment period that commenced on the above date. I authorize High Plains Mental Health Center to release to the above listed entities or their agents, and every insurance plan that I have coverage under during the course of treatment, any information needed to determine these benefits or the benefits payable for related services. I understand that the purpose of this disclosure is to determine eligibility and payment for services. I understand I may revoke this consent at any time except for information that has already been sent. Unless I revoke it earlier, this consent will expire when claims for all services provided to me have been settled. *Denotes optional field

Kansas Medical Assistance Program: I understand that I am responsible for non-covered services which may include but not limited to: -services provided when consumer was not eligible for Medicaid; the consumer was eligible when services were provided, however, did not inform the provider of his/her Kansas Medical Assistance Program eligibility timely; services Medicaid does not cover such as court appearances, telephone conferences/therapy, services in excess of Medicaid allowed benefits, and psychotherapy for patients whose only diagnosis is mental retardation.

CHECK ONE: COMPLETE THIS SECTION EVEN WHEN YOU HAVE INSURANCE OR A MEDICAL CARD

☐ I do NOT LIVE in the 20 county area served by High Plains Mental Health Center and understand I am not eligible for a sliding scale fee.
☐ I live in _________________county and wish to apply for a sliding scale fee based on financial information which I have provided below.
☐ I live in _________________county and do not wish to apply for the sliding scale fee. I am willing to pay the usual and customary fee for services.

Total Family Income per year (Gross Pay before taxes and other deductions) $____________________
If self employed, how much did you use for all family expenses during the year? $____________________
How many people are supported by your family income? _____________

High Plains Mental Health Center is supported by patient fees and funds from state and local government. Your fee is based upon financial information certified by you. The Percent of Reduction will be applied to charges on the account. Failure to provide required information on insurance coverage will void the Percent of Reduction and charges will become payable at the Center's usual and customary charge. The Center reserves the right to adjust its usual and customary charge. Your Percent of Reduction will expire upon discharge. High Plains provides services in 14 different locations. All statements are mailed from the Hays Office.

To the best of my knowledge, the above information is true and correct. I agree to pay for outpatient services at each visit or, if I have insurance, upon receipt of statement indicating the balance due, and to pay Woodhaven Community Support Services monthly upon receipt of statement indicating the balance due. I further understand that should benefits be denied or fees not be fully covered by my insurance, I am responsible for payment of any balance due in accordance with this agreement. If unable to follow this policy, I am responsible for contacting the Insurance Department (785) 628-2871. The Responsible Person of SPMI or SED patients may request a special fee agreement beyond the sliding fee reduction when extenuating circumstances exist. If the request is denied the consumer or responsible person may file a complaint with the Manager of Quality Improvement. No one will be denied necessary and appropriate services that the Center is required to provide by K.A.R. 30-60-64, solely because of the patient's inability to pay the fees charged by the center for those services. The Center reserves the right to refer delinquent accounts to a professional collection agency and/or the Center's attorney.

I have read and understand the terms of the Fee and Payment Agreement and agree to pay for services provided by High Plains Mental Health Center to the patient listed above according to these terms.

I have received a copy and a verbal explanation of the Center's Insurance, Billing, and Payment Policies, including treatment service fees.

_______________ ____

Date Signature of Responsible Person

OFFICE USE ONLY: Percentage of Reduction_______ Initials ______

*Notice To Whomever Records are Disclosed: These records are protected by Federal Regulations (42 C.F.R. Part 2) and Kansas Statutes. Any further disclosure of this information is PROHIBITED.

HIGH PLAINS MENTAL HEALTH CENTER
BILLING, INSURANCE AND PAYMENT POLICIES EFFECTIVE 01/01/2017

In order to cover the cost of professional services offered, High Plains Mental Health Center relies on a combination of funding from patient fees, county mill levies, state funding, and other small special funding grants to serve the people of Northwest Kansas. In compliance with K.A.R. 30-60-17, it is the Center's policy that no one will be denied medically necessary and appropriate services that the center is required to provide by K.A.R. 30-60-64 solely because of the patient's inability to pay the fees charged by the Center for those services. Patients living in one of the counties that provide financial support to the Center may complete an Application for Sliding Scale Fee and enter into an agreement to receive a Percent of Reduction based on ability to pay. All statements are billed from the Hays Office.

OUTPATIENT SERVICES:
PAYMENT is due at the time of each visit. Payment of deductibles or co-insurance required under your insurance plan is due at the time of the service. Payment is due on any other balances filed with your insurance or other third party coverage upon receipt of a statement indicating the balance is due.

WESTSIDE SCHOOL:
Funding for services provided to students of Westside school is obtained through insurance coverage, DCF funds and USD 489 funds. Parents are not billed for services provided as part of Westside School. Westside students receiving other services in addition to services at Westside will be billed according to the policies stated in the above paragraph for outpatient services.

COMMUNITY SUPPORT SERVICES, COMMUNITY BASED SERVICES AND REHABILITATION SERVICES:
PAYMENT for these services is due monthly upon receipt of statement indicating the balance due.

INSURANCE COVERAGE: The Center will prepare insurance claims for submission to your insurance carrier. Patients are required to provide the Center with the necessary information/forms for filing claims. Insurance carriers will be billed at the Center's usual and customary charge, as required by law. If you have more than one form of insurance, we will bill the additional carriers before determining any balance due from you.

Claims will be filed as services are performed. When payment or denial is received from your insurance carrier, the balance due will be transferred to Your Responsibility. If you have a current Fee and Payment Agreement indicating a Percent of Reduction as a Participating County Citizen, your Percent of Reduction will be applied to charges on the account. Failure to provide required information on insurance coverage will void the Percent of Reduction and charges will become payable at the Center's usual and customary charge. We require that patients make regular payments during treatment toward any anticipated balances due after insurance (deductible, co-insurance, insufficient payments). This will prevent a large balance which would become due when insurance payment or denial is received. Any payments made by you which are later covered by insurance will be refunded to you.

SPECIAL FEE CONSIDERATION: Patients should contact the Business Office (785) 628-2871 when they encounter problems in meeting the payment requirements for services provided by High Plains Mental Health Center. Special fee consideration may be available for patients meeting the criteria for these arrangements.

INTERPRETERS FEES: KanCare members should contact their assigned MCO for interpreter services. Language interpretation services for non-English speaking patients will be provided to patients for mandated services free of charge.

DELINQUENT ACCOUNTS: The Center reserves the right to refer delinquent accounts to a professional collection agency, the State of Kansas debt setoff program and/or the Center's attorney for collection.

POLICY ON MISSED APPOINTMENTS: Appointments made by you or on your behalf on staff schedules are reserved for you and represent a mutual commitment. Your fee may be charged for appointments not kept unless arrangements are made to cancel or change them at least one day (24hours) in advance. In addition, High Plains may modify your access to routine services based on a pattern of missed appointments.

HIGH PLAINS MENTAL HEALTH CENTER
FEE SCHEDULE

A complete listing of our fees is available upon request.

Outpatient and Substance Use Therapy Services:
Psychiatric Diagnostic Evaluation is $250.00 per event.
Substance Use Assessment/Referral is $250.00 per event.
Individual Outpatient Therapy ranges from $100.00 - $175.00, based on the duration of the service.
Group Therapy charge is $100.00 per session.
Family Therapy - $250.00 per session

Other Services:
Crisis Intervention LMHP –$225.00 per hour
Crisis Intervention BA/BS –$175.00 per hour
Crisis Intervention Attendant –$100.00 per hour
Community Psychiatric Supportive Treatment is $150.00 per hour.
Targeted Case Management charge is $125.00 per hour.
Attendant Care charge is $50.00 per hour
Adult Psychosocial Rehabilitation Group is $75.00 per hour.
Child and Adolescent Psychosocial Rehabilitation Group is $75.00 per hour.
Peer Support – Individual is $75.00 per hour.
Peer Support –Group is $50.00 per hour.

Medication Services
Psychiatric Diagnostic Evaluation with Medical Services by APRN or psychiatrist is $375.00 per event.
Medication Services by APRN or psychiatrist range from $100.00 - $250.00 based on the level of service provided.

Evaluations:
Psychological Evaluations and testing for diagnostic and treatment purposes is $200.00 per hour. Psychological evaluations are not eligible for a fee reduction. A $400 prepayment is required prior to scheduling for patients who do not have insurance coverage.
Employment Evaluation: $300.00 per evaluation.
Competency to Stand Trial Evaluation: $315.00 per evaluation.
DUI Evaluation: $150.00 per event.
Alcohol and Drug Evaluation: $200.00 per hour. A pre-payment of $250.00 is required if financial responsibility belongs to the patient. Alcohol and Drug Evaluations are not submitted to insurance.
DOT Evaluation: $200.00 per hour. A pre-payment of $250.00 is required if financial responsibility belongs to the patient.

HAYS OFFICE
208 East 7th Street
Hays, KS 67601
(785) 628-2871
1-800-432-0333
FAX (785) 628-0330

BRANCH OFFICES

Colby
750 South Range
Colby, KS 67701
(785) 462-6774

Goodland
723 Main
Goodland, KS 67735
(785) 899-5991

Norton
211 South Norton
Norton, KS 67654
(785) 877-5141

Osborne
209 W. Harrison
Osborne, KS 67473
(785) 346-2184

Phillipsburg
783 7th Street
Phillipsburg, KS 67661
(785) 543-5284

High Plains Mental Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or any other protected class. High Plains Mental Health Center does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or any other protected class.

High Plains Mental Health Center:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Charlene Anderson, Manager of Quality Improvement.

If you believe that High Plains Mental Health Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or any other protected class, you can file a grievance with: Charlene Anderson, Manager of Quality Improvement, 208 E 7th Street, Hays KS 67601, (785) 628-2871 (phone), (785) 628-1438 (fax). You can file a grievance in person or by mail or fax. If you need help filing a grievance, Charlene Anderson, Manager of Quality Improvement, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de High Plains Mental Health Center, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1 (844) 787-4924.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về High Plains Mental Health Center, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1 (844) 787-4924.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 High Plains Mental Health Center]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字1 (844) 787-4924。

Falls Sie oder jemand, dem Sie helfen, Fragen zum High Plains Mental Health Center haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1 (844) 787-4924 an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 High Plains Mental Health Center 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1 (844) 787-4924 로 전화하십시오.

ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ High Plains Mental Health Center, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1 (844) 787-4924.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص High Plains Mental Health Center، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 787-4924 (844) 1 .

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa High Plains Mental Health Center, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1 (844) 787-4924.

s ngya s nyya, darmhamahote sain kuunye hkyinnhpyitkyaungg suu tait u u, High Plains Mental Health Center paatsaat. mayyhkwannmyarr shipark myaha konekya mhar saint bharsarhcakarr aatwat aakuuaanye nhaint satainnaahkyetaalaat rashiraan hkwin shisai . hcakarrpyan nhaint aatuu pyawwso raan, 1 (844) 787-4924 ko hkaw par .

Si vous, ou quelqu’un que vous êtes en train d’aider, a des questions à propos de High Plains Mental Health Center, vous avez le droit d’obtenir de l’aide et l’information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1 (844) 787-4924.

ご本人様、またはお客様の身の回りの方でも、High Plains Mental Health Center についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1 (844) 787-4924 までお電話ください。

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу High Plains Mental Health Center, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1 (844) 787-4924.

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog High Plains Mental Health Center, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1 (844) 787-4924.

اگر شما، يا کسی که به او کمک ميکنيد ، سوال در مورد High Plains Mental Health Center ، داشته باشيد حق اين را داريد که کمک
و اطلاعات به زبان خود را به طور رايگان دريافت نماييد 1 (844) 787-4924. تماس حاصل نماييد

Kama wewe, au mtu unaye mpa usaidizi ana maswali kuhusu High Plains Mental Health Center, Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Kuzungumza na mkalimani, piga nambari hii: 1 (844) 787-4924.