SAMPLE FORM

Illinois Department of Human Services Division of Mental Health

The Illinois Department of Human Services (DHS), Division of Mental Health provides funding to community mental health agencies for qualifying people in Illinois who need these services. For consumers who are recipients of Medicaid or AllKids, this funding is part of the Medicaid program. For other consumers, community mental health providers decide whether or not to use DHS funding. In the interests of consumer rights and compliance with federal laws about protected information, consumers must be informed when a provider makes this decision.

Under its contract with the Department of Human Services, Division of Mental Health, a community mental health provider is required to inform a consumer if the provider intends to bill DHS for their services. The provider must give the consumer the opportunity to refuse to have DHS pay for the treatment. It is not required that consumers consent, only that they be given the opportunity to decline.

Therefore, DHS requires that for every consumer for whom the provider bills DHS for community mental health services, the following form must be completed and maintained in the consumer's file, subject to review by DHS.

SAMPLE FORM

Documentation of Consumer Choice to Receive DHS-Funded Services

The Department of Human Services (DHS) may pay for some or all of the costs of your community mental health services. If DHS is to pay for these services, the provider must report certain personal information to the Department. If you do not want the provider to report this information, you may decline to be a recipient of DHS funding. If you do not decline, the provider will report all of the following information to the Department of Human Services:

- Your full name (first, last, and middle initial)
- Your social security number
- Your birth date
- Your gender (male, female)
- Your county of residence
- Your household income and size
- All mental health services for which the provider expects payment

Consumer name (please print)____

To ACCEPT being considered as a DHS consumer

______ I choose to have the provider bill DHS for my services, and I understand the provider will report the information above to the Illinois Department of Human Services.

____ ____________
Signature of Consumer or Parent or Guardian Date

To DECLINE being considered as a DHS consumer

______ I DO NOT choose to have the provider bill DHS for my services, and I understand the provider will NOT report the information above to the Illinois Department of Human Services.

____ ____________
Signature of Consumer or Parent or Guardian Date

Explanation by the provider why consumer choice was not documented