Human Resource Training Inc.
Parenting Skills Program
2131 East Broadway Road, Suite 14
Tempe, Arizona 85282
Tel: (480) 967-6895
Fax: (480) 967-4986

To: New Clients

Re: Setting up services at our agency.

Please take note of the proper procedures for setting up services:

1. **A signed court order/minute entry** must be received in our office specifically appointing Parenting Skills Program as the agency for services. We must know who is responsible for the fees. Our agency charges a $10 per person, $20.00 per case intake fee to set-up services. Basic supervision is $60.00 per hour. Supervised Exchanges are $30.00 per exchange. Therapeutic Services with a Masters Level Prepared Mental Health Provider are $90.00 per hour. Fees are due at time of service; payable in cash or by money order made payable to Parenting Skills Program. We do not accept credit cards or personal checks. Please bring exact amounts for payments as we do not have change available. You will be issued a credit in lieu of change.

2. ***Both* parties involved *must comply*** with that court order **by calling** our **Exchange and Visitation Service line at 480-967-6895, Extension 102** and leaving their mailing address and daytime/evening contact phone numbers; then *both* parties must **complete and return** the appropriate **agency paperwork and the intake fees**. Paperwork can be sent to the parties or obtained from our website: www.hrtaz.com/programs/family-court-services **We must have paperwork with original signatures for our agency records.**

If there is no court order or the court order does not designate PSP as the service provider and clearly stipulate fee responsibility, then…

Both parties must submit a letter of agreement to our agency in addition to the initial paperwork and intake fees. The letter of agreement must state that the parties agree to use our agency for services, and what service they are requesting. It will also state that the parties agree to abide by our rules and regulations. The letter should designate *who is primarily responsible for the service fees. (Please note the exception to fees responsibility as noted in our paperwork.)*

These procedures must be completed before any services are provided.

Once an exchange/visitation schedule has been agreed upon by the parties and our agency, it is the party's responsibility to be present *at that scheduled time*. If for any reason you need to cancel the appointment you must call at least 24 hrs ahead of the appointment day. Please note: all Saturday, Sunday, and Monday visitation/exchange appointments must be cancelled by 9 am on Friday. Failure to do so will result in the missing party(s) being responsible for the fees. Confirmation of appointments must be made promptly, within 24 hours, or you will lose the appointment time offered.

It is very important to note that Parenting Skills Program *will not accept letters signed by 3rd parties* or accept compliance calls from 3rd parties (attorneys, spouses, friends, relatives etc., unless the court order allows such 3rd party to be involved). Both Service participants are responsible for communications with the agency regarding their services and appointments.

Please complete the appropriate paperwork for the service you are requesting and return it to the address above along with your intake fees. Thank you for your cooperation in setting up services.

Visit our website for more information: www.hrtaz.com

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Information and Policies for Therapeutic Services

Why you or your family may have been court-ordered to participate in therapeutic services:

1. When parents and children have been separated for a long time;
2. When children are alienated from the visiting parent;
3. When parents may need help with parenting skills;
4. When divorced parents need to learn to communicate in the best interests of their children;
5. When the court wants a professional assessment of family dynamics and relationships;
6. When a parent may have emotional or behavioral issues that may impede their interaction with their children.

Please note: court-ordered intervention is not therapy. If you or someone in your family is experiencing distress because of the intervention, please seek mental health services from another agency and have that service address their concerns to the court.

POLICIES

1 Limited Confidentiality Court-ordered therapeutic supervision/counseling may have limited confidentiality. Parenting Skills Program makes every effort to protect the confidentiality of the children involved in this process and therapeutic records are not released, even with subpoena, unless both parties have signed a release or the assigned judge orders that they be released. However, the therapeutic interventionist's notes do become part of the case file which may end up in public court records. In addition, therapists may be asked to report to the court and/or family court advisor on the progress of the case.

2. Cancellation

Therapeutic appointments will be arranged through this office by the therapeutic interventionist assigned to your case. Your schedule will be taken into account to the best of our ability to do so. Once an appointment has been confirmed, our expectation is that you either attend that appointment or cancel at least 24 hours in advance. Failure to do so will result your having to pay the entire fee for the missed session (even if the court order stipulates that the other party or both parties must pay).

3. Communication

Because of the need for neutrality, the therapeutic interventionist assigned to your family will have only enough communication with you to set up appointments and/or to insure the well-being of the children involved. Any other communication can be considered ex-parte and should not occur. If you have a concern about the services your family is receiving, please put them in writing and address it to the agency. Be sure to copy all parties on that communication and you will receive a written response from either the therapeutic interventionist assigned or the agency director.

4. No-Show

Your therapeutic interventionist will wait fifteen minutes past the scheduled appointment time. If you do not show up by then, he/she will have the option to consider you a "no show" in which case you will be required to pay the fee for the missed session as stated in #2 above. Also please be aware that the court will be notified of missed appointments.

5. Fees

All fees must be paid at the start of the appointment by cash or money order. A $20.00 service charge will be added for any nonpayment, including no-shows. Services may be discontinued until your account is clear. An exception may be made, at the discretion of the therapist, if non-payment by the residential parent is precluding visitation and the visiting parent wishes to pay the whole fee. Note that the visiting parent is under no obligation to do so. Again, all non-payment is reported to the court (even if the difference is made up by the other parent).

6. Participation of Others

Please be aware that, when it may be helpful to the therapeutic process, the therapist may elect to call other family members/significant others to participate in counseling/visitation.

7. Waiting

Unless invited to remain by the therapist, the non-visiting parent will be asked to leave the premises and come back at the end of the visit.

8. Separation

If for any reason you are not comfortable seeing the other parent, please inform the therapist so he/she can arrange for you to wait in a private area.

It is our belief that children benefit greatly from quality contact with both parents and when parents are able to communicate with each other in a positive manner. If you feel that you are ready to do this or can contribute positively to the situation, please inform the therapist so you can assist in resolving the situation.

9. Reports, Testimony and Records

The assigned therapeutic interventionist will write a progress report when it is requested by the court or before significant court dates if requested by either parent. Please submit a filled out request for therapeutic report form with the appropriate fee at least two weeks before you need the report. The fee for each report is $100. All reports will be provided both parents and the judge. If the court requests the report, we will ask the parties to split the fee for preparing the report.

Parenting Skills Program's records are confidential. We report directly to the court. Therapeutic files are especially confidential. In order to release them we will need a subpoena and a release from both parents or an order from the judge

If for any reason you feel the need to access our files, we must have a subpoena for them, a release from both parents or a court order as well as a $20 fee to cover copying costs. If records are more than 50 pages, you will be billed for additional costs. This fee must be paid at the time the subpoena is served.

Should any member of Parenting Skills Program staff be called to testify, the court provides that we must be compensated for our time. Our Basic SV fee is $100 per hour (2 hour minimum/ $200).Telephonic testimony fee is $120 per hour (1 hour minimum) for the person requested to be available at a company phone for the court to contact them during the hearing within a specified period. The testimony of PhD's will be collected at the rate of $300 per hour (2 hour minimum/ $600). Any time above two (2) hours will be collected at the hourly rate for that category.. This fee must be paid at the time the subpoena is served.

Subpoenas for court appearances or copying of records should be served in a timely manner; at least two (2) weeks before the trial date or when the records are needed. Please be aware that if we are given insufficient notice regarding court appearances or copying of records, or if payment does not accompany the subpoena, we will approach the court to quash the subpoena.

I have read the above information and policies. Any confusion or concerns were explained to me in language I could understand.

_____	_____
Client Signature	Witness
_____	_____
Print Name	Print Name
_____	_____
Date	Date

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I acknowledge having received a copy of the rules and regulations for court-ordered and elective domestic relations services. I have read the rules and regulations and have had any questions I may have had answered by Parenting Skills Program staff.

Please indicate the service you are requesting:

☐ Therapeutic Services

☐ Supervised Exchange

☐ Supervised Visitation

Please list below the days and hours that you are available for visitation or the days and times that you are requesting for exchanges**:**

_____ _____
Signature Date

_____
Print Name

_____ _____
Parenting Skills Program Representative Date

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CLIENT IDENTIFICATION

Your Name: _____ Name of Other Party: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cellular #: _____ Work #: _____

Gender:
- ☐ Male
- ☐ Female

Marital Status:
- ☐ Single
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Widowed

Legal Status:
- ☐ Self- referred
- ☐ Court ordered
- ☐ CPS
- ☐ Domestic Relations
- ☐ Other: _____

Birth Date: _____ Age: _____ Place of Birth: _____

Race/Ethnicity: _____ Maiden Name (if different): _____

Clients Occupation: _____ Employer: _____

Employer's Address: _____ Employer's Phone: _____

(Name of party to notify in case of emergency)

Spouse or Nearest Relative: _____ Relationship: _____

Address: _____ Phone #: _____

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Physician(s): _____ Physician's Phone: _____

This information is needed in case of a medical emergency.

Physician's information is for: ☐ Adult ☐ Child(ren)

Payment Agreement: The undersigned agrees to pay the supervisor/ therapist the determined fee when service is rendered unless other arrangements have been made. Accepted forms of payment are cash or a money order made payable to Parenting Skills Program.

Payment Source: ☐ Self ☐ Other(specify): _____

_____ _____
Client's Signature Date

_____ _____
Responsible Party if not Client Date

_____ _____
Witness Date

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Agreement for Therapeutic Services

I _____, the parent of _____

_____minor child(ren), agree to have the visitation of my child(ren) therapeutically supervised by Parenting Skills Program. I understand that the counselors at Parenting Skills Program follow the agency's established policy for therapeutic services and that will be obliged to abide by the responsibilities of the parents designated in the "Information and Policies for Therapeutic Services".

_____	_____
Client Signature	Parenting Skills Program Staff
_____	_____
Print Name	Print Name
_____	_____
Date	Date

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Client Rights/Grievance/Fees/Service Info Acknowledgment

I have been informed of and know how to obtain written information regarding:

(Client's Initials)

_____Customary Fees

_____Client Rights

_____Grievance Policy and Procedure

_____Refund Policy

_____List of addresses and phone numbers (Addresses and phone numbers for the Office of Behavioral Health Licensing, The Departments Division of Behavioral Health, Adult Protective Services, Child Protective Services and the local Regional Behavioral Health Authority)

Any questions I had were answered to my satisfaction.

_____	_____
Client Signature	Parenting Skills Program Staff
_____	_____
Print Name	Print Name
_____	_____
Date	Date

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Acknowledgement of Being Informed of Cancellation Policy for Family Court Services Clients

- A client is expected to keep his or her appointments with Parenting Skills staff.
- Barring an unforeseen documentable emergency, if a client cannot keep his or her appointment, he or she will be expected to call the agency to cancel within 24 hours of the appointment if the appointment is Tuesday through Friday. Saturday, Sunday and Monday appointments must be cancelled by 9 am on Friday. Failure to do this will be considered a missed appointment.
- If a person had an unforeseeable emergency, written, verifiable documentation of this emergency must be given to Parenting Skills Program. The Program Director will make a decision as to the integrity of the excuse and deem the occasion either an emergency or a missed appointment.
- Any person responsible for a missed appointment shall be obligated to pay for the entire appointment plus a $20.00 service charge. No further scheduling or appointments will be made until this obligation is met.
- If a client incurs a missed appointment, the DR coordinator shall write and send a letter to the client deemed responsible, detailing the date and time of the missed appointment and the financial obligation necessary to resume services.
- A copy of this letter shall be sent to the other party in the family court case as well as to the referring judge and any *best interest attorney* involved with the case. A copy of the letter shall also be placed in the DR file.

I have been informed of the agency cancellation policy and any questions I had were explained to me.

_____	_____
Client Signature	Witness
_____	_____
Print Name	Print Name
_____	_____
Date	Date

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Court-ordered therapeutic supervision/counseling has limited confidentiality. Supervisors/counselors may report to the court on the progress of the case, both by phone and in writing; they may also be asked to testify during court proceedings.

I have discussed the above limits to confidentiality with _____, representative of the Parenting Skills Program staff, and I hereby consent to therapeutic supervision/counseling under those circumstances. Any areas of confusion or concern were explained to me in language I could understand.

_____	_____
Client Signature	Authorized client rep. signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date

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CLIENTS' SERVICE CONTACT LIST

OFFICE OF BEHAVIORAL HEALTH LICENSING
150 N.18TH Ave., Suite 410
Phoenix, AZ 85007-3242
Phone: 602-364-2595

OFFICE OF HUMAN RIGHTS
150 N. 18th Ave, 2nd floor
Phoenix, AZ 85007-3242
Phone: 602-364-4558

DIVISION OF BEHAVIORAL HEALTH SERVICES
150N.18TH Ave.
Phoenix, AZ &007
Phone: 602-542-1001

ADULT PROTECTIVE SERVICES
Administration: 3221 N. 16th St., Suite 400
Phoenix, AZ 85016
Phone: 602-542-4446
Senior Help Line: 602-264-4357

CHILD PROTECTIVE SERVICES
Administration: 3221 N. 16th St, Suite 400
Phoenix, AZ 85016
Phone: 602-264-1360
To Report Child Abuse: 1-888-767-2445

LOCAL REGIONAL BEHAVIORAL HEALTH AUTHORITY
Magellan Health Services
Administration: 444 N. 44th St., Suite 400
Phoenix, AZ 85008
Phone: 1-800-564-5465

POISON CONTROL CENTER
Phoenix-602-253-3334
Statewide-1-800-362-0101

EMERGENCY: 911

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CLIENT RIGHTS

A client has the following rights:

1. To be treated with dignity, respect, and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
    a. Supports and respects the client's individuality, choices, strengths, and abilities;
    b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
    c. Is provided in the least restrictive environment that meets the client's treatment needs;
4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
6. To have grievances considered by a licensee in a fair, timely, and impartial manner;
7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;
10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
    a. For photographing for identification and administrative purposes, as provided by A.R.S.§36-507(2);
    b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
    c. For video recordings used for security purposes that are maintained only on a temporary basis; or
    d. As provided in R9-20-602(A)(5)
12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
13. To review the following at the agency or at the Department:
    a. This Chapter;
    b. The report of the most recent inspection of the premises conducted by the Department;
    c. A plan of correction in effect as required by the Department;
    d. If the licensee has the submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
    e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
14. To be informed of all fees that the client is required to pay and the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
16. To be offered or referred for the treatment specified in the client's treatment plan;
17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to the A.R.S. §36-512;
19. To be free from:

a. Abuse;
b. Neglect;
c. Exploitation;
d. Coercion;
e. Manipulation;
f. Retaliation for submitting a complaint to the Department or another entity;
g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
h. Treatment that involves the denial of:
    i. Food,
    ii. The opportunity to sleep, or
    iii. The opportunity to use the toilet; and
i. Restraint or seclusion, or any form, used as a means of coercion, discipline, convenience, or retaliation;

20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
21. To control the client's own finances except as provided by A.R.S. §36-507(5);
22. To participate or refuse to participate in religious activities;
23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan:
25. To participate or refuse to participate in research or experimental treatment;
26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility; and
29. If receiving treatment in a residential agency, an inpatient treatment program, a Level 4 transitional agency, or a domestic violence shelter:
    a. If assigned to share a bedroom, to be assigned according to R9-20-405(F) and, if applicable, R9-20-404(A)(4)(a);
    b. To associate with individuals of the client's choice, receive visitors, and make telephone calls during the hours established by the licensee and conspicuously posted in the facility, unless:
        i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
        ii. The client is informed of the reason why this right is being restricted; and
        iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
    c. To privacy in correspondence, communication, visitation, financial affairs, and personal hygiene, unless:
        i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
        ii. The client is informed of the reason why this right is being restricted; and
        iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
    d. To send and receive uncensored and unopened mail, unless restricted by court order or unless:
        i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
        ii. The client is informed of the reason why this right is being restricted; and
        iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
    e. To maintain, display, and use personal belongings, including clothing, unless restricted by court order or according to A.R.S. §36-507(5) and as documented in the client record;
    f. To be provided storage space, capable of being locked, on the premises while client receives treatment;
    g. To be provided meals to meet the client's nutritional needs, with consideration for client preferences;
    h. To be assisted in obtaining clean, seasonably appropriate clothing that is in good repair and selected and owned by the client;
    i. To be provided access to medical services, including family planning, to maintain the client's health, safety, or welfare;
    j. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;
    k. To be informed of the requirements necessary for the client's discharge or transfer to a less restrictive physical environment; and
    l. To receive, at the time of discharge or transfer, recommendations for treatment after the client is discharged.

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I. **POLICY**: Refund

II. **INTENT OF POLICY:** To establish a procedure for a paying client to obtain refund of fees.

III. PROCEDURE:

1. If a client feels that he warrants a refund of fees, he should submit his claim in writing and addressed to the Program Director. If the client is a mandated or court-ordered client, a copy of this letter should be sent to all parties involved in the legal action in order for the Program Director to address the claim.

2. Once receiving the letter, the Program Director will review the claim, assess its validity and respond in writing to the client and all copied parties.

3. If refund is due, a check will be sent to the client within 30 days.

4. If the client is not satisfied with the decision, he/she may file a grievance as outlined in the grievance policy.

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I. **POLICY**: CLIENT GRIEVANCE

II. **INTENT OF POLICY**: To establish a clear line of communication to file grievances with the administration and outside licensing/contracting bodies.

III. **PROCEDURE:**

A. All Mental Health Service clients are informed of their right to file a grievance regarding the services they receive from PSP. This information is part of the application packet

B. At the time a complaint or grievance is initiated, the client, parent or guardian is provided with a new copy of PSP grievance procedure.

C. If the problem cannot be resolved through the Client Complaint Policy and Procedure, the client, parent or guardian may put their grievance in written form. The grievance form will be distributed to client, therapist, Clinical Supervisor and Executive Director.

D. The therapist's Clinical Supervisor will respond, in writing, within 5 working days.

E. If the action taken by the Clinical Supervisor taken on behalf of a client regarding a violation of the client's rights is unfavorable, insufficient, or not forthcoming within the allotted time, the client or his representative may appeal to the Executive Director. The Executive Director will respond in writing within 5 working days.

F. If the client, parent or guardian is not satisfied at any point in the process, he/she has the right to contact the Arizona Department of Health Services - **Office of Behavioral Health Licensure, 150 N. 18th Ave. Ste 410, Phoenix, AZ 85007-3342 Phone: 602-364-2595, Fax: 602-364-4801**

FORMS: Grievance Form

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Fax: 480-967-6895

Date Filed:_____

Name of applicant or client Involved:_____
(last, first, mi)

Address:_____
(Street, City, State, Zip Code, Telephone Number)

Name of person filing appeal:_____
(last, first, mi)

Address:_____
(Street, City, State, Zip Code, Telephone Number)

Relationship of person filing appeal or client:

____Self (Age 14+) _____Family Member _____Friend _____ Advocate

____Other

An appeal on behalf of a child may be initiated by: a custodial parent; a legal guardian; a court appointed guardian ad litem, or attorney; a court appointed physical custodian; or a representative of a court ordered legal custodian.

Description of Complaint (Please include dates, names, locations, also any other attempts to resolve the problem, attach additional pages if necessary):

What solution do you want?

Name of person completing this form if other than person filing for this appeal:

_____

Relationship to applicant/client:

_____

_____ _____
Signature Date

CC: Client
PSP Therapist
PSP Clinical Director
HRT Executive Director