TN VOICES
Support Services From Firsthand Experiences

Rights and Responsibilities

This packet contains information that will help you to understand your rights and responsibilities and our commitment to your mental health service.

Please take a few minutes to read the material. If you have any questions, your Intake Specialist will do their best to answer them for you today.

- **HIPPA Notice and Client Service Agreement**
- **Client Rights and Responsibilities**
- **Treatment Agreement**
- **Emergency Contact Authorization**
- **No Surprises Act**
- **TennCare Kids Program**
- **Declaration for Mental Health Treatment**
- **Advanced Directive and Living Wills**

HIPPA NOTICE AND CLIENT SERVICES AGREEMENT

Welcome to TN Voices. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information before treatment begins. Although these documents are long and sometimes complex, it is very important that you read them carefully before we meet. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Your signature on the TN Voices Assurance of Choice and Consent to Treatment is required before we can provide services.

MENTAL HEALTH SERVICES

Psychotherapy/case management is not easily described in general statements. These services vary with the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy and case management are not like medical doctor visits. Instead, they call for a very active effort on your part. In order for the treatment to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy and case management can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy and case management often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with treatment. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy and case management involves a large commitment of time, money, and energy. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

If appropriate, you may be evaluated by medical professionals who are specially trained in psychiatry. If medications are indicated, you will be informed of potential side-effects, drug interactions, and anticipated benefits. You should take medications as they are prescribed. All changes including stopping your medications, changing times you take your medications, or changing dose should occur only after you consult with your provider. As part of monitoring your response to

medications, it may be necessary to have lab work performed. It is your responsibility to discuss any medication concerns you have with your provider. It is also your responsibility to inform us of any prescribed or over-the-counter medications you are taking.

MEETINGS

For our first meeting, we normally conduct a diagnostic interview and brief therapy session that will last approximately 45-90 minutes. If psychotherapy is begun, we will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Case management sessions are shorter, and the content varies depending upon your needs. No psychotherapy takes place in case management. Case management sessions are conducted in the office, in the community, and/or at your home.

Once an appointment hour is scheduled you will be expected to provide 24 hours notice of cancellation or you may be billed unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for canceled sessions.

CONTACTING TN VOICES STAFF

Due to work schedules, the TN Voices staff member who has been assigned to you may not be immediately available by telephone. Generally, office hours are 8:00 a.m. to 4:30 p.m., Monday – Friday. The office telephone numbers are located at the top of this document. Some providers may also have alternative numbers where they can be reached. **The TN Voices emergency after-hours may be reached by calling the office from which you receive services and following the prompts for speaking with an after-hours clinician.** We will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform us of some times when you will be available. If your situation is a life-threatening emergency, you should call 911 or go to the nearest emergency room. If any of our staff will be unavailable for an extended time, that staff member will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and our licensed clinicians. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the client's identity. The other professional is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.
- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to

release any information outside of the practice without the permission of a professional staff member.

- The licensed clinicians working at TN Voices also have contracts with the non-clinical staff at TN Voices (business associates), signed by our Executive Director, Kenny Mauck. As required by HIPAA, the licensed clinicians have formal business associate contracts with the non-clinical TN Voices staff, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- If a client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided to you, such information is protected by the psychologist-client privilege law. We cannot provide any information without your written authorization, or court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting information for health oversight activities, we may be required to provide it for them.
- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client to defend ourselves.
- If a client files a worker's compensation claim, we must, upon appropriate request, provide a report to the appropriate individuals, including the client's employer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment. These situations are unusual.

- **Child Abuse:** If we have reason to believe that a child under 18 has been injured because of brutality, abuse, or neglect or has been sexually abused, the law requires that we report to the appropriate governmental agency, usually the Department of Children's Services. Once such a report is filed, we may be required to provide additional information.
- **Adult and Domestic Abuse:** If we have reason to suspect that an adult has suffered abuse, neglect, or exploitation, the law requires that we report to the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
- **Serious Threat to Health or Safety:** If a client has communicated an actual threat of bodily harm against a clearly identified victim, and we believe that the client has the apparent ability to commit such an act and we believe that he/she is likely to carry out the threat, then we are required to take reasonable steps to protect the victim, including notifying the potential victim, contacting the police, or seeking hospitalization for the client.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. This includes our electronic and paper charts. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your clinician or have them forwarded to another mental health professional so you can discuss the contents. We are sometimes willing to conduct this review meeting without charge. In most circumstances, we are allowed to charge a copying fee of $5 for reports of twenty pages or less in length and 25 cents per page thereafter. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your Clinical Record, you have a right to review, which we will discuss with you upon request. In addition, some of our clinicians may also keep personal, handwritten Psychotherapy Notes about their sessions. These Notes are for clinicians' use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, analysis of those conversations, and how they impact your therapy. They may also contain particularly sensitive information that you reveal that is not required to be included in your Clinical Record. They may also include information from others provided to TN Voices confidentially. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies, without a court order and your written signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal to provide it. Tennessee law allows a clinician to provide the client with either a copy of the record or a summary. We are making the legal assumption that material in your psychotherapy notes would, almost by definition, not be information that would normally be included in a summary. Based on this assumption, our preemption analysis of HIPAA and state law indicates that a clinician may completely deny access to his/her psychotherapy notes, providing the client with the Clinical Record as required by HIPAA.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. We are happy to discuss any of these rights with you.

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. At your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

MINORS & PARENTS

Parents of clients under 18 years of age who are not emancipated should be aware that their children may be permitted to independently consent to psychotherapy if they are sufficiently mature to understand and make judgments about the risks and benefits of such treatments to themselves. In this instance, their parents do not have access to their records. Because parental involvement in treatment is important and because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is our policy to request an agreement from all parties with regard to what information parents can have access. If everyone agrees, during treatment, we will provide parents with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Upon request, we will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of the concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear up confusion, we will be willing to call the company on your behalf. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMO's and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to provide appropriate referral information to help you continue your treatment. You should also be aware that your contract with your health insurance company requires that we provide information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit if you request it. By signing this Agreement, you agree that we can provide the requested information to your carrier. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract. Your signature on the TN Voices Assurance of Choice and Consent to Treatment form indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

QUESTIONS AND COMPLAINTS

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact our main office at 1-800-670-9882. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human

Services, the address for which be provided upon request. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

EFFECTIVE DATE, RESTRICTIONS, AND CHANGES TO PRIVACY POLICY

This notice will go into effect on January 1, 2021.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. As soon as reasonably possible after a revision becomes effective, we will notify you by mail or by direct contact with a TN Voices staff member.

TN Voices Client Rights and Responsibilities

As a Client of TN Voices, I have the following Rights:

- To be treated with respect and dignity at all times;
- To be provided equal treatment regardless of age, race, sex, religion, ethnic background or handicap, sexual orientation or ability;
- To privacy and confidentiality related to all aspects of care, including but not limited to the unwarranted disclosure of medical records, whole or in part, as provided by HIPAA;
- To be informed of treatment alternatives;
- To be informed about the risks, benefits, and potential side effects of any TN Voices prescribed medication(s);
- To participate in all aspects of treatment and treatment planning regarding my individual treatment;
- To refuse to participate partially or fully in treatment or therapeutic activities, including visual or audio recording;
- To be provided quality treatment by competent staff members;
- To be afforded continuity of care from one service provider to the next;
- To be provided treatment in the least restrictive treatment feasible;
- To voice complaints, grievances, and appeals about the care or services provided at the agency without fear of restraint interference, coercion, discrimination, or reprisal;
- To formulate advanced psychiatric directives (or a crisis plan);
- To allow or refuse the release of my information, except as required by the insurance/payer source;
- To receive information about the agency, providers, guidelines related to my treatment, and my rights and responsibilities;
- To make recommendations regarding the agency's Client Rights and Responsibilities policies; and
- To appeal any clinical decision that is made about my care;
- To choose or refuse care from specific providers.
- To be protected by the agency from neglect, physical, verbal, and emotional abuse (including corporal punishment) and from all forms of exploitation;
- To be free of any requirement by the agency that I perform services that are ordinarily performed by agency staff.

- To have advanced psychiatric directives should I have a mental health crisis at the hospital of my choosing.

As a Client of TN Voices, I have the following Responsibilities:

- To provide accurate and complete information to the TN VOICES staff providing services to me;
- To follow plans, instructions, and guidelines for care that I have agreed upon with my practitioner;
- To understand the medication being prescribed and keep scheduled appointments;
- To take part in my treatment, set goals with my providers, and work toward those goals;
- To work toward changes in my daily life to improve my health and stability; and
- To show respect for all staff members and other people who are present at the agency.

TREATMENT AGREEMENT

TN Voices offers comprehensive mental health care, which means we recommend therapy, in-home services, or other behavioral treatments in addition to any medication services. Staff time is a valuable resource, so when clients do not keep appointments, resources are lost and wasted. It is your responsibility to be on time for appointments and we expect you to be as dedicated to your treatment and healing as we are.
A No Show appointment is defined as a scheduled appointment that you do not call to cancel at least 24 hours in advance. Calling on the day of the appointment is considered a no-show appointment.

THERAPY CLIENTS: Should you miss two therapy appointments (no show) in any two-month period your situation will be reviewed with your therapist's supervisor and may be placed on standby status. This means you will not have a designated appointment time but provided a time frame for which you will be seen on a first come first serve basis. Once you have attended three standby appointments as scheduled you will be allowed to return to appointment scheduling. If you fail to attend two standby appointments, you may be discharged.

IN-HOME SERVICES: CCFT clients must see their clients 2-3 times per week. If, for whatever reason, you are unreachable by the contact phone number you have provided, it is your responsibility to contact your in-home specialist as soon as possible. If you choose to not participate in the services due to multiple cancellations, or two No Show appointments in a single month, it will be considered your choice to be discharged from the program. **I understand being discharged may result in my inability to participate in any TN Voices services including medication management.**

MEDICATION CLIENTS: <u>It is necessary for you to keep your appointments with your assigned provider. We do not refill medications for clients who are not seen regularly.</u> You are expected to store your medications in a secure place (locked cabinet, out of reach from children) that prevents others from taking them. Lost, stolen, or accidentally discarded medications will not be replaced.
Controlled substances such as Xanax or Klonopin or Valium are prescribed sparingly. If you are prescribed medication in this class, extra monitoring including random urine drug screens may be performed. You may also be asked to bring your medication to the office for a pill count. If these medications are not taken as prescribed, they may be discontinued. <u>Early refills WILL NOT be authorized.</u> Giving or selling your medication to others, securing the same medication from another provider, or use of alcohol or street drugs WILL result in discontinuation. Stimulant medications and other controlled substances are tightly regulated by the FDA. These medications CANNOT be called in. They require an appointment and at times a handwritten prescription. If you or your child is taking one of these medications, you may be required to visit our office in order to pick up your prescription.

TRANSPORTATION: I understand TN Voices staff are not responsible for my transportation to and from appointments, however, if I am a TennCare recipient then I am eligible for transportation services. I can consult my benefits guide for more information or call these numbers to schedule a ride:
United Healthcare Community Plan: 1-866-416-9209 **BlueCare: 1-800-468-969698**
TennCare Select: 1-800-263-5479 **Amerigroup: 1-800-600-4441**

CANCELLATION: If I have commercial Insurance and should not show or cancel an appointment with less than 24 hours' notice, I know that I am subject to a cancellation fee equivalent to the co-pay for the service I was to receive. I will be expected to pay this fee before my next appointment may be scheduled.

I have read and understand the above explanation of what is expected of me as a client of TN Voices. I agree to participate in the services for which I have consented. I understand that I may be discharged for not keeping appointments with my service providers.

If 21 and under: **I have been provided with a brochure regarding the EPSDT TennCare Kids program. I understand the importance of preventative medical, dental, and vision care as well as addressing any ongoing concerns of developing bodies.**

Emergency Contact Authorization for Disclosure of Protected Health Information

I hereby authorize sharing of information between the person/entity indicated below and TN Voices. The purpose of the release is for the notification of responsible parties about an emergency situation and to facilitate coordination of care in the event of an emergency for myself or my child.

I understand that:

- The information disclosed may include diagnoses, alcohol and drug use and/or dual diagnosis and health conditions including Acquired Immune Deficiency Syndrome (AIDS) or HIV status, dates of services, types of treatment, results of evaluations, and other information about services received.
- I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it;
- The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations;
- I am entitled to a copy of this document;
- I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits;
- There may be a charge for the release of these records pursuant to 45 CFR 164.524 (c) (4) (HIPAA);
- This authorization shall expire upon my written request to revoke or according to state law, (1 year from the date signed); and
- A copy of this authorization is as valid as the original.

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(You will be given an opportunity to authorize or decline naming an Emergency Contact on the Consent to Treatment form)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, TDCI's website https://www.tn.gov/commerce/insurance/Client-resources.html or call TDCI's Client Insurance Services team at 1-800-342-4029 or (615) 741-2218.

Visit https://www.tn.gov/commerce/blog/2022/1/12/the-no-surprises-act-will-protect-tennessee-Clients.html for more information about your rights under federal law.

Your child's FREE checkup will include:

- Health History
- Complete Physical Exam
- Lab Tests (as needed)
- Immunizations
- Vision/Hearing Screening
- Developmental/Behavioral Screening (as needed)
- Advice on how to keep your child healthy

Helpful numbers

DentaQuest
1-855-418-1622

East Tennessee

AMERIGROUP: 1-800-600-4441

BlueCare: 1-800-468-9698

UnitedHealthcare: 1-800-690-1606

TennCare*Select*: 1-800-263-5479

Middle Tennessee

AMERIGROUP: 1-800-600-4441

BlueCare: 1-800-468-9698

UnitedHealthcare: 1-800-690-1606

TennCare*Select*: 1-800-263-5479

West Tennessee

AMERIGROUP: 1-800-600-4441

BlueCare: 1-800-468-9698

UnitedHealthcare: 1-800-690-1606

TennCare*Select*: 1-800-263-5479

We do not allow unfair treatment in TennCare.
No one is treated in a different way because of race, color, birthplace, language, sex, age, religion or disability.

TN Division of TennCare | TennCare Kids

kidcentral tn
KIDCENTRALTN.COM

Division of TennCare, Authorization No. 318167, 5000 copies, October 2017. This public document was promulgated at a cost of $0.10 per copy.

health

TennCare cares.

Tennessee has made a commitment to promote good health in children from birth until age 21.

It's called the TennCare Kids program.

TN Division of TennCare | TennCare Kids

Client Copy

TennCare Kids is a full program of checkups and health care services for children who have TennCare. These services ensure babies, children, teens and young adults receive the health care they need.

Good health begins at birth, so it's important to: **Check In...Check Up...Check Back!**

What does TennCare Kids provide?

- Free medical and dental checkups
- Free medical and dental services
- Free behavioral health services

Check In!

Checkups and other services are done by doctors, who are Primary Care Providers (PCPs), dentists and other health professionals.

Where do I take my child to get their checkups?

- Your child's PCP
- Your child's dentist
- Your local health department

Do you need help making an appointment?

- For medical or behavioral health appointments, call your TennCare health plan.
- For dental appointments, call DentaQuest at 1-855-418-1622.

Do you need a ride to an appointment?

- Call your TennCare health plan.

Check Up!

Your child's FREE medical checkup will include:

- Health history
- Complete physical exam
- Lab tests (as needed)
- Immunizations
- Vision/Hearing screening
- Developmental/Behavioral screening (as needed)
- Advice on how to keep your child healthy

How often should your child get a checkup?

Birth	9 Months
3-5 Days	12 Months
1 Month	15 Months
2 Months	18 Months
4 Months	24 Months
6 Months	30 Months
Every Year: Ages 3-20	

TennCare will cover services needed to find or treat medical or dental problems.

- To schedule a TennCare Kids visit, call your child's PCP. If your child does not have a PCP, call your health plan or local health department.
- For a healthy smile, take your child to the dentist every six months. If you don't have a dentist, call DentaQuest at 1-855-418-1622.

Check Back!

Check back for:

- A follow-up appointment (if needed)
- Your next scheduled visit
- Any new health problems that come up
- Dental checkups every six months

Did you know that your child's health plan has a Nurse Help Line?

It's a free service that is available any time, day or night, for TennCare members. You can talk with a skilled nurse with questions about:

- Your child's symptoms
- How to care for your sick child
- What to do if your child is hurt
- Determine if you should take your child to the doctor, an urgent care clinic or the emergency room.

To speak with a nurse, call the **24/7 Nurse Help Line** for your child's health plan:

- **Amerigroup OnCall (24/7)**: 1-866-864-2544 (English) or 1-866-864-2545 (Spanish)
- **BlueCare 24/7 Nurseline***: 1-800-262-2873
- **UnitedHealthcare Advocate4Me (24/7)***: 1-800-690-1606
- **TennCare*Select* 24/7 Nurseline***: 1-800-262-2873

*Translation services are available upon request.

DECLARATION FOR MENTAL HEALTH TREATMENT

TN Department of Mental Health & Substance Abuse Services

www.tn.gov/behavioral-health

This form was developed based on Tennessee Code Annotated, Title 33, Chapter 6, Part 10.

The DMHT in Tennessee

What Is a DMHT?

For those of us with mental illness, our commitment to recovery includes making a plan for keeping well. Many of us use the Wellness Recovery Action Plan (WRAP®) by Mary Ellen Copeland to list what we need to stay well, to identify our triggers, and to create a crisis plan. But there are times when, despite our commitment to recovery, we get worse. Perhaps something big happens in our lives and it's just more than we can cope with. Sometimes our symptoms get the better of us.

Tennessee has created a legal document that can help. It's called a Declaration for Mental Health Treatment (DMHT). And when we find ourselves in a crisis, it can give us peace of mind. The DMHT is a legal document where we can write down our wishes in case of a mental health crisis. We can write down mental health treatments and medications that are okay with us and any that are not okay with us. We can write down what it looks like when we are in a mental health crisis and need help. Some people like to write down which hospitals they prefer and which mental health agencies they prefer, too.

Here's how to fill out your DMHT:

1. Read the entire DMHT form first.

2. Some sections of the DMHT form ask you to choose at least one option. In those sections, you will have to pick one of the options.

3. When you write down your wishes on the form, be as specific as you can.

4. There is a place at the bottom of each page where you need to put your initials and the date.

5. When you are ready to sign, get two adults to be your witnesses.

6. Pick two people who already know you. You cannot pick anyone who works for a mental health facility. That's against the rules for the DMHT because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to.

7. Before you sign in front of the witnesses that you picked, tell them about what you wrote in your DMHT.

8. Be sure to talk with the friends and family members of your choice about what you wrote in your DMHT so they can be there for you in the way you want.

Important Legal Information

The Tennessee Department of Mental Health and Substance Abuse Services developed this form based on Tennessee Code Annotated, Title 33, Chapter 6, Part 10.

Tennessee Code Annotated, Title 33, Chapter 6, Part 10, gives the right to individuals, 16 years of age and older, to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A "Declaration for Mental Health Treatment" allows people receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

This "Declaration for Mental Health Treatment" form describes what a service participant wants to occur when receiving mental health treatment. It describes mental health services that a service participant might consider, the conditions under which a declaration may be acted upon, and directions on how a service participant can revoke/cancel a declaration.

For example, completion of a "Declaration for Mental Health Treatment" form allows a service participant to state:

- Conditions or symptoms that might cause the declaration to be acted upon;
- Medications you are willing to take and medications you are not willing to take;
- Specific instructions for or against electroconvulsive or other convulsive treatment;
- Mental health facilities and mental health providers which you prefer;
- Treatments or actions which you will allow or those which you refuse to permit; and
- Any other matter pertaining to your mental health treatment which you wish to make known.

You must sign the form in front of two (2) competent adult witnesses (18 years or older) who know you. You must discuss the contents of this form with the witnesses prior to them signing it. It is important to note that restrictions exist on who may witness the declaration. The following parties may <u>not</u> act as witnesses:

- o The service participant's mental health service provider;
- o An employee of the service participant's mental health service provider;
- o The operator of a mental health facility; or
- o An employee of a mental health facility.

This declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Declaration for Mental Health Treatment for:

____

(Print Your Full Name)

This DMHT says what my wishes are for mental health treatment when I am in a mental health crisis and can't make decisions for myself.

I understand that sometimes I cannot make decisions about mental health treatment because of the symptoms of my mental illness. This is when I am in a mental health crisis.

Here are my symptoms when I am having a mental health crisis:

____.

Initials____Date__________

This DMHT gives me the right to say what medications I am okay with, how I feel about ECT (electroconvulsive therapy), and which psychiatric hospital I prefer (for up to 15 days).

Medication *(Psychoactive and other Medications)*

If I am in a mental health crisis and cannot make my own mental health treatment decisions, here are my wishes about medication:

You must check one:

☐ I do not have a preference about medications.

☐ I do not want the following medications:

Name of medication: _____

Reason I don't want it: _____
_____
_____
_____

Name of medication: _____

Reason I don't want it: _____
_____
_____
_____

Name of medication: _____

Reason I don't want it: _____
_____
_____
_____

Name of medication: _____

Reason I don't want it: _____
_____
_____
_____

Initials____Date_____

These medications have worked for me in the past:

Name of medication: _____

How it worked for me: _____
_____
_____
_____

Name of medication: _____

How it worked for me: _____
_____
_____
_____

Name of medication: _____

How it worked for me: _____
_____
_____
_____

Additional medication concerns:

_____
_____
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_____.

Initials____Date_____

Going to the Hospital
*(Admission to and Remaining in a Hospital for Mental Health Treatment)**

If I am in a mental health crisis and not able to make decisions, these are my preferences about going to the hospital:

You must check one:

☐ I do not have a preference about being admitted to a hospital for mental health treatment.

☐ I am okay with being admitted to a hospital for mental health treatment. I consent.

☐ I do not want to go voluntarily to a hospital for mental health treatment. I do not consent.

If I have to go to a hospital for mental health treatment, then I want the following to happen:

You must check one:

☐ I will remain voluntarily in the hospital for mental health treatment. I consent.

☐ I do not want to remain voluntarily in the hospital for mental health treatment. I do not consent.

Additional hospitalization concerns:

_____
_____
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_____
_____.

*Psychiatric hospital authorization in a DMHT is limited to 15 days.

Initials____Date_____

Mental Health Services from Other Places

Tennessee has places other than the hospital where you can receive help for your mental illness. These are places like a Crisis Stabilization Unit (CSU), a respite facility, and others.

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving mental health services from places other than a hospital:

You must check one:

☐ I do not have a preference about receiving mental health services from places other than a hospital.

☐ I am okay with receiving mental health services from places other than a hospital. I consent.

☐ I do not want to receive mental health services from places other than a hospital. I do not consent.

Additional concerns about mental health services from other places:

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____.

Initials____Date__________

Specific Mental Health Agencies, Hospitals, and Other Places for Treatment

If I am in a mental health crisis and not able to make decisions, these are my preferences about certain mental health agencies, specific hospitals, and other places for mental health treatment:

Check all that apply:

☐ I do not have a preference about any specific mental health agencies, specific hospitals, and other places for mental health treatment.

☐ I do not prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.

☐ I do prefer the following specific mental health agencies, specific hospitals, and other places for mental health treatment.

Names of hospitals, mental health agencies, and other places for mental health treatment that I...	
DO NOT CONSENT TO:	**PREFER:**

Additional concerns about specific mental health agencies, hospitals and other places for treatment:

_____
_____
_____
_____
_____
_____
_____
_____
_____.

Initials____Date_____

ECT (Electroconvulsive Therapy) and Other Convulsive Therapies*

If I am in a mental health crisis and not able to make decisions, these are my preferences about receiving ECT (electroconvulsive therapy) and other convulsive therapies:

You must check one:

☐ I do not have a preference about receiving ECT (electroconvulsive therapy) and other convulsive therapies.

☐ I do not want to receive ECT (electroconvulsive therapy) or other convulsive therapies. I do not consent.

☐ I am okay with ECT (electroconvulsive therapy). If I have any conditions, I have written them below.

☐ I am okay with other convulsive therapies. If I have any conditions, I have written them below.

**Your decision to consent to electroconvulsive therapy may be limited if you are considered to be a child under certain provisions of the law. Your decision to consent to electroconvulsive therapy may be limited if you are a child in the state's custody under certain provisions of the law.*

Initials____Date_____

Other Preferences

If I am in a mental health crisis and not able to make decisions, here are some additional things I prefer:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Here are the people I want to be called if I am in a mental health crisis:

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Name _____

Home Phone (with area code) _____

Work Phone (with area code) _____

Cell Phone (with area code) _____

Initials____Date_____

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this "Declaration for Mental Health Treatment" to be followed if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship preceding, or (2) two examining physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this DMHT, in whole or in part, at any time, by word or in writing, when I am able to make informed treatment decisions.

This declaration will expire two years from the day it is signed by me and two witnesses or a shorter period specified by this date: _____/_____/_____ or until revoked.

My Name (printed) _____

My Signature _____ Date _____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Date of Birth _____

Initials____Date_____

Affirmation of the First Witness

I affirm that _____ is personally known to me; that he or she signed this "Declaration for Mental Health Treatment" in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant's mental health services provider
An employee of the service participant's mental health services provider
The operator of a mental health facility
An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.*

☐ Yes ☐ No

You must check one:

I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

☐ Yes ☐ No

First Witness Name (print) _____

First Witness Signature_____ Date_____

Address _____

Phone (with area code) _____

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.
**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.

Initials____Date_____

Affirmation of the Second Witness

I affirm that _____ is personally known to me; that he or she signed this "Declaration for Mental Health Treatment" in my presence; that he or she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He or she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:

The service participant's mental health services provider
An employee of the service participant's mental health services provider
The operator of a mental health facility
An employee of a mental health facility.

You must check one:

I am a relative by blood, marriage, or adoption.*

☐ Yes ☐ No

You must check one:

I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

☐ Yes ☐ No

Second Witness Name (print) _____

Second Witness Signature_____ Date_____

Address _____

Phone (with area code) _____

*Only one of the two witnesses can be a relative by blood, marriage, or adoption.
**Only one of the two witnesses can be a person likely to benefit from the death of the person completing the declaration.

Initials____Date_____

Frequently Asked Questions

What is a Declaration for Mental Health Treatment?

A Declaration for Mental Health Treatment (DMHT) is a legal document where you can write down your wishes in case of a mental health crisis. You can write down mental health treatments and medications that are okay with you and any that are not okay with you. You can write down what it looks like when you are in a mental health crisis and need help. Some people like to write down which hospitals they prefer and which mental health agencies they prefer, too.

Who can make a DMHT?

Anyone sixteen (16) years of age or older, or an emancipated minor with capacity to make informed mental health treatment decisions.

Can you be required to fill out a DMHT?

No. Tennessee law specifically states that you cannot be required to complete a DMHT. In particular, a mental health service provider or a health insurance plan cannot require you to complete a DMHT in order to access services.

When may a DMHT be used?

A DMHT is used when you are unable to make informed decisions about treatment due to a mental illness. Note: A DMHT is only in effect when you are unable to make informed mental health treatment decisions.

What are the advantages of having a DMHT?

A DMHT allows you to plan and guide your mental health treatment according to your stated wishes if you later become unable to make informed decisions about your mental health treatment.

What areas of treatment can be covered by a DMHT?

A DMHT allows you to state which mental health treatments are, or are not, okay with you. You can make your wishes known about three types of mental health treatment:

1. Medications
2. Electroconvulsive and other convulsive therapies
3. Psychiatric hospitalization (for up to fifteen (15) days)

Who can help you fill out the form?

Anyone can help you complete the form. Many community mental health organizations have peer staff members who may be able to help you. Remember: A DMHT cannot be signed on the premises of a mental health service provider because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to.

Who can I choose to be my witnesses to my DMHT?

Pick two adults who already know you. You cannot pick anyone who works for a mental health facility because the people who wrote the DMHT rules want to make sure you aren't pressured to write down anything you don't want to. At least one of the witnesses cannot be related to you by blood, marriage or adoption, or be someone who, at the time of signing, would benefit from your will or be entitled to any portion of your estate in the event of your death.

How can I make sure that the people who provide my mental health treatment know about my wishes?

You should give a copy of your completed DMHT to your mental health service provider and anyone who may help you when you are not able to make informed mental health decisions. You may want to give a copy to your medical doctor. You should discuss your DMHT with these individuals and keep a copy for yourself. Note: Many insurance providers are willing to keep a copy of your DMHT on file for you so that if you do have to be hospitalized, the insurance provider can send a copy of your DMHT to the hospital.

How can I change my DMHT?

If you are able to make informed mental health treatment decisions, you may change your DMHT at any time. You can make these changes verbally or in writing. You may also cancel an old DMHT and create a new one. It is important to give a copy of the new DMHT to the same people you gave your previous declaration. You should also give a copy to your service provider.

What happens if a court appoints a conservator?

If a court appoints a conservator to make mental health treatment decisions for you, your DMHT remains in effect and overrides the conservator with respect to mental health treatment covered under the DMHT.

What is the responsibility of the physician or other mental health service provider?

The physician or other mental health service provider must assess your capacity to make informed decisions about your treatment. Generally, the physician or other service provider will follow the DMHT only when you lack the capacity to make informed mental health treatment decisions.

Can a physician or other mental health service provider choose not to follow my DMHT?

Yes. If there is an emergency that places your health or life in danger, or if the mental health service provider, as a matter of conscience, cannot follow your DMHT, then they can legally choose not to follow your DMHT. In addition, if you are hospitalized against your will, your DMHT may not be followed. If this occurs, a Treatment Review Committee must review the proposal to not follow your DMHT so that it is not only one doctor or mental health professional making that decision.

Does a DMHT affect your insurance benefits?

No. A DMHT is not related to insurance benefits or payment for services. When completing a DMHT, you should consider the limitations of your insurance benefits. For example, if you request a service provider that is not approved by your insurance provider, you may have to pay for that service out of your own pocket.

Does a DMHT need to be notarized?

No. The DMHT does not need to be notarized.

Where can I find another copy of the DMHT form?

A DMHT form is available at the Tennessee Department of Mental Health and Substance Abuse Services website: http://tn.gov/mental/legalCounsel/olc.html. This form is also available from the TDMHSAS Office of Consumer Affairs and Peer Recovery Services by calling toll-free 1-800-560-5767.

Definitions

Electroconvulsive or other convulsive therapies: Treatments for depression that use electric shock or chemical agents to induce mild seizures. Electroconvulsive therapy is sometimes called ECT or "shock therapy".

Informed Mental Health Treatment Decision: A decision made by a person with mental illness who has the ability to understand the proposed procedures, their risks and benefits, and the available alternative procedures.

Mental Health Service Provider: An agency or a person who provides mental health services and supports.

Mental Health Facility: An agency or facility licensed to provide mental health services and supports.

Psychoactive Medication: A drug that acts directly on the central nervous system to influence consciousness, mood, and awareness.

Revoke: To withdraw, cancel, or take back.

Service Participant: A person who is receiving services, has applied for services, or for whom someone has applied for or proposed services because the person has mental illness or serious emotional disturbance. Service participants can be called consumers, clients, or patients.

For additional information about the
Declaration for Mental HealthTreatment, contact the
Tennessee Department of Mental Health and Substance Abuse Services
Office of Consumer Affairs and Peer Recovery Services
at (800) 560-5767
or by email to
OCA.TDMHSAS@TN.GOV

For questions about information on the www.tn.gov/behavioral-health
website, contact the Publication Editor c/o the
Tennessee Department of Mental Health and Substance Abuse Services at
(800) 560-5767
or by email to
OC.TDMHSAS@TN.GOV
Visit: tn.gov/behavioral-health/declaration-for-mental-health-treatment

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TennCare

Division of Health Care Finance & Administration

Advance Directives and Living Wills:

Making sure your wishes are honored for end of life care

Advance Directives

Advance Directives are your written wishes about what you want to happen, if you get too sick to be able to say.

Living Will or Advance Care Plan

Machines and medicine can keep people alive when they otherwise might die. Doctors used to decide how long someone should be kept alive. Under the Tennessee Right to Natural Death Act, you can make your own choice. **You can decide if you want to be kept alive by machines and for how long** by filling out a Living Will. In 2004, Tennessee law changed the Living Will to **Advance Care Plan**. Either one is ok to use.

A Living Will or Advance Care Plan needs to be filled out while you can still think for yourself. These papers tell your friends and family what you want to happen to you, if you get too sick to be able to say.

Your papers have to be signed, and either witnessed or notarized.

If your papers are witnessed, your papers need to be signed in front of two people who will be your witnesses. These people:

- One of these people cannot be related to you by blood or marriage.
- Cannot receive anything you own after you die.
- Cannot be your doctor or any of the staff who work in the place where you get health care.

Once they are signed by everyone, it is your rule. It stays like this unless you change your mind.

Tennessee Durable Power of Attorney for Health Care or Appointment of Health Care Agent

The Durable Power of Attorney for Health Care paper lets you name another person to make medical decisions for you. In 2004, Tennessee law changed the Durable Power of Attorney for Health Care to **Appointment of Health Care Agent.** Either one is ok to use.

This person can only make decisions if you are too sick to make your own. He or she can say your wishes for you if you can't speak for yourself. Your illness can be temporary.

These papers have to be signed, and either witnessed or notarized. Once the papers are signed by everyone, it is your rule. It stays like this unless you change your mind.

These papers will only be used if you get too sick to able to say what you want to happen. As long as you can still think for yourself, you can decide about your health care **yourself**.

If you fill out these papers, make **3** copies:

- **Give** 1 copy to your Primary Care Provider to put in your medical file.
- **Give** 1 copy to the person who will make a medical decision for you.
- **Keep** a copy with you to put with your important papers.

Important! You **do not** have to fill out these papers. It is your choice. You may want to talk to a lawyer or friend before you fill out these papers.

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions **(you can check as many of these items as you want)**:

- ☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.

APPOINTMENT OF HEALTH CARE AGENT
(Tennessee)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip Code	_____ City State Zip Code
(_____) _____ Area Code Home Phone Number	(_____) _____ Area Code Home Phone Number
(_____) _____ Area Code Work Phone Number	(_____) _____ Area Code Work Phone Number
(_____) _____ Area Code Mobile Phone Number	(_____) _____ Area Code Mobile Phone Number
_____ Patient's name (please print or type) Date	_____ Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

_____ Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____ Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____ Signature of Notary Public

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005