



YOUTH AND FAMILY RIGHTS ATTESTATION

State Form 55692 (R2 / 03-26)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)
- 1915(i) CHILDREN'S MENTAL HEALTH WRAPAROUND SERVICES PROGRAM

DIVISION OF MENTAL HEALTH AND
ADDICTION
402 W. WASHINGTON ST, ROOM W353
INDIANAPOLIS, IN 46204-2739
317-232-7800
FAX: 317-233-3472

Full name of applicant / participant		
Medicaid RID number	Date of birth (month, day, year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Type of Evaluation <input type="checkbox"/> Initial Evaluation <input type="checkbox"/> Re-Evaluation	Service Program 1915(i) Children's Mental Health Wraparound Services Program	

CONFLICT OF INTEREST
I, the applicant, participant and/or guardian of the applicant/participant have been informed about and understand that, in an effort to prevent a conflict of interest between the person completing the assessment/application and the person determining the youth's eligibility for Home and Community-Based Services (HCBS), the Division of Mental Health and Addiction (DMHA) is the State entity that will determine final eligibility and authorization for CMHW program services.

STATEMENT OF FREEDOM OF CHOICE
I, the applicant, participant and/or guardian of the applicant/participant have been fully informed of the available services for the eligible youth and understand that I have the freedom of choice regarding the following: <ul style="list-style-type: none"> • The individuals who will be a part of the treatment team. • Identification of the youths plan of care goals and methods for achieving those goals. • Selecting the CMHW services, as supported by the youth's assessment and level of need that will be included within the individualized plan of care. • The rights to choose a DMHA-certified CMHW service provider or providers who will provide, oversee, and monitor the implementation of the plan of care. • The right to change the CMHW service provider(s) at any time during the youth's enrollment in the CMHW services program.

GRIEVANCE OR COMPLAINT
I, the applicant, participant and/or guardian of the applicant, have been fully informed of the formal process to express concerns, complaints and grievances to DMHA for review and resolution regarding the HCBS program in which my youth is participating. I have been informed that a formal grievance or complaint is neither a pre-requisite nor a substitute for a fair hearing. I understand additional resources are available to HCBS participants and family members wishing to file a formal complaint or concern on the DMHA portal at: DMHA Incident and Complaint Reporting , https://dmhareport.fssa.in.gov/ Grievance or complaints may be submitted to: <p style="text-align: center;">Division of Mental Health and Addiction 402 West Washington Street, Room W353 Indianapolis, IN 46204</p>

Name of Applicant / Participant	Identification Number of Applicant / Participant
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FAMILY NOTICE OF FIDELITY AND SATISFACTION EVALUATIONS
<p>Annually, DMHA administers a Youth and Family Survey. Information from the survey is used in quality improvement (QI) and evaluation activities.</p> <p>I, the applicant, participant or guardian of the applicant/participant have been informed about and understand the following:</p> <ul style="list-style-type: none"> • I have been informed of the survey process. I understand that my participation is voluntary. If I chose to participate in the survey, my responses would assist DMHA in evaluating the effectiveness of the HCBS program in which I am enrolled. • I will be asked to complete the Youth and Family Survey by email, mail or by telephone. I have the right to decline participation. • For quality assurance purposes I understand my selected Wraparound Facilitator may record the full Child and Family Team meeting and share the recording with DMHA.

YOUTH AND FAMILY ATTESTATION *	
<p>I, the applicant, participant and/or guardian of the applicant/participant am signing below to acknowledge that I understand the information included above in this Youth and Family Attestation Form. If I have any additional questions, I am free to contact DMHA Youth Services for assistance by emailing DMHAyouthservices@fssa.IN.gov.</p>	
Date of attestation (month, day, year)	
Signature of youth (applicant / participant)	Date signed (month, day, year)
Printed name of youth (applicant / participant)	
Signature of parent / guardian	Date signed (month, day, year)
Printed name of parent / guardian	
Signature of witness	Date signed (month, day, year)
Printed name of witness	

* A copy of this form is to be given to the Participant and the original signed form is to be uploaded into the DMHA database and then retained in the Participant's clinical record.