SOUTH CAROLINA
Healthy Connections
MEDICAID

Rehabilitative Behavioral Health Services (RBHS)
Parent/Caregiver/Guardian Agreement to Participate in Community Support Services

Name of Beneficiary: Date of Birth:
Medicaid Number:

What are Rehabilitative Behavioral Health Services (RBHS) Community Support Services?
RBHS Community Support Services help the child and you develop skills to live successfully in the home and community. Services include Psychosocial Rehabilitation Services (PRS), Behavior Modification (B-Mod), and Family Support (FS). These services are for youth with mental health and/or substance use disorders. Services are not for child care service, mentoring or recreation.

The child has been diagnosed with the following mental health and/or substance use disorder(s).
Please list both code and description (*your provider is required to explain the diagnoses to you*):

Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/
Diagnosis - Code / Description	/

The provider has recommended the following services (check all that apply):

☐ Psychosocial Rehabilitation Services (PRS): PRS helps the child build skills to successfully live in the home and community, succeed in school and/or work and build healthy relationships with family, friends and others.

☐ Behavior Modification (B-Mod): B-Mod helps the child to reduce undesirable behaviors. You and the child will receive training in managing these behaviors. This training will help the child replace undesired behaviors with suitable ones, during and after treatment.

☐ Family Support (FS): FS helps you to serve as an active member of the child's treatment team and improve your ability to care for the child's behavioral health needs. FS can connect you to groups that support youth with mental health needs. FS may also encourage you to participate in other types of groups which may be helpful to you.

What will be asked of you?
You will be asked to:

- Participate in treatment planning meetings
- Participate in training sessions where you will be taught skills to help the child like modeling, redirecting, coaching, and reinforcing
- Monitor the child's behaviors and report to the treatment team
- Based on the child's needs, you may be asked to participate in other activities the treatment team recommends

What can you expect of _____ staff?
(Provider Name)

- Explain all treatments in language you will understand
- Explain all known benefits and risks of the treatment in a way you will understand

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- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team
- Work with you to schedule visits, and notify you in advance if the provider must cancel or reschedule
- Discuss the child's progress with you during every visit
- Answer any questions you have regarding the child's treatment
- Respond to your concerns in a timely and respectful manner
- Provide information about community resources

Because your participation is a key to success, you will be asked to confirm your willingness to participate in these services every ninety (90) days.

By signing this form:

- I, _____, agree to participate in the following recommended RBHS
  (Name of Parent/Caregiver/Guardian)
  Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)

- I give permission for _____, to participate in the following
  (Name of Beneficiary)
  recommended RBHS Community Support Services:

  ☐ Psychosocial Rehabilitation Services (PRS)
  ☐ Behavior Modification (B-Mod)
  ☐ Family Support (FS)

- I agree the provider has explained the mental health and/or substance use disorder diagnoses to me.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I also understand that I can end these services at any time, unless participation is court-ordered.

_____ _____
Printed Name of Parent/Caregiver/Guardian Relationship to Beneficiary

_____ _____
Signature of Parent/Caregiver/Guardian Date

_____
Printed Name of Staff

_____
Name of Provider

_____ _____
Signature and Credentials of Staff Date