Community Treatment Services
Participation Agreement (Informed Consent)

Client Name:
Register Number:
Date of Birth:

You have been referred for Community Treatment Services (CTS) while residing in the community. **Your participation in any of these services is voluntary, and you have the right to decline treatment now or at any time in the future**.

You are not required to participate in counseling to receive psychiatric or medication-assisted treatment (MAT) medications unless mandated by state regulations. If your treatment includes medication, prior to receiving the medications you will be informed of intended outcomes and possible side effects and must give your consent. Additionally, if you choose to engage in counseling, the frequency of sessions will be determined collaboratively between you, CTS, and the CTS Provider.

If you wish to request counseling or any other services beyond those indicated below, you may inform the Residential Reentry Center (RRC) or the CTS Provider, and CTS will facilitate the referral process if deemed appropriate.

TREATMENT TYPE	REFERRED	CONSENT	DECLINE*
Services below may include initial assessments and/or evaluations.	Provider will indicate referred services below.	Initial each box for services you wish to participate in.	Initial each box for **referred** services you wish to decline.
Substance Use Counseling	☐		
MAT Counseling (Individual Substance Use Counseling)	☐		
MAT Medications / Medication Monitoring	☐		
Sex Offender Counseling	☐		
Mental Health Counseling	☐		
Psychiatric Medications / Medication Monitoring	☐		

**Individuals residing in an RRC, on HC, or FLM may only receive counseling, psychiatric, or MAT medication through the contracted CTS provider.*

If you choose to participate in CTS you are required to adhere to the following rules:

1. attend and actively participate in all scheduled treatment sessions and maintain confidentiality;
2. take medication as prescribed (if applicable);
3. abide by the rules/regulations of the Bureau of Prisons, CTS Provider, and the RRC;
4. notify the RRC as soon as possible if you have any conflicts with your scheduled treatment sessions.

By signing this form, you acknowledge you have discussed this document with the community-based treatment contract staff member and understand your rights and options regarding community-based treatment.

Client Signature: **Client gave verbal consent through telehealth**	Today's Date:
Client Primary Contact Number:	Client Secondary Contact Number:

Contract Staff Witness Signature:	Contract Staff Witness Printed Name: **Lauren Herraiz**

cc: Community Treatment Services Office