By signing this form, you acknowledge you have received a copy of the San Mateo County Behavioral Health and Recovery Services, Alcohol and Other Drug Services (BHRS AOD) Drug Medi-Cal Organized Delivery System (DMC-ODS) Member Handbook.

The Member Handbook gives you information about our substance use treatment services, access to services, your rights as a beneficiary, and the problem resolution process should you be dissatisfied with anything concerning our services. Please read the handbook carefully. You may ask your provider or contact San Mateo County BHRS AOD with any questions you may have regarding your services. The Member Handbook is subject to change. If we change the Member Handbook, we will post the revisions on our website at https://www.smchealth.org/bhrs/aod/policy where you may obtain a copy.

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Date: __________________ Signature:__________________________________________
(beneficiary/advocate for beneficiary)

Client Name: _____________________________________________________________
(please print)

INABILITY TO OBTAIN ACKNOWLEDGEMENT
This portion must be completed only if no signature can be obtained. If it is not possible to obtain the beneficiary’s acknowledgement, describe good faith efforts made to obtain the acknowledgement, and the reasons why the acknowledgement could not be obtained:____________________________________________________________
___________________________________________________________________
___________________________________________________________________

Date: __________________ Signature: __________________________________________
(treatment provider name, title)

Staff Name: __________________________
(please print)