



Patients' Rights & Responsibilities

Policies and Procedures

Revised/Updated: 9/9/2026 **Board Last Approved:** 10/20/2026



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Consent to Treat

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Consent to Treat
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

Obtain voluntary written or approved electronic consent before nonemergency care. General consent covers routine evaluation and treatment, permitted use of health information for treatment, payment and operations, insurance billing, and approved care coordination. It does not replace procedure-specific informed consent or separate permissions required for protected information, recording, research, or publicity.

2. Purpose and Scope

Establish a consistent consent process for FCHC medical, dental, mental health, specialty, telehealth, and school-based services.

3. Procedure

1. Obtain and renew consent. Obtain consent before the first nonemergency service. Renew at least annually and when the legal representative or form/program terms materially change. Verify consent status and signer identity and authority at every visit. For school-based services consent remains valid for the duration of the time the student is enrolled in the public school system.
2. Support understanding and choice. Explain care in plain language and provide qualified interpreters or accessible formats as needed. Allow questions and voluntary decisions. Clinicians explain the purpose, risks, benefits, alternatives, and follow-up for interventions requiring informed consent and document the discussion and decision.
3. Address special circumstances. Verify representative authority for minors and patients unable to consent; involve the patient as appropriate. Follow applicable confidential-minor, mental health, and other protected-information requirements. Use separate SBHC enrollment and information-release forms for school communications and confirm telehealth consent.
4. Respect refusal. Patients may refuse or withdraw consent, subject to applicable law. Stop nonemergency treatment when consent is withdrawn; document consequences, alternatives, and follow-up. Escalate unresolved concerns to the Clinical Director and Compliance/Privacy. Document any emergency exception and why consent could not be obtained.
5. Explain billing and privacy. Notice of Privacy Practices available for all clients. Explain insurance billing, assignment of benefits, and financial responsibility under FCHC fee, sliding-fee, hardship, and collections policies. Do not deny medically necessary Health Center Program services solely because of inability to pay. Share information through approved workflows, with additional permissions when required.



6. Document and monitor. Store signed, dated consent and applicable signer-authority and interpreter documentation in Epic. Document procedure-specific consent and refusal in the encounter. During downtime, protect paper forms and upload them within one business day after restoration. Never backdate signed consent. Train responsible staff initially and annually; review consent records at least quarterly and correct gaps.

Related policy: FCHC PC-02 Consent to Treat, Payment, and Care Coordination (draft; pending approval). This condensed language is proposed for review and approval.

Patients will be informed within the consent to treat documents that Family Center may record the visits for transcription purposes.



Photography Video Audio and Other Imaging

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Photography Video Audio and Other Imaging
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

Family Centers Health Care (FCHC) is committed to protecting patient privacy, confidentiality, dignity, and safety by ensuring that all photography, video, audio recordings, clinical imaging, and AI-assisted documentation are conducted only for authorized purposes, with appropriate consent and approved technology. All recordings and images must be securely stored, accessed, and managed in accordance with FCHC policies, HIPAA requirements, and applicable federal and state regulations. Unauthorized recording, use, or disclosure is strictly prohibited.

2. Purpose and Scope

Protect privacy, dignity and safety when taking photographs, recording or monitoring video or audio, using ambient AI, or capturing screens or other images. Applies to all FCHC sites and services, personnel, practitioners, trainees, contractors, patients and visitors, including personal devices and third-party platforms. Routine diagnostic imaging follows its clinical policy and these privacy, storage and disclosure rules. Non-identifiable specimen images are excluded.

3. Procedure

CORE RULES

Before capture, confirm the purpose, permission, approved device or application, storage location, access and retention. Capture only what is needed and exclude unrelated people, conversations, screens and records.

Use only FCHC issued or expressly approved and managed technology. Personal devices, accounts, email, messaging, cloud storage and unapproved AI tools are prohibited for staff capture or sharing. IT must approve settings and disable unapproved backup, syncing, location tracking, facial recognition and analytics.

Do not record secretly, for personal use, social media, curiosity, harassment or retaliation. Any lawful security exception requires Privacy/Legal review.

Respect refusal and withdrawal. Optional recording cannot be a condition of care, payment, enrollment or benefits. Explain alternatives when imaging is essential to a specific service.

PERMISSION BEFORE CAPTURE

Routine clinical photographs or intraoral images: explain the purpose and obtain verbal consent each time. Document consent within a visit note.



Audio, video and ambient AI: obtain agreement from the patient and every participant before each encounter. Obtain written authorization if audio/video is retained or otherwise required. General consent to treat does not replace separate authorization.

Sensitive encounters: record therapy, psychiatric, substance use, confidential minor, reproductive, HIV-related or intimate care only when essential, specifically approved and separately authorized as required. Use applicable representative permission and minor assent; consult Privacy for confidential services.

Education: obtain separate written authorization. Internal quality, risk or peer-review recording requires Privacy/Risk and Clinical Director approval and patient authorization unless a documented legal exception applies.

Publicity, marketing, fundraising, testimonials, public education and social media: obtain Privacy-approved HIPAA authorization and an image/voice release before capture or access. Research requires IRB/Privacy approval and applicable consent, authorization or documented waiver.

CLINICAL CAPTURE AND STORAGE

Confirm the clinical need and consider a written description, diagram or less intrusive option. Verify two patient identifiers.

Explain what will be captured, why, whether sound is included, who can view it and where it will be stored. Obtain the required permission. For sensitive areas, limit exposure, use draping and offer a chaperone.

Use approved technology. Do not edit images in ways that change clinical meaning. Label orientation and laterality when needed.

Upload promptly to the correct Epic patient and encounter. Include the date/time, creator, purpose, body site or content, media type and consent documentation. Verify that the image opens and is usable.

Delete temporary copies securely after verified upload, normally before the end of the shift and no later than 24 hours, unless the approved system manages secure automatic transfer and deletion.

Document findings, image limitations, patient communication and follow-up. Images used for care are part of the patient record.

Store nonclinical recordings only in the approved restricted repository. Limit access to job-related need, apply additional protections to sensitive records. Follow approved retention schedules and legal holds. Privacy/HIM must confirm the basis for release; preserve the original. Withdrawal stops future optional use but does not require deletion of material already relied upon or legally retained.

AMBIENT AI CALLS AND TELEHEALTH

Ambient AI requires written approval from Privacy, Information Security, Clinical Leadership, Legal/Procurement and Epic governance, with a business associate agreement when applicable. Explain the tool and audio retention before each encounter. If anyone declines, use standard documentation.

Sensitive encounters, group visits, interpreter calls and encounters with nonconsenting third parties cannot use routine ambient capture without specific written workflow approval and required authorization. Clinicians must review, correct and sign generated notes. Orders, messages and disclosures require authorized human review.



Consent For Session Recording And EMR Transcription

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Consent for Sessions Recording and EMR Transcription
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

Family Centers requires informed patient consent and agreement from all participants before using approved audio recording, video recording, or AI-assisted transcription technology during clinical encounters. Recording is voluntary, and patients may decline or withdraw consent at any time without affecting their care. All recordings and transcriptions must be managed securely using Family Centers-approved systems, with appropriate consent documented in Epic. Clinicians are responsible for reviewing and verifying the accuracy of all AI-generated documentation before signing. All recording activities must comply with FCHC privacy and security policies, HIPAA, and applicable federal and Connecticut state regulations.

2. Purpose and permission.

A Family Centers-approved recording or ambient scribe tool may capture an encounter to prepare a draft note for the electronic medical record (Epic). Before starting each encounter, explain the purpose, tool/vendor, who processes or can access the audio, whether audio or a transcript is retained, its approved storage location and retention period, and whether any recording will become part of the patient record. Obtain the patient's or verified authorized representative's permission and agreement from every participant. Seek minor assent when appropriate and follow confidential-minor and sensitive-encounter controls. Use qualified language assistance when needed.

3. Procedure

CONSENT METHOD.

Document verbal consent before capture when permitted by the approved workflow. Obtain separate written or electronic authorization when audio/video is retained or when required by the existing recording policy or approved legal workflow. General treatment consent or use of telehealth alone is insufficient. Reconfirm permission if a new participant joins or the recording purpose changes.

Patient choice. Recording is optional. Declining or stopping recording will not affect access to care; the clinician will document the visit using standard methods. Stop capture immediately if any participant withdraws agreement. Document the withdrawal and explain what happens to material already captured under the approved retention policy. Do not promise deletion of information that must be retained.



EMR DOCUMENTATION AND STORAGE.

Document the consent discussion, decision, date/time, signer and relationship when applicable, participant agreement, interpreter assistance, tool used, and disclosed retention terms in the encounter. Verbally approved consents must be documented on the EMR. Enter the clinician-reviewed and signed note into Epic. Recording for transcription does not automatically authorize uploading or permanently retaining the raw audio or unreviewed transcript in Epic; use only the approved storage and deletion workflow.

PATIENT AND VISITOR RECORDING

Patients may ask to record their own visit. The provider and every identifiable person must agree, and privacy and safety must be protected. Offer written instructions, an after-visit summary, an interpreter or a support person when needed. Evaluate disability-related requests through the accommodation process without retaliation.

Staff may assist with a patient's device only if they agree, the content includes only that patient, no other person or protected information is captured, and care is not disrupted. FCHC does not control or retain that copy.

UNAUTHORIZED RECORDING AND INCIDENTS

Calmly ask the person to stop, explain the privacy concern and protect nearby people and information. Do not search, seize or damage a personal device, physically obstruct recording or order deletion.

Continue emergency evaluation and stabilization. Nonemergency care may be moved, paused or rescheduled only after leadership review when privacy or safety cannot otherwise be protected. Document the reason and offer a safe alternative.

Immediately notify the supervisor and Privacy/Information Security through the incident process. Involve Security, HR, Risk or Clinical Leadership as needed. Record facts, witnesses, exposed information, known sharing and actions taken without searching the device.

Privacy/Security directs containment, removal requests, breach assessment, notifications and corrective action. Do not promise deletion or outcomes. Keep investigation details in the incident system; document only care-relevant effects in the patient record. Retaliation is prohibited.

SECURITY MONITORING AND OTHER USES

Security cameras require a documented risk assessment and written Facilities/Security, Privacy, IT, HR, Legal/Risk and operational leadership approval before installation or major changes. Limit cameras to approved common areas; avoid screens, records, treatment conversations and neighboring private property. Post visible notice and maintain the camera map, purpose, retention period, access list/log and testing records.

No general security cameras are allowed in exam or treatment rooms, dental operatories, counseling rooms, bathrooms, changing or lactation rooms, or staff break rooms. A time-limited safety exception requires individual written approval, the least intrusive approach and applicable notice/consent. Audio, biometrics, analytics and third-party monitoring require specific approval, legal review and clear notice.

Media crews need Privacy/Legal approval, prior authorization from every patient whose information could be exposed, confidentiality terms and an escort within approved areas. Blurring afterward does not replace authorization. Workforce recording requires HR/Medical Staff and Privacy approval and individual consent for the approved use.



Privacy/Legal verifies government and law-enforcement requests before capture or disclosure. For abuse, neglect or forensic concerns, follow reporting and evidence policies, consult Clinical Leadership and Privacy/Risk unless immediate action is legally required, and preserve chain of custody. Refusal must not delay required reporting. Disaster identification follows emergency/privacy procedures with the basis and recipients documented.

RESPONSIBILITIES AND MONITORING

Privacy approves permissions and disclosures and leads investigations; IT controls technology and security; Clinical Directors approve clinical use and consent requirements. Program and site leaders manage training, signage, implementation and corrective action. Clinicians document permission and verify storage. Communications manages publicity releases; HR/Medical Staff oversees workforce uses. Everyone must report concerns.

Train personnel at onboarding and annually; verify device competency before use. Privacy and program leaders audit quarterly across services for consent, approved technology, correct storage, timely deletion, security controls and incidents. Report findings through QI/QA and re-audit corrections. Targets: full compliance and zero unauthorized personal-device or social use. Maintain approvals, inventories, vendor/BAA records, consent forms, training, audits and retention/deletion evidence.

Use the separate Privacy-approved recording authorization form unless explicitly stated in general consent and related FCHC privacy, consent, clinical, security, retention and incident policies. Compliance/Legal verifies HIPAA, 42 CFR Part 2, Connecticut recording and mental health confidentiality requirements, and HRSA QI/QA and board authority references before approval.



Patient Rights Policy

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Patient Rights Policy
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

Consistent with our mission and core values and with applicable state and federal law, FCHC respects and upholds the rights and responsibilities of all individuals receiving care and services at FCHC clinics. Patients are made aware of their rights and responsibilities prior to receiving medical care.

2. Purpose

To outline the accountability of Family Centers Health Care (FCHC) caregivers and representatives to ensure that all patients are informed of their rights and responsibilities.

3. Procedure

"Patient Rights and Responsibilities" are posted at all key entries to FCHC Health Center.

All patients or their designated representative will be given a patient rights brochure; given the opportunity to read it, ask questions and have their questions answered.

In every encounter, patients will be treated with compassion and respect. Caregivers and providers will be educated on our patients' rights and responsibilities.

If a caregiver becomes aware of a situation where a patient's rights may have been violated, the caregiver will inform his or her supervisor and complete an Incident Report.

PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to respectful, nondiscriminatory care; privacy and confidentiality; information they can understand; participation in care decisions; consent or refusal; reasonable accommodations; access to their records through the approved process; information about charges and financial assistance; and complaints without retaliation. Explain any lawful limits and offer appropriate assistance.

Patients are asked to provide accurate health, medication, contact, and coverage information; ask questions; tell the team when a plan is unclear or difficult to follow; participate in agreed care and follow-up; notify the clinic of appointment changes; and respect others' safety, privacy, and dignity. Financial responsibilities follow FCHC assistance policies. Responsibilities do not waive patient rights.



Patient/Client Complaints & Grievances

CATEGORY: Patients' Rights and Responsibilities/ Compliance	POLICY NAME: Patient/Client Complaints & Grievances
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

Statement

Family Centers is committed to providing high-quality services and ensuring the satisfaction of our patients and clients. We recognize that patients and clients may have concerns regarding their care or services received. This policy outlines the process for patients and clients to voice complaints, initiate, monitor, and investigate complaints and grievances, and the procedures for addressing them in a timely and effective manner.

1. Policy

This policy is established to ensure each patient/client has the right to file a complaint or grievance without fear of discrimination, retaliation, or barriers to service, it is the policy of FCHC to:

Provide patients/ clients with the procedure to file a complaint or grievance internally through FCHC and/or externally through the Connecticut Department of Public Health.

Receive, investigate and resolve patient/client complaints and grievances in a prompt manner

Follow a uniform procedure for addressing and monitoring complaints and grievances

Ensure complaints and grievances are handled confidentially, with details disclosed only to those directly involved in the investigation.

- **RESPONSIBILITY**

Program Directors
Director of Compliance

- **DEFINITIONS**

Complaint: An expression of dissatisfaction involving minor issues (i.e. housekeeping, poor communication between patients and staff, unprofessional staff, etc.) that can be resolved promptly by staff present or within 24 hours.



Grievance: a formal complaint made by the patient/client or a patient representative that is not immediately resolved regarding (but not limited to) the following: failure to meet the patient's care expectations and needs, failure to notify treating providers of patient's concerns, allegations of abuse or neglect, issues related to compliance such as failure to protect patient confidentiality and/or obtain informed consent, premature discharge. All written complaints are considered grievances, including whenever the patient/client requests a response from FCHC or requests that a complaint be handled formally. Grievances can be received in person, by email, social media messages and reviews, suggestion boxes, patient satisfaction surveys, or other written methods.

2. Purpose

To establish a clear and accessible process for patients/clients and their representatives to express complaints and grievances regarding the care and services provided by Family Centers.

3. Procedure

This policy applies to all patients, family members, and their representatives who wish to express complaints or grievances about the services, care, or treatment provided by FCHC.

- All Staff are authorized to attempt to resolve a complaint in a courteous and reasonable manner at the time it is presented. If the staff member is unable to resolve the complaint, a complaint report is initiated, and the Program Director or designee is notified.
- The Program Director will investigate the complaint by interviewing the relevant parties and reviewing relevant documentation and materials.
- The Program Director will document the findings, develop an action plan, and submit all documentation to the QA/QI Department within 30 days of complaint initiation.
- The Program Director informs the patient/client of the outcome of the investigation. If the patient/client is not satisfied with the outcome, they may appeal to the Chief Health Officer.
- The QA/QI Department reviews the complaint investigation to ensure all corrective actions and follow-up have been completed, conferring with the legal department if necessary, and reports findings/resolution of complaints to the QA/QI Committee.

FCHC will maintain a confidential file of complaint documentation.

Protocol

1. Filing a Complaint or Grievance

1. Complaints:

- Verbal complaints can be expressed to any staff member at the point of service.
- Staff members receiving a complaint will attempt to resolve it immediately.
- If the complaint cannot be resolved at the point of service, it will be escalated to the department supervisor or manager.
- A complaint must be documented and reported quarterly to the risk management team.

2. Grievances:

- Grievances should be submitted in writing by the patient or their representative.



- Written grievances can be submitted through the following methods:
- Delivered in person to the Program Director
- Mailed to the Executive team at 40 Arch Street, Greenwich, CT 06830.

2. Acknowledgment

3. Complaints:

- Immediate acknowledgment by the staff member receiving the complaint.
- Escalated complaints will be acknowledged by the department supervisor or manager within 24 hours.

4. Grievances:

- Written acknowledgment of the grievance will be sent to the patient or their representative within 5 business days of receipt.

3. Investigation

5. Complaints:

- Investigate promptly and thoroughly by the department supervisor or manager.
- Staff involved in the incident will be interviewed as part of the investigation.

6. Grievances:

- Investigated by the Program Director and Director of Compliance or a designated committee.
- All relevant documentation, including medical records and staff interviews, will be reviewed.

4. Resolution

1. Complaints:

- The goal is to resolve complaints within 24 hrs.
- Resolution will be communicated to the patient or their representative verbally and documented in the patient's file.

2. Grievances:

- Upon completion of the investigation, the Program Director and QA/QI Committee will determine the appropriate resolution.
- The goal is to resolve grievances within 30 days.
- A written response, including findings and actions taken, will be provided to the patient/client or their representative.
- If additional time is required, the patient or their representative will be notified of the delay and the reason for it.

5. Appeal Process

If the patient or their representative is not satisfied with the resolution, they may request a review of the grievance by the FC's management team or Program's Chief. This request must be made within 10 business days of receiving the resolution.

6. Documentation and Reporting

1. All complaints and grievances, along with the investigation details and resolution, will be documented in the Risk Management Log.
2. A quarterly report of grievances and complaints, along with trends and resolutions, will be presented to the Quality Improvement Committee for review and further action as necessary.

7. Training

Staff will receive training on this policy and procedures to ensure they understand how to assist patients in voicing their complaints and grievances.



- **FOLLOW-UP**

1. Patients or their representatives may request a follow-up meeting or discussion if they are not satisfied with the resolution provided.
2. The QA/QI Committee will coordinate follow-up discussions with the relevant department leaders.

- **REVIEW AND EVALUATION**

This policy will be reviewed annually and updated as necessary to reflect changes in regulations, accreditation standards, and best practices.

- **SPECIAL CONSIDERATIONS**

Complaints and grievances made post discharge from agency will follow the same patient grievance procedure as outlined.

References:

ECRI Managing patient complaints and grievances. Health Syst Risk Manage 2016 Aug 17.

<https://www.ecri.org/components/HRC/Pages/PtSup1.aspx>

Attachments: Complaint Form



Minors and MyChart Proxy Access

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Minors and MyChart Proxy Access
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

FCHC is committed to protecting the privacy and confidentiality of minors' health information by ensuring that MyChart proxy access is granted only to verified and legally authorized individuals. Access to medical records, test results, communications, and other protected health information will be managed in accordance with approved Epic/YNHH protocols, HIPAA, and applicable Connecticut laws governing minors' consent and confidentiality. Proxy access must be reviewed and updated when a minor's age, legal status, or authorized representative changes, with Privacy/HIM oversight when needed.

2. Procedures:

Proposed control:

Verify the identity and legal authority of each proxy. Do not assume a parent or portal proxy may access every service or record. Apply approved Epic/YNHH settings for confidential minor services, messages, results, billing, and releases. Document the legal basis and route questions to Privacy/HIM before disclosure. Reassess proxy authority when age, legal status, or representative authority changes.

Open implementation requirement:

Privacy/HIM and Epic governance must approve a Connecticut service-specific consent and disclosure guide and validate portal age transitions and proxy permissions before this subsection is implemented. No unverified age thresholds or blanket access permissions are established here.



Protecting Patients from Abuse, Neglect, and Exploitation

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Protecting Patients from Abuse, Neglect, and Exploitation
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

Family Centers reports concerns based on information disclosed, observed, or learned during work. Reasonable suspicion is sufficient; proof is not required. Staff do not investigate allegations or establish whether abuse occurred. The receiving protective agency or law enforcement determines the appropriate response.

2. Purpose and scope

To establish a consistent process for reporting and documenting suspected abuse, neglect, domestic violence, and exploitation while providing appropriate patient care. This policy applies to all Family Centers outpatient primary care and school-based health sites, including clinical and administrative staff.

3. Definitions and responsibility

Abuse includes physical or emotional harm, sexual abuse, or harmful deprivation of essential care. Neglect includes failure to provide necessary care, supervision, or protection. Exploitation includes improper use of a person or their money, property, or resources. Apply the reporting criteria for the patient's age and circumstances below.

Responsibility

Mandated reporters are responsible for making required external reports promptly. Other staff immediately notify the treating provider or site clinical lead and may report directly. Notification to leadership, Compliance, or school personnel does not replace or delay an external report. Supervisor approval and patient or parent consent are not required for a legally mandated report.

4. Procedure

1. Respond to immediate danger. Call 911 for a life-threatening condition or immediate safety threat. Provide care within the site's capabilities and arrange emergency transfer when needed. Emergency care and protective reporting must proceed without unnecessary delay.
2. Report promptly. Use the appropriate reporting route below and provide the facts already known. Do not delay a report to obtain missing information, confirm an allegation, or complete internal forms.
3. Notify leadership. Promptly notify the site clinical lead and Family Centers Compliance after making the required report, or concurrently when this will not delay reporting. At school-based sites, follow applicable



school notification requirements while limiting disclosure to authorized personnel; notifying the school alone does not satisfy reporting duties.

4. Document and support care. Record the concern, external report, treatment, and referrals. Continue appropriate outpatient follow-up and cooperate with authorized agency requests through Family Centers privacy and record-release procedures.

Children under 18

Report to DCF when information provides reasonable cause to suspect or believe a child has been abused, neglected, or placed at imminent risk of serious harm, regardless of the alleged perpetrator's relationship to the child. Reports may be based on disclosure, observed findings, or information from another person.

Under this Family Centers procedure, call the Connecticut DCF Careline at 1-800-842-2288 as soon as practicable and no later than 12 hours after reasonable suspicion arises. Submit the written DCF-136 report to the DCF Careline within 48 hours after the oral report, using DCF's current submission instructions. Retain confirmation of submission. Do not wait until the deadline.

Medical neglect

For children, medical neglect includes an unreasonable delay, refusal, or failure by a responsible caregiver to obtain or maintain necessary medical, dental, or mental health care when the caregiver knows, or should reasonably know, that this may adversely affect the child. Examples include withholding essential treatment or repeated missed necessary care that places the child's health at risk.

A missed appointment, poverty, lack of insurance, transportation difficulty, or other access barrier alone does not establish medical neglect. Document known barriers and offer care coordination and access support. When the available facts create reasonable suspicion of neglect or imminent serious harm, report to DCF within the child-reporting deadlines; support services must not delay reporting.

For older adults or adults covered by disability-reporting laws, suspected deprivation of necessary health care is reported through the applicable adult route below. An adult's informed refusal of treatment is not by itself evidence of neglect.

Victims of domestic violence

When a patient discloses domestic violence, or staff learn of suspected domestic violence, respond respectfully, provide appropriate clinical care, and offer support. Accept the information disclosed without requiring proof or a detailed account. Do not confront the alleged perpetrator or attempt to substantiate the allegation.

Immediate safety and care. Call 911 for immediate danger or a life-threatening condition. Provide treatment within the site's capabilities and arrange emergency care when needed. Promptly notify the site clinical lead and Family Centers Compliance without delaying emergency care or required reporting.

Advocacy and referrals. Offer connection to CT Safe Connect at 1-888-774-2900 or www.ctsafeconnect.org, available 24 hours a day, seven days a week for free, confidential domestic violence support. Advocates can assist with safety planning and connections to local services. With the patient's permission, help connect the patient to an advocate and arrange appropriate behavioral health or other care referrals.



Patient choice and safe communication. Respect an adult patient's decision to accept or decline voluntary assistance. Do not require the patient to leave the relationship or contact police as a condition of receiving care. Provide resource information only in a way the patient indicates is safe; avoid voicemail, printed materials, portal messages, or other communications that could expose the disclosure to the alleged perpetrator. Use qualified language assistance when needed.

Confidentiality and reporting. Explain that information is protected, but legally required reports must be made. Follow the child, older-adult, and disability-reporting sections when applicable. For children residing in a home where domestic violence is disclosed, follow the DCF reporting criteria in the next section. An adult domestic violence disclosure alone does not require an automatic police report; follow other applicable legal reporting requirements and obtain consent for voluntary referrals or police assistance.

Documentation and follow-up. Record relevant statements already disclosed, objective findings, care provided, resources offered, assistance accepted or declined, required reports, and the agreed safe method of follow-up. Arrange clinically appropriate outpatient follow-up. Limit disclosure to authorized persons and do not promise absolute confidentiality.

Domestic violence and children in the home

Domestic violence includes physical, sexual, emotional, or financial abuse and coercive control within intimate or family relationships. Provide appropriate care and offer domestic violence advocacy resources using a safe method of communication.

When staff learn of domestic violence in a home where children reside, report to DCF when the known information creates reasonable suspicion that a child is abused, neglected, or at imminent risk of serious harm. This includes violence that threatens a child's physical safety, harms the child emotionally, or compromises necessary care or supervision. A child need not be physically injured for a report to be required.

Use the child-reporting deadlines above. Include the children's names, ages, location, and known exposure or safety concerns, if available. Do not delay reporting because details are missing. The presence of children in a household alone is not the statutory reporting threshold; DCF determines whether the report warrants a protective response.

For an adult experiencing domestic violence, offer advocacy and voluntary law-enforcement assistance. Do not automatically report every adult domestic violence disclosure to police. Make required child, elder, disability, or other legally mandated reports, and call 911 for immediate danger. Explain applicable limits of confidentiality when safe to do so.

Older adults age 60 and over

Report suspected abuse, neglect, exploitation, abandonment, or need for protective services immediately under this Family Centers procedure and no later than the Connecticut statutory deadline of 24 hours after reasonable suspicion arises. Contact DSS Protective Services for the Elderly at 1-888-385-4225, Monday through Friday, 8:00 a.m. to 4:30 p.m.; after hours, weekends, and state holidays, call 211. Follow agency instructions and document the report.

**Adults ages 18 through 59 covered by disability reporting**

For suspected abuse or neglect of an adult with intellectual disability, or an adult receiving services from DSS's Division of Autism Spectrum Disorder Services, report promptly to DDS Abuse Investigation Division at 1-844-878-8923. The initial report is due as soon as practicable and no later than 48 hours after reasonable suspicion arises. Submit a written PA-6 follow-up within five calendar days after the initial report, following DDS instructions.

For other adults under 60, caregiver dependence alone does not establish eligibility for this DDS reporting route. Provide care and advocacy referrals, contact 911 for immediate danger, and promptly consult Compliance about any other applicable reporting obligation without delaying a required report.

Documentation and confidentiality

Document the date and time the concern became known; its source; objective clinical observations; relevant statements already disclosed, using the speaker's words when possible; care provided; reporting agency and contact; report date and time; reference number, if available; written report submission; internal notifications; and referrals or follow-up. Distinguish reported allegations from observed findings.

Protect records and share information only as authorized or required by law. Follow Family Centers consent and privacy procedures for any clinically necessary photographs or imaging; do not assume a blanket consent exception. Staff receive applicable mandated-reporter training. Compliance maintains current reporting contacts and reviews this policy when reporting requirements change.



Language Access and Interpretation Services

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Language Access and Interpretation Services
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 10/7/2026	

1. Policy:

Family Centers is committed to delivering respectful, high-quality care and services in the preferred language of each client.

2. Purpose:

To establish standards for providing services in each client's preferred language, ensuring equitable and respectful care.

3. Procedures:

During the initial contact, Family Centers ask patients and/or their parent/guardian about their preferred language. This may also be collected via the registration form. This information is documented in the client's Epic chart. Every effort is made to match the client with a provider who speaks the preferred language. When internal interpretation is not available, then Family Centers utilize external interpreter services contracted with our agency.

All staff are trained to access and use interpreter services. Instructions are provided during onboarding and are available to all staff. Family Centers actively recruits and hires bilingual and multilingual staff who are qualified to provide services in languages other than English to better serve the community's diverse needs.



Provision of Culturally/Linguistically Competent Care

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Provision of Culturally/Linguistically Competent Care
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

FCHC caregivers will provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery of care to meet patients' social, cultural, and linguistic needs.

2. Procedure

Informing Patients of Their Right to Interpreting Services

At no time, shall a provider of service require nor request a patient, family member, or patient representative provide their own interpreter.

FCHC will develop and post in high traffic patient and visitor locations notices that advise patients and their families of:

The availability of language interpretation services at no charge.

The telephone numbers, including a Telecommunications Device for the Deaf (TDD) number for the hearing impaired, where complaints may be filed concerning language access or interpreting issues.

IDENTIFICATION AND DOCUMENTATION OF LANGUAGE NEEDS

Patients will be asked their preferred language of communication at time of registration.

Documentation of language preference and/or need will be made on the Patient Registration Form and filed in the patient's medical record by corresponding registration staff.

If the patient is a minor, is incapacitated, or has a designated representative, the language preference of the parent, guardian, or representative will be documented.

USE OF APPROPRIATE INTERPRETATION SERVICES FOR LIMITED ENGLISH PROFICIENCY (LEP), DEAF, OR HEARING-IMPAIRED PATIENTS OR THEIR FAMILY MEMBERS

Appropriate modes of interpreting services will be determined taking into consideration availability of interpreting services for the language required, reasonable timeliness in obtaining interpreting services, a department's technical capacity for phone/video interpretation, and patient preference.

Available modes of interpreting services include:

In-person interpreting from a professional medical interpreter or qualified bilingual staff member.



Telephonic interpreters via FCHC's contracted language service provider.

Note: With the exception of emergency situations and in cases of exotic languages, FCHC providers will not use family members, friends, or unqualified interpreters in any clinical encounter. The use of minor children as interpreters is not allowed in any clinical situation at FCHC except for emergency situations or when interpreting services in the required language are not available after all viable resources have been exhausted. Necessary emergency care is not to be withheld pending the arrival of interpreter services.

AVAILABLE INTERPRETING SERVICES DECLINED: PATIENT PREFERENCE FOR PERSONAL INTERPRETER

Should the patient/patient representative insist on having a family member or friend interpret during an appointment, clinic staff shall:

Ensure that the patient understands that interpreting services are legally guaranteed and free of charge;

Document in the patient's chart the offer of interpreting services and the patient's declination;

Obtain the services of a qualified medical interpreter to remain on stand-by/ listening mode in conjunction with the family member or friend in order to ensure accuracy and effective communication during the encounter; and

Document the presence of the stand-by interpreter in the patient's chart.

TRANSLATION SERVICES

Translation requires human expertise. Therefore, to ensure the accuracy, proper linguistic register, and cultural sensitivity of all translated materials at FCHC, all written translations will be performed by the appropriately credentialed Language and Cultural Services staff. The use of automatic machine translation tools or computer applications such as Google Translate is prohibited due to their limitations regarding accuracy and content management.



Advance Directives, DNR and MOLST

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Advance Directives
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy:

Family Centers Health Care (FCHC) respects each adult patient's right to participate in decisions regarding medical care, including the right to accept or refuse treatment and to establish advance care planning documents in accordance with applicable federal and Connecticut law.

FCHC will not discriminate against or condition care on whether a patient has executed an Advance Directive, Do Not Resuscitate (DNR) order, or Medical Orders for Life-Sustaining Treatment (MOLST).

FCHC will recognize and honor valid Advance Directives, DNR orders, and MOLST orders consistent with applicable law, the patient's current wishes, and the scope of services provided in the outpatient setting.

2. Purpose

The purpose of this policy is to:

- Support patients' rights to make informed decisions regarding their health care;
- Provide patients with information regarding Advance Directives;
- Establish a process for documenting Advance Directives, DNR orders, and MOLST forms in the electronic health record;
- Distinguish an Advance Directive from an immediately actionable medical order such as a DNR or MOLST; and

Provide staff with clear guidance regarding emergency response when a patient has, or may have, a DNR or MOLST order.

3. Definitions

Advance Directive: A legal document through which an individual provides instructions regarding future health care and/or designates a health care representative to make health care decisions if the individual becomes unable to make those decisions. An Advance Directive is not, by itself, a DNR order or MOLST.

Living Will: A type of Advance Directive that expresses an individual's wishes regarding life-sustaining treatment under circumstances specified by Connecticut law.

Health Care Representative: An individual appointed by a patient to make health care decisions when the patient lacks decision-making capacity, consistent with Connecticut law.



DNR Order: A medical order directing that cardiopulmonary resuscitation not be initiated in the event of cardiopulmonary arrest. A DNR order applies to resuscitation and does not mean that other medically appropriate treatment or comfort measures should be withheld.

MOLST: Medical Orders for Life-Sustaining Treatment. A Connecticut MOLST is a medical order addressing a patient's preferences regarding specified life-sustaining treatments. Unlike an Advance Directive, a valid MOLST is effective immediately. Connecticut MOLST is intended for qualifying patients approaching the end stage of a serious life-limiting illness or experiencing advanced chronic progressive frailty.

4. Procedure

A. Advance Directive Information

At the patient's initial registration or as otherwise appropriate, adult patients will be informed of their right to establish an Advance Directive and will be provided information regarding Connecticut Advance Directives or directed to an appropriate source for such information.

Staff will ask whether the patient has an Advance Directive.

A patient's decision to execute or not execute an Advance Directive will not affect the availability, quality, or provision of care at FCHC.

Patients who request assistance understanding or completing an Advance Directive may be referred to their medical provider or other appropriate resource. FCHC staff will not provide legal advice.

B. Documentation

If a patient provides an Advance Directive, DNR order, or MOLST form, staff will:

1. Scan the document into the patient's electronic health record;
2. Return the original document to the patient or authorized representative;
3. Notify the treating provider that the document has been received; and
4. Document or update the patient's advance care planning/code status information in the appropriate location in Epic, when applicable.

DNR and MOLST information should be entered or flagged in a manner that allows clinical staff to identify the patient's resuscitation status promptly during an emergency.

The treating provider is responsible for reviewing clinically significant Advance Directive, DNR, or MOLST documentation and reconciling it with the patient's current medical record as appropriate.

C. Patient With Decision-Making Capacity

As long as a patient has decision-making capacity, health care providers will communicate directly with the patient regarding treatment decisions.

A competent patient's current expressed wishes generally guide care, even when the patient has previously completed an Advance Directive.

If a patient's wishes have changed, the provider should assist the patient in updating appropriate documentation.



D. Advance Directive When Patient Lacks Capacity

When a patient lacks decision-making capacity, applicable Advance Directive documentation and decisions of the patient's legally authorized health care representative will be considered and followed in accordance with Connecticut law.

An Advance Directive, living will, or appointment of a health care representative should **not automatically be interpreted as a DNR order**.

E. DNR Orders

A valid DNR order directs that cardiopulmonary resuscitation not be initiated if the patient's breathing and circulation stop.

A DNR order does **not** mean "do not treat." Patients with DNR orders remain eligible for medically appropriate evaluation, treatment, medications, oxygen, pain management, comfort measures, and other interventions that are consistent with the patient's treatment preferences.

Connecticut recognizes DNR orders and mechanisms for transferring such orders between health care settings and EMS.

F. MOLST

A valid Connecticut MOLST is an actionable medical order and will be honored in accordance with the orders documented on the form.

MOLST is not required for all patients and should not be routinely completed solely because of age, disability, or diagnosis. Connecticut limits the MOLST process to qualifying individuals with serious life-limiting illness or advanced chronic progressive frailty.

Only an eligible Connecticut physician, APRN, or physician assistant who has completed the required DPH MOLST training may execute a Connecticut MOLST.

G. Emergency Response

If a patient experiences cardiopulmonary arrest or another life-threatening medical emergency while at an FCHC location:

1. No known DNR/MOLST

Staff will:

- Immediately activate EMS by calling 911;
- Initiate CPR, use the AED, and provide emergency assistance consistent with staff training and FCHC emergency-response procedures; and
- Continue appropriate emergency measures until EMS assumes care.

2. Valid DNR or MOLST is known and readily available

Staff will:

- Immediately call 911;



- Inform the dispatcher and responding EMS personnel that the patient has a DNR or MOLST;
- Follow the patient's valid medical orders and refrain from initiating resuscitative measures prohibited by the order;
- Provide other appropriate supportive or comfort measures consistent with the patient's medical orders; and
- Make the DNR/MOLST documentation immediately available to respond to EMS personnel.

Connecticut EMS protocols recognize specified DNR documentation, DNR bracelets, MOLST orders, and qualifying facility DNR orders.

3. DNR status is uncertain or cannot be promptly verified

If staff cannot promptly establish that a valid DNR or MOLST order exists, staff will:

- Call 911;
- Initiate CPR and AED use as indicated; and
- Continue emergency measures until a valid order is established or EMS assumes responsibility for the patient's care.

Emergency treatment **must not be delayed** while staff search for documentation, contact family members, attempt to reach another provider, or resolve uncertainty regarding the patient's DNR status.

A verbal statement from a family member, health care representative, or other person that the patient "is DNR," without readily verifiable medical-order documentation, should not by itself cause staff to withhold emergency resuscitation.

H. Patient or Representative Presents an Informal Written Request

A handwritten statement, letter, living will, Advance Directive, or other document stating that the patient does not want CPR will not automatically be treated as an actionable DNR order unless it satisfies applicable requirements for a valid DNR or MOLST medical order.

The treating provider should review the patient's wishes with the patient or legally authorized representative and assist with appropriate medical-order documentation when clinically indicated.

I. Objection to Following an Advance Directive or Medical Order

If an individual provider cannot comply with a patient's valid treatment decision, Advance Directive, DNR, or MOLST because of an ethical, philosophical, religious, or other legally recognized objection, the matter must be immediately escalated to clinical leadership.

FCHC will take appropriate steps to transfer responsibility for care to another provider who can honor the patient's lawful treatment decisions without unnecessary delay. Connecticut's DNR regulations specifically address transfer of care when an individual provider objects to implementing a DNR.

J. Staff Education

Relevant clinical and administrative staff will receive education regarding:

- Advance Directives;
- The distinction between Advance Directives, DNR orders, and MOLST;



- Location and documentation of Advance Directive/DNR/MOLST information in Epic;
- FCHC emergency-response procedures; and
- The appropriate response when a patient's code status is unclear.



Informed Consent

CATEGORY: Patients' Rights and Responsibilities	POLICY NAME: Informed Consent
PROGRAM/DEPARTMENT: FCHC Clinical	BOARD APPROVED: 10/20/2026
REVISION DATES: 9/9/2026	

1. Policy

Family Centers Health Care (FCHC) obtains informed consent before providing a specific treatment or procedure. Patients must receive understandable information and voluntarily agree to the proposed care. General Consent to Treat does not replace this discussion or any required procedure-specific consent.

2. Purpose

To protect patient choice and establish a consistent informed consent process across FCHC medical, dental, and behavioral health services.

3. Procedure

1. **Explain the proposed care.** The treating clinician discusses the condition, recommended treatment or procedure, expected benefits, significant risks, reasonable alternatives, and likely consequences of declining care.
2. **Support understanding.** Use plain language, qualified interpreters and communication accommodations when needed. Allow questions and confirm understanding before proceeding.
3. **Confirm decision-making authority.** Assess the patient's ability to make the decision. When necessary, verify the authority of the legally authorized representative. Follow applicable requirements for minors who may consent independently and seek minor assent when appropriate.
4. **Obtain and document consent.** Record the discussion, patient or representative's decision, date, clinician, and interpreter assistance in Epic. Obtain a signed, dated procedure-specific form when required by law or FCHC policy and retain it in the record. A signature alone does not replace the discussion. Clinical Directors, with Compliance, maintain the list of services requiring written consent.
5. **Respect refusal or withdrawal.** Patients may decline or withdraw consent. Explain the potential consequences, discuss alternatives, and document the decision and follow-up plan. Stop or safely discontinue the affected treatment when consent is withdrawn.
6. **Reconfirm when care changes.** Repeat the discussion and obtain updated consent when the proposed procedure, treatment plan, or relevant risks materially change. Resolve unanswered questions before proceeding.
7. **Address emergencies.** When urgent treatment is necessary, the patient cannot consent, and an authorized representative is unavailable, follow applicable emergency-consent requirements. Document the circumstances and obtain consent for ongoing care as soon as possible.



Responsibility: Treating clinicians are responsible for the informed consent discussion. Supporting staff verify required documentation before the procedure. Unresolved questions are referred to the Clinical Director and Program Director.

Related Policies: Consent to Treat; Patient Rights and Responsibilities; Photography, Video, Audio and Other Imaging; Consent for Session Recording and EMR Transcription.



Patient Transportation Policy

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REVISION DATES: 9/9/2026	

1. Policy

Family Centers limits the use of client transport funds to clients without adequate travel capability. Clients eligible for free transportation may be individuals or families who meet one of the following criteria areas:

- Do not have vehicle(s)
- Have undependable vehicle(s)
- Are unable to drive (elderly, handicapped, or without a valid driver's license)
- Significant financial burden to transport themselves
- The client will be having a procedure that they are unable to transport themselves and have no other available transportation.
- Referral from client's primary provider
- Public transportation is not readily available
- Service is not locally available

2. Purpose

To help with the burden of transportation cost for our lowest income and medically fragile clients to seek healthcare services.

3. Procedure

Medical, vision, dental or mental health related transportation requests will be honored, provided clients meet the above eligibility. Preferred requests made two (2) working days in advance of the appointment. Transportation services has the following restrictions:

- Travel Distance – **15 miles** radius from site of service
- Pickup/Drop Off – Directly to/from home, pharmacy, and/or another medical specialist. Two ride limit per day per service site.
- Transportation is provided only for appointments at the nearest local facility.
- Cancellations – Cancel two (2) times, then the client will lose privilege to utilizing transportation services. On second cancellation, client will be responsible to pay the cancellation fee.

Family Centers funds for medical, dental, and mental health transport cannot be used for the following purposes:

- Non-health care related activities
- Court appearance/ Probation
- School or job-related activities
- Taxi service
- Clients Guidelines and Safety:



- When using the transportation services the client is responsible to follow the following guidelines:
- Client is responsible to be on time and wait for drivers outside for pickup
- Clients are expected to be respectful and follow the guidelines given by the transporter.
- All adults must wear a seat belt for the duration of the trip.
- Children transported must be secured in an age/weight/size appropriate child safety seat or child booster seat.
- Clients prohibited from drinking alcohol or smoking while being transported.
- Violence, rudeness, verbal assaults, threatening behavior, intimidating behavior, excessive use of foul language, sexual harassment, destruction of property, theft and any other disruptive or inappropriate conduct will not be tolerated during transports. Police will be alerted if necessary. Any report of conduct will result in termination of the client's transportation privileges for a duration of time determined by the Directors.
- Client has the right to file a complaint with the transportation service and/or driver. Complaint must be filed directly to the transportation agency and inform Family Centers of incident.

Client Code of Conduct:

- It is the intent of Family Centers to ensure the safety of staff, clients and the general public. This includes at the time of pick up, in the transportation vehicle, at the medical facility or during any other stops made throughout the duration of the transport.
- Violence, verbal assaults, threatening behavior, intimidating behavior, excessive use of foul language, sexual harassment, destruction of property, theft and any other disruptive or inappropriate conduct will not be tolerated during transports.
- Weapons such as firearms, knives or any other device or material capable of being used to cause bodily injury will, under no circumstances, be allowed in Family Centers vehicles.

Any infraction to this Client Code of Conduct will result in termination of the client's transportation privileges for a duration of time determined by the Program Director.