DEMOGRAPHIC FORM **MID-COLUMBIA CENTER FOR LIVING** **DATE: _____**

Name: _____ _____
First MI Last Maiden/Birth Name

Address: _____ _____ _____ _____
PO Box, Street Number City State Zip Code

Is it ok to send mail to this address? □ Yes □ No Drivers Lic # _____
(DUII only)

Primary Phone: _____ (Note: We will use these phone numbers to contact you about appointments and to leave messages).

Alternate Phone: _____

Male □ Female□ Non-Binary □ DOB: ___/___/_____ Age: _____ Social Security # _____

For Minor Children: Who is Contact Person: _____ Phone: _____

Is Child in DHS Custody Y□ N□ Caseworker Name: _____

Have you previously been seen at Mid-Columbia Ctr for Living: Y□ N□

Agency Voter Registration Form
State of Oregon

If you are not registered to vote where you live now would you like to register here today?

□ **YES**, I want to register to vote. Where you submit your registration is confidential.

□ **NO**, I do not want to register to vote or I am already registered. The fact that you checked "no" is confidential.

IF YOU DO NOT CHECK A BOX, WE WILL ASSUME YOU CHOOSE NOT TO REGISTER.

_____ _____
Signature Date

To Register To Vote In Oregon, You Must Be:

- A resident of Oregon
- A United States citizen
- At least 18 years old by Election Day.

Other Information:

➔Your county elections office will mail you a card to let you know that your registration was received.

➔You may ask us to help you fill out the registration, or you may fill it out yourself. The service or benefits you might receive from this agency will not be affected by your decision to register or not to register or to select a party preference.

➔If you believe someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register, or your right to choose your political preference, you may file a complaint with the *Secretary of State, Salem, Oregon 97310 Phone (503) 986-1518.*

MID-COLUMBIA CENTER FOR LIVING
State Required Demographic Information

Name: _____ #_____

ETHNIC:
□ - Non-Hispanic
□ - Puerto Rican
□ - Mexican
□ - Cuban
□ - Hispanic – Other Specific Origin
□ - Hispanic – Origin Not Specified
□ - Unknown

PRIMARY LANGUAGE:
□ - English
□ - Spanish
□ - Sign Language

RACE:
□ - White
□ - Alaska Native
□ - American Indian
□ - Black or African American
□ - Asian
□ - Native Hawaiian or other Pacific Islander
□ - Other Single Race
□ - Two or More Unspecified Races

TRIBAL AFFILIATION:
(If American Indian)
□ - Burns Paiute Tribe
□ - Confederated Tribes of Coos, Lower Umpqua and Siuslaw
□ - Confederated Tribes of Grand Ronde
□ - Confederated Tribes of Siletz
□ - Confederated Tribes of Umatilla
□ - Confederated Tribes of Warm Springs
□ - Coquille Indian Tribe
□ - Cow Creek Band of Umpqua Indians
□ - Klamath Tribes
□ - Not Applicable
□ - Other

****

MARITAL STATUS:
□ - Never Married
□ - Married / Living as Married
□ - Separated
□ - Divorced
□ - Widowed
□ - Unknown

EDUCATION:
Highest Grade Completed: _____

LIVING ARRANGEMENT
□ - Private Residence at home
□ - Private Residence with relative
□ - Private Residence with non-relative
□ - Transient / Homeless
□ - Foster Home
□ - Residential Facility
□ - Jail
□ - Room and Board
□ - Supported Housing
□ - Supportive Housing (scattered site)
□ - Supportive Housing (congregate setting)
□ - Alcohol/Drug Free Housing
□ - Oxford House
□ - SUD Residential Facility – AOD Inpatient
□ - BRS Residential Facility - Inpatient
□ - CSEC Residential Facility - Inpatient
□ - PRTS Residential Facility - Inpatient
□ - SCIP/SAIP Residential Facility - Inpatient
□ - SRTF for YAT Residential Facility - Inpatient
□ - RTH for YAT Residential Facility - Inpatient
□ - Secure Residential Facility (SRTF)
□ - Residential Sub-Acute Care Facility – MHS Inpatient
□ - Unknown

EMPLOYMENT STATUS:
□ - Full Time - 35 or more Hours per Week
□ - Part Time - 34 or less Hours per Week
□ - Unemployed
□ - Homemaker
□ - Student
□ - Retired
□ - Disabled (Unable to work)
□ - Hospital / Institutional Patient
□ - Volunteer
□ - Sheltered/Non-Competitive Employment
□- Not in Labor Force – Not Looking
□- Unknown

****

Are you interested in receiving employment services? □ Yes □ No

****

MILITARY SERVICE –
Are you a veteran?
Choose Only One
□ Yes, I'm a Veteran (Branch of Service not Specified)
□ Yes, I'm a Veteran and Current or Former Active Duty
□ Yes, I'm a Veteran and Current or Former Guard / Reserve Military
□ No, I'm not a Veteran
□ No, I'm not a Veteran, but am Current or Former Guard / Military Reserve
□ Unknown

****

MID-COLUMBIA CENTER FOR LIVING
Income and Benefit Statement

NAME: Last/ First :_____ **DATE:** _____

TOTAL GROSS MONTHLY INCOME (If None = 0000)
(IMMEDIATE FAMILY ONLY): $_____ (If Refused = 0001)

Primary Source of Income / Support:
- □ Wages / Salary
- □ Public Assistance / Social Security / Welfare
- □ Retirement / Pension / SSI
- □ Disability / SSDI
- □ Other / Foster Child / Alimony
- □ None
- □ Unknown

Source of Payment: (mark all that apply)
- □ - Self-Pay
- □ - Medicare
- □ - Medicaid / OHP # _____
- □ - Slide / Financial Assistance Agreement
- □ - Other Gov't Payments – Non Medicaid (Intox Driver Fund)
- □ - Worker's Compensation
- □ - Private Health Insurance _____
- □ - No Charge (Free, charity, research or teaching)
- □ - Other
- □ - Unknown

⇨ Are you covered by any insurance other than listed above? □ Yes □ No If yes, please explain : _____
_____

Dependency:
# of people dependent upon client's household income: _____
# of child dependents: _____

Please List All Household Members:

Name	Age	Relationship to Client

AGREEMENT TO PAY FOR SERVICES

I agree to pay for services at the time of my appointment unless other prior arrangements have been made with MCCFL.

Signature:_____ Date :_____
Client / Parent / Guardian or Personal Representative
for Health Care Decisions

CLIENT BILLING ELECTIONS

Name _____ **AZ#** _____

☐ **I choose to have all of my services billed to insurance. By doing so I understand that I will not be eligible for a reduced fee.**

- I agree that all services provided to me will be billed to my insurance company.
- I agree that MCCFL will mutually exchange information for the purposes of billing to any third party for which I am or may become eligible.
- I agree to assign all benefits to which I may be entitled toward the cost of service that my family or I may receive.
- I agree to pay my estimated deductible or co-payment at the time of each appointment.
- I agree I am financially responsible for any fees not covered by my insurance.

Signature:_____ Date:_____

- - - - - - - - - - OR - - - - - - - - - - -

☐ **I elect to apply for a reduced fee or grant program. By doing so I understand that my services <u>will not</u> be billed to third-party insurance. A separate Reduced Fee Application is required.**

- I will submit an application for a reduced fee. If I am eligible I will receive services at a reduced fee.
- I agree to pay my reduced fee at the time of each appointment.
- I understand that the reduced fee program has an expiration date and that I must reapply for the reduced fee program in a timely manner in order to continue to receive the reduced fee.
- When my reduced fee term expires I agree to pay for services at full price until I reapply for a reduced fee.

Signature:_____ Date:_____

- - - - - - - - - - OR - - - - - - - - - - -

☐ **I agree to pay for all services at full fee. I do not want to apply for a reduced fee and I do not want MCCFL to bill my insurance.**

- I agree to pay for all services at the time of each appointment.

Signature:_____ Date:_____

MID-COLUMBIA CENTER FOR LIVING
Referral and Contact Information

Client Name: _____

Doctor Information:

Name: _____ Phone# _____

Address: _____

Dentist Information:

Name: _____ Phone# _____

Address: _____

Referral Information:

Name: _____ Agency: _____

Telephone: _____

Emergency Contact Information:

Name: _____ Relation: _____

Address: _____

Phone# _____

Alternate Local Contact:

Name: _____ Relation: _____

Address: _____

Phone# _____

Guardian/Personal Representative for Health Care Decisions:

Name: _____ Relation: _____

Address: _____

Phone# _____

Have you ever been hospitalized for Mental Health Issues? Y N

If so, when and where: _____

Mid-Columbia Center for Living

CONSENT TO TREATMENT, CONFIDENTIALITY and INFORMATION ON SERVICES

Services shall not be denied any person without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability.

I am voluntarily seeking services from the Mid-Columbia Center for Living (MCCFL). I understand that both MCCFL and I have the right to terminate services at any time by simply notifying the other party of this intention. *Additionally, the following infractions may result in termination as well as possible legal action:* Verbal or physical aggression toward staff or property of the MCCFL; and/or theft or vandalism of property of staff or of the Mid-Columbia Center for Living.

ÿ *I have received the* ***Notice of Privacy Practices*** *and understand that MCCFL will keep information about my case confidential, including the fact that I am participating in services, with the following exceptions:*

- If a medical emergency occurs, information necessary to help me may be shared with my physician or other medical personnel.
- In a life-threatening situation, information may be released to the appropriate authority.
- MCCFL is legally obligated to report abuse of children, elderly, disabled persons and/or individuals enrolled in our mental health services.
- My case record and/or my counselor may be subpoenaed and information about me disclosed in a court of law.
- Information (for example: age, gender, income, name, etc.) will be sent to the State Office of Mental Health and Addiction Services and Community Development Block Grant office and will be used only for statistical purposes.
- MCCFL may disclose information to other additional parties only when given written permission by me.
- Any exceptions listed in the Notice of Privacy Practices provided to me.
- My case may be discussed with staff members of the MCCFL, State Office of Mental Health and Addiction Services or my Coordinated Care Organization (CCO) (for OHP members only) and subject to audits for assurance of quality or treatment.

ÿ ALL CLIENTS: *I have been offered a* ***Medical Advanced Directive*** *& understand my options for health care treatment.*

ÿ Clients participating in MENTAL HEALTH SERVICES:

I have received the ***Notice of Right to Make a Declaration of Mental Health Treatment*** *and understand that I may obtain more information on this matter from MCCFL staff, if I am interested.*

ÿ Clients participating in SUBSTANCE USE TREATMENT SERVICES:

a) Clients are to remain abstinent from alcohol and mood altering drugs. The treatment program may require urinalysis to substantiate this requirement. Attending individual or group sessions while intoxicated is grounds for termination.
b) Fees will be paid at time of service unless otherwise arranged prior to treatment.
c) Clients are responsible for attending sessions as scheduled.

ÿ I have reviewed and received a copy and understand my rights and responsibilities.

I understand and agree with the above terms and consent to participate in the services at the Mid-Columbia Center for Living.

Signed:_____ Date:_____
Client

Signed:_____ Date:_____
Parent/Guardian or Personal Representative for Health Care Decisions

For Mid-Columbia Center for Living Use Only: *Client and/or guardian refused to sign consent because:*

_____

_____ _____
Staff signature *Date*

Mid-Columbia Center for Living
Confidential Medical Questionnaire

Name:
Date:

LIST ANY MEDICAL OR EMOTIONAL CONDITIONS FOR WHICH ARE YOU ARE NOW BEING TREATED:

LIST *ALL* OF THE MEDICINES YOU ARE TAKING. BE SURE TO INCLUDE MEDICATIONS FOR COLDS/ALLERGIES, HEART TROUBLE, HIGH BLOOD PRESSURE, THYROID, "WATER", BIRTH CONTROL, AND SLEEPING AIDS, ETC.

Name of Medication	Dose	How Often Taken	For What Reason	Side Effects/Problems

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY MEDICATION? _____YES _____NO
IF YES, WHAT MEDICINE AND WHAT REACTION?

CHECK ANY MEDICAL PROBLEM YOU HAVE HAD IN THE LAST TWO YEARS:

	YES	NO		YES	NO
Hearing Problems			Musculoskeletal Problems		
Liver Problems			High Blood Pressure		
Seizures			Shakes or Tremors		
Weight (Gain/Loss)			Depression		
Stomach Trouble			Head Injuries		
Nervousness			Hepatitis		
Trouble Sleeping			Cancer		
Injuries/Accidents			Heart Problems		
Headaches			Urinary Problems or Bedwetting		
Ulcers			Stroke		
Asthma/Emphysema			Kidney Trouble		
Thyroid Problems			Eye Disease/Vision Problems		
Reproductive or Menstrual Problems			Sexually Transmitted Disease		
Diabetes			Anxiety/Panic Attack(s)		
Tested Positive for T.B.			Shortness of Breath		
Dental Problems			Loss of Consciousness		

OTHER:

Patient Health Questionnaire (PHQ- 9)

Name:_____ **Date:**_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		add columns			
		PHQ9 TOTAL SCORE:			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult

AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?					**SCORE**
Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	_____
2. How many drinks containing alcohol do you have on a typical day when you are drinking?					
1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)	_____
3. How often do you have six or more drinks on one occasion?					
Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	_____
TOTAL SCORE Add the number for each question to get your total score.					_____

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Mid-Columbia Center for Living

CLIENT COMPLAINT/GRIEVANCE PROCEDURE INFORMATION SHEET

Individuals receiving services at Mid-Columbia Center for Living (MCCFL) have the right to address problems and concerns during treatment or contact with Mid-Columbia Center for Living. It is important to Mid-Columbia Center for Living to be responsive to individuals and the community. Individuals seeking information about services should expect to be treated with courtesy, and have their questions or concerns addressed as quickly as possible.

A complaint is defined as a situation in which a person expresses concern or dissatisfaction about treatment, staff, or services. A complaint may also be filed if a client feels there has been unjust termination, suspension, or reduction of previously authorized services; these types of complaints are technically referred to as grievances and a Notice of Action will be mailed 10 days prior to the start date of the action unless specific conditions exist.

Whenever an individual has unaddressed concerns regarding services, he/she should feel free to ask for help from the Mid-Columbia Center for Living staff who is working with him/her. If the individual/client feels the issue is not being adequately addressed or the issue is about the individual who is working with him/her, he/she may directly contact a Program Supervisor of Mid-Columbia Center for Living. The Program Supervisor will then ensure that the matter gets prompt attention and review. The Program Supervisor shall contact and/or meet with the individual to resolve the complaint and further discuss their concerns.

“Grievance" means a formal complaint submitted to a provider verbally, or in writing, by an individual, or the individual’s chosen representative, pertaining to the denial or delivery of services and supports. OAR 309-019-0105(46).

If an individual feels that the informal process has not addressed the matter, then he/she may follow the formal complaint process as listed below:

1. The individual with the grievance will receive a copy of the Grievance Form and Client Grievance Procedure Information Sheet. The individual will be asked to submit the grievance in writing. The Grievance Form and Client Grievance Procedure Information Sheet can be obtained at each MCCFL clinic or office. Oregon Health Plan (OHP) members must use the OHP-specific form.

2. Clients will be provided assistance in filling out the Grievance Forms, if requested. Clients will be provided any reasonable assistance in completing forms and taking procedural steps that may include, but not limited to interpreter services and toll free numbers with Teletypwriting Device for the Deaf/ Teletypewriter TTY/TTD and interpreter capabilities.

3. The original grievance will be sent to MCCFL’s Compliance Officer no later than 24 hours following the completion of the form. Additionally, a copy is forwarded to the Program Supervisor and/or appropriate Manager for rapid attention. The final determination will be made by an individual not involved in a previous level of review or decision making.

4. If the circumstances surrounding client's grievance may result in harm due to inaction, client/guardian or staff may request expedited processing to either the MCCFL Executive Director and/or Coordinated Care Organization (CCO). The Executive Director will provide a written response within 48 hours of the client's request. The written response must include information about the appeals process.

5. If information pertinent to the grievance is required from individuals outside of MCCFL, and there is no release of information for that individual already present in the client's chart, an Authorization for the Release of Confidential Information naming those individuals, must be signed by the client prior to communication.

6. For a non-expedited grievance a formal decision will be made by the Compliance Officer or designee after an investigation into the grievance is made and within 5 working days from receiving the grievance. The decision may be communicated orally or in writing within the 5 working days. If the grievance was received in writing, a written decision must be provided. If a written decision cannot be made within 5 working days, a written explanation and an expected date of response (not to exceed 30 calendar days from the date the grievance was received), will be sent to the individual filing the grievance.

7. **There are no negative consequences for filing a complaint, and it will be kept as confidential as possible.**

8. At any time a client has the right to grieve directly with their Coordinated Care Organization (CCO) Pacific Source (PS) or Managed Care Organization (MHO) Greater Oregon Behavioral Health Inc. (GOBHI) or request a State fair hearing through the Department of Human Services and Oregon Health Authority.

9. If the individual is an Oregon Health Plan Prepaid Health Plan Member, and is dissatisfied with the disposition of the grievance, the individual may present their complaint to the Division of Medical Assistance Program (DMAP) Ombudsman as outlined in the OHP Member Handbook. A copy of this procedure may be requested at MCCFL's clinics and offices.

APPEALS

Clients may request an appeal of the Grievance decision if he/she disagrees with the outcome of the grievance.

1. Appeals will be resolved and a notification will be sent to the client within ten (10) calendar days from the request for the Appeal. Staff members conducting the review will not have been directly involved in making the original decision regarding the Action or Grievance.

2. Clients covered by OHP may request an expedited Appeal if mental status of the client meets the definition of an Emergency Situation or an Urgent Situation. MCCFL will follow the OHP "HOW TO APPEAL A DECISION" highlighted below.

~~4.~~3. A client may request that his/her services are continued pending the outcome of their Appeal.

5.4. If information pertinent to the appeal is required from individuals outside of MCCFL, and there is no release of information for that individual already present in the client's chart, then an Authorization for the Release of Confidential Information naming those individuals must be signed by the client prior to communication.

6.5. If, after an individual has gone through both the entire MCCFL Grievance and Appeal process, the individual still wishes to contest the decision, and if he/she is an Office of Mental Health Addictions Services, (OMHAS) member, he/she may request a DHS Administrative Hearing, as outlined in the "Notice of Hearing Rights" and the Hearing Request Form (MSC 443).

GRIEVANCES, APPEALS AND HEARING RIGHTS, OHP 2017 HANDBOOK

The following information will be provided to clients at intake regarding their rights and responsibilities on grievances and complaints.

HOW TO MAKE A COMPLAINT OR GRIEVANCE

You can complain or file a grievance if you are unhappy with OHP or your CCO, provider or services. If you are in a CCO, call its customer service department or send the CCO a letter.

The CCO will call or write back in five days to let you know that staff are working on it. If the CCO needs more time, the letter will say so. The CCO must address your complaint within 30 days.

If you are a FFS member call OHP Client Services.

"NOTICE OF ACTION" NOA

If your CCO or OHP denies, stops or reduces a medical, dental or behavioral health service your provider has ordered, you will receive a "Notice of Action" letter in the mail. This letter explains why they made that decision.

The letter will explain how to appeal (through your CCO) or request a hearing (through OHP) to ask to have the decision changed. You have a right to ask for both an appeal and a state fair hearing at the same time. You must ask no more than 45 days from the date on the "Notice of Action" letter.

IMPORTANT INFORMATION ABOUT NOAs

Receiving a NOA is important because it allows you to request an appeal from your CCO/plan or a hearing with OHA if you do not agree with the decision. If your health care provider tells you that you will need to pay for a service that is not covered, ask to get a "Notice of Action" that shows the service is not covered. Once you have it, you can ask for an appeal with your CCO/plan or a hearing with OHP.

If you did not receive an NOA, ask your CCO/plan or OHP to send you one.

NOA CONTENT

The NOA you receive from OHA and your plans may look different, but every NOA must:

- Clearly state that it is a Notice of Action
- List a date of notice
- List an effective date
- List the provider who has requested the service, treatment or item
- Clearly explain why the CCO/plan or OHA decided not to approve the request
- List the Oregon Administrative Rules that the decision to deny were based on
- Give you a contact number to get information that was used to deny requested services or item
- Include a telephone number to call if you have questions about the information in the NOA, or your appeal and hearing rights

IN ADDITION, THE NOA MUST INCLUDE INFORMATION ABOUT:

- Your hearing rights (all OHP members have the right to a hearing, even if you're in a CCO/plan and are also requesting an appeal)
- How to appeal the decision, if you are in a CCO or plan
- How you can continue to receive the service/ item while you wait for the appeal or hearing
- Getting an expedited (fast) appeal or hearing

HOW TO APPEAL A DECISION

In an appeal, your CCO will ask a health care professional to review your case. To ask for an appeal:

- Call or write your CCO's customer service.

You can ask for an appeal and a hearing by completing the "Appeal and hearing request for denial of medical services" (DMAP 3302). Your CCO will include this form when it sends you a "Notice of Action" letter.

You also can get this form in your preferred language by calling your CCO or OHP Client Services or by going to OHP.Oregon.gov. Click "Complaints and appeals."

Call your CCO if you want help asking for an appeal.

You will get a "Notice of Appeal Resolution" from your CCO within 16 days. It will tell you if the reviewer agrees or disagrees with your CCO's decision.
In the meantime, if the notice is about a service you are already getting, you may be able to ask to keep getting the service if you:

- Ask your CCO to continue the service and
- Ask within 10 days of the effective date on the "Notice of Action" letter

If you receive the letter after the effective date, please call your CCO for instructions.

If the reviewer agrees with the original decision, you may have to pay for services you

IF YOU NEED A FAST (EXPEDITED) APPEAL

You and your provider may believe that you have an urgent medical, dental or mental health problem that cannot wait for a regular appeal. If so, tell your CCO that you need a fast (expedited) appeal.

Fax your request to your CCO. Include a statement from your provider or ask the provider to call and explain why it is urgent. If your CCO agrees that it is urgent, a staff person will call you with the decision in three workdays.

YOUR PROVIDER CAN HELP

Your provider has a right to appeal for you when a CCO denies the provider's physician's orders.

HOW TO GET A STATE FAIR HEARING

CCO members and FFS members can have a hearing with an Oregon administrative law judge. A CCO member can have a hearing only after asking for an appeal, which resulted in the appeal not changing the original decision. You will have 45 days from the date on your "Notice of Action" or "Notice of Appeal Resolution" to ask OHP for a hearing.

You can ask for a hearing by completing the (DMAP 3302) form. Your CCO will include this form when it sends you a "Notice of Action" letter. You can get this form in your preferred language by calling your CCO or OHP Client Services. You can also find it online at OHP.Oregon.gov. Click "Complaints and appeals." If you are enrolled in a CCO, you can request an appeal and a hearing at the same time.

At the hearing, you can tell the judge why you do not agree with the decision and why you think OHP should cover the services. You do not need a lawyer, but you can have one or ask someone else, such as your doctor, to be with you.

If you hire a lawyer, you must pay the lawyer's fees. You can call the Public Benefits Hotline (a program of Legal Aid Services of Oregon and the Oregon Law Center) at 1-800-520-5292, TTY 711, for advice and possible representation. Find information on free legal help at www.oregonlawhelp.org.

IF YOU NEED AN EXPEDITIED HEARING

You and your provider may believe that you have an urgent medical problem that cannot wait for a regular state hearing.

Fax your hearing request form to the OHP Hearings Unit at 503-945-6035. Include a statement form (DMAP 3302) to your provider explaining why it is urgent. If OHP agrees that it is urgent, the Hearings Unit will call you in three workdays, (541) 382-5920, (800) 431-4135 Toll-free (800) 735-2900 TTY. Please note: A provider can file an appeal or grievance on a member's behalf.

At any time a client has the right to grieve directly with their Coordinated Care Organization (CCO) Pacific Source (PS) or Managed Care Organization (MHO) Greater Oregon Behavioral Health Inc. (GOBHI). Please see contact information:

PacificSource Community Solutions Customer Service
(541) 382-5920
(800) 431-4135 Toll-free
(800) 735-2900 TTY

Greater Oregon Behavioral Health, Inc.
Complaint and Appeals Coordinator
401 E. 3rd Street
Suite 101
The Dalles, OR 97058
Member Services: 1-800-493-0040
Fax Number: 541-298-7996

Disability Rights Oregon 1-800-452-1694

MCCFL reserves the right to amend this policy at any time.

Mid-Columbia Center for Living

NOTICE OF RIGHT TO MAKE A DECLARATION FOR MENTAL HEALTH TREATMENT

Under Oregon law, individuals have the right to make a written Declaration for Mental Health Treatment.

A Declaration for Mental Health Treatment allows you to make decisions in advance about certain types of mental health treatment: psychoactive medication, short-term (not to exceed 17 days) admission to a treatment facility, convulsive treatment and outpatient services. Outpatient services are mental health services provided by appointment by licensed professionals and programs. The instructions that you include in this declaration will be followed only if a court or two physicians believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held pursuant to civil commitment law.

You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint has a duty to act consistently with your desires as stated in this document or, if not stated, as otherwise known by the representative. If your representative does not know your desires, he or she must make decisions in your best interests. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your representative at any time. A "representative" is also referred to as an "attorney-in-fact" in state law but this person does not need to be an attorney at law.

The Declaration for Mental Health Treatment will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke the Declaration in whole or in part at any time you have not been determined to be incapable. ***YOU MAY NOT REVOKE A DECLARATION OF MENTAL HEALTH TREATMENT WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT OR TWO PHYSICIANS.*** A revocation is effective when it is communicated to your attending physician or other provider.

If you would like more information regarding a Declaration of Mental Health Treatment, please ask your counselor or case manager to provide this information to you.

MID-COLUMBIA CENTER FOR LIVING
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA). Contact MCCFL by phone in The Dalles at 541.296.5452, in Hood River at phone 541.386.2620

This Notice describes the privacy practices of **Mid-Columbia Center for Living** physicians, counselors, therapist, case managers, and other personnel in counties served by the Center. All Center locations are considered as one covered entity under HIPAA.

I. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure). *Mental Health Client PHI is protected under the HIPAA Privacy Rule (45 C.F.R. Parts 160 & 164) as well as Oregon state law. Alcohol and Drug Client Personally Identifiable Information (PII) is protected under both HIPAA and the more stringent Federal Law 42 CFR Part 2 and Oregon state law. Allowable uses and disclosures of PHI for mental health clients and PII of alcohol and drug clients are outlined in Sections III and IV, respectively.*

II. Uses and Disclosures REQUIRING YOUR WRITTEN AUTHORIZATION

In certain situations, we must obtain your written consent or authorization ("**Your Authorization**") in order to use and/or disclose your PHI.

Right to Revoke Your Authorization. As a mental health client, you may revoke Your Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to your service provider. [45 CFR 164.520(b)(1)(ii)(E)] Alcohol and Drug clients may cancel authorizations orally or in writing. For Alcohol and Drug clients, a criminal justice system authorization can be irrevocable. [42 CFR Part 2].

MCCFL cannot take back any uses or disclosures already made with your prior authorization.

• **Uses and Disclosures of Your Highly Confidential Information.** Federal and Oregon law impose special privacy protections for "Highly Confidential Information", which includes (1) treatment of mental illness, (2) alcohol and drug abuse treatment, (3)

HIV/AIDS testing, (4) child abuse/neglect, (5) sexual assault, and (6) genetic testing. We must obtain your authorization in order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law.

III. Uses and Disclosures WITHOUT YOUR AUTHORIZATION

We may use and disclose your PHI without Your Authorization for the following purposes. These apply to all clients; Section IV, which is more stringent, applies to AOD clients only.

Treatment, Payment and Health Care Operations.

- Treatment. We use and disclose your PHI to provide treatment and other services to you. We may also disclose PHI to other providers involved in your treatment.
- Payment. We may use and disclose your PHI to obtain payment for services that we provide to you from Medicare, the Oregon Medicaid program or another governmental program that arranges or pays the cost of some or all of your health care. We will obtain Your Authorization to disclose PHI to your private health insurer, HMO or other private payor. We must obtain authorization of Alcohol and Drug clients in order to disclose PII to and HMO, health insurer or other private payor.
- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you.

Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure. [45 CFR 164.510(b)]

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclosure your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death. [45 CFR 164.510(b)]

Public Health Activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and

neglect to the Oregon Department of Children and Family Services or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance. [45 CFR 164.512(b)]

Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to the Oregon Department of Human Services or other governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence. [45 CFR 164.512(c)]

Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid. [45 CFR 164.512(d).

Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. Further, unless specifically authorized by a court order, we may not use or disclose PHI identifying you as a recipient of alcohol and drug treatment services. [45 CFR 164.512(e)][42 CFR part 2]

Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. [45 CFR 164.512(f)].

Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law. [45 CFR 164.512(g)] [ORS 432.307(3)]

Health, Safety or Other Government Functions. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety. [45 CFR 164.512(j)]

Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs. [164.512(l)] [OAR 436-010-0240(1)]

Business Associate Agreement

We may disclose your PHI to a Business Associate who has contracted with us and has agreed to abide by the federal and state confidentiality protections to safeguard the information. These disclosures will be limited and relevant only to the specific work being done by the Business Associate.

Research
We may disclose your PHI to researchers conducting scientific research if the Program Director has determined that the researcher (1) is qualified to the research; (2) has protocol securing the privacy and redisclosure of PII; *and* (3) has had stringent review of an Internal Review Board and it is deemed safe enough to protect confidentiality of PII in light of the potential research benefits.

Cadaveric Donation
We may disclose your PHI in the event of Cadaveric donation.

As required by law when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures WITHOUT YOUR AUTHORIZATION *for Clients receiving Drug and Alcohol Treatment Services*

We may use and disclose your Personally Identifiable Information (PII) without Your Authorization for the following purposes:

Internal Communications. We may disclose your PII within the Alcohol and Drug Treatment Program (referred to hereafter as Program) at MCCFL, as well as between the Program and the agency Administration that has control over the Program.

Anonymous Disclosures. We may disclose information that does not in any way link you to a substance abuse program.

Qualified Service Organization Agreements (QSOAs). We may disclose your PII if we have a written agreement between the Program and an outside Service Organization (SO). The SO may *not* be a law enforcement agency or another substance abuse program that provides the same or similar services. Permissible disclosures are limited to the extent that the PII/PII being exchanged is needed by the SO to provide the agreed-upon services to the Program. MCCFL has a QSOA with its mental health services program in order to provide integrated services. The agency also has such agreements with testing labs to assure confidentiality of PII being passed between entities.

Medical Emergency. We may disclose your PII in the case of a medical emergency if the disclosure is made to medical personnel; a condition is present that poses an immediate threat to your health; *and* a need exists for immediate medical intervention. The specifics of the incident must be documented.

Research. We may disclose your PII to researchers conducting scientific research if the Program Director has determined that the researcher (1) is qualified to the research; (2) has protocol securing the privacy and redisclosure of PII; *and* (3) has had stringent

review of the protocol and it is deemed safe enough to protect confidentiality of PII in light of the potential research benefits.

Audit & Evaluation. We may disclose your PII to regulatory agencies, funders, third-party payers, and peer review organizations so that they may monitor the Program to ensure that it is complying with regulatory mandates and are properly accounting for and disbursing all funds received. These disclosures are time-limited, involve signed confidentiality agreements, disallow redisclosure of information to third parties, and require secure facilities and recordkeeping practices to protect PII when not in use.

Authorizing Court Order. We may disclose your PII with a *special court order* with specific criteria (dependent on the type of case). A regular subpoena, search warrant, or arrest warrant in and of itself is insufficient to permit or require disclose of PII.

Patient Threat/Crime on Program Premises or Against Program Personnel. We may disclose your PII to law enforcement when a client commits or threatens to commit a crime on the program premises or again program personnel. The permitted disclosure is limited to the incident, including client name, address, last known whereabouts, and status.

Reporting Suspected Child Abuse or Neglect. Compliance with State laws requires staff to report suspected child abuse or neglect. Program staff can report client name, address, nature of suspected abuse/neglect, and how the reporter became aware of it.

V. Your Rights Regarding Your Protected Health Information

Complaints. If you are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. You may also file written complaints with the Secretary, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Secretary. We will not retaliate against you if you file a complaint with the Secretary or us.

Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please notify your service provider. We will send you a written response within 10 working days.

Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable **written** request for you to receive your PHI by alternative means of communication or at alternative locations. [45 CFR 164.522(b); 164.520(b)(1)(iv)(B)] If you wish to request confidential communications, please notify your service provider.

Right to Review and Receive A Copy of Your Record. You may request access to your medical record file and billing records maintained by us in order to review and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Business Support staff or your worker and submit the completed form to the Privacy Officer. If you request copies, we will charge you **$0.50** for each page, up to a maximum of **$20.00**. We will also charge you for our postage costs, if you request that we mail the copies to you.

Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain a *Request for Amendment of PHI* form from MCCFL staff and submit the completed form to the Privacy Officer. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six (6) years and does not apply to disclosures that occurred prior to April 14, 2003. If you desire a copy of an accounting of disclosures, please notify MCCFL staff. You are entitled to one free accounting of disclosures every 12 months (164.528(c)(2)); subsequent request are subject to a fee of $.50 per page for copying costs and clerical work necessary to complete the requested accounting.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective as of April 14, 2003.

B. Right to Change Terms of this Notice. MCCFL may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting rooms in our clinics. You also may obtain any new notice by contacting the Privacy Officer.

VII. Privacy Officer

You may contact the Privacy Officer at: MCCFL Privacy Officer, Mid-Columbia Center for Living, 1610 Woods Court, Hood River, Oregon 97031; Telephone Number: (541) 386-2620.

CLIENT RIGHTS & RESPONSIBILITIES

Oregon Administrative Rules 309-019-0115

Every individual receiving services has the RIGHT to:

(a) Choose from available services and supports that are consistent with the service plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to my individual liberty, that are least intrusive and provide for the greatest degree of independence. Examples of services that may be provided are assessments, counseling, training, personal skill development, progress evaluations, urinalysis, medication management, or referral to another agency. No services shall be performed on my behalf unless I, or my guardian, have participated in its planning and have voluntarily agreed to it.

(b) refuse treatment and have the right to an explanation of the consequences of such a refusal and provided information regarding alternatives for care and treatment.

(c) Be treated with dignity and respect;

(d) Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan;

(e) Have all services explained, including expected outcomes and possible risks;

(f) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;

(g) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:

(A) Under age 18 and lawfully married;

(B) Age 16 or older and legally emancipated by the court; or

(C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.

(h) Review my clinical records(ORS 179.505) in the presence of a clinical staff OR have a copy of my records within 5 working days upon request and that I am responsible for the cost of copying all or part of my records. I also understand that MCCFL does not re-disclose information not created by MCCFL staff.

(i) Refuse participation in experimentation;

(j) Receive medication specific to the diagnosed clinical needs, including medications used to treat opioid dependence;
(k) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

(l) Be free from abuse or neglect and to report any incident of abuse or neglect as defined by Oregon Revised Statutes 430.735 by any staff of Mid-Columbia Center for Living and can exercise my rights without reprisal or punishment.

(m) Have religious freedom;

(n) Be free from seclusion and restraint;

(o) Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;

(p) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;

(q) Be informed of suicide risk and receive best practice lethal means counseling and a safety plan, including methods for the individual, family, and guardian to mitigate risk over time;

(r) Have family and guardian involvement in service planning and delivery;

(s) Make a Declaration for Mental Health Treatment when legally an adult;

(t) File grievances, including appealing decisions resulting from the grievance;

(u) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;

(v) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and

(w) Exercise all rights described in this rule without any form of reprisal or punishment.

(2) MCCFL must give to the individual and, if appropriate, the guardian a document that describes the applicable individual's rights as follows:

(a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

(b) The rights and how to exercise them must be explained to the individual, and if applicable the guardian.

ADVANCE DIRECTIVE INFORMATION

Every adult may accept or refuse any medical treatment. The right to self-determination is relatively easy when a person is well and can speak. Unfortunately, during severe illness, people may be unconscious or otherwise unable to communicate their wishes.

Making decisions about care sometimes presents questions, conflicts, or other dilemmas for the clinical professionals and the patient, family, or other decision-makers. These dilemmas may arise around issues of admission, treatment, or discharge. They can be especially difficult to resolve when the issues involve, for example, withholding resuscitative service, or foregoing on withdrawing life-sustaining treatment. Dilemmas that do arise will be addressed with patient, family members, and caregivers as needed to assist with conflict resolution.

Federal laws provide a means by which you may make your wishes known regarding your health care decisions: The *Advance Directive* allows you to direct health care providers to withhold or withdraw life-sustaining procedures in the event you suffer from a terminal illness, are permanently unconscious, have advance progressive illness, or extraordinary suffering.

The appointment of a **Health Care Representative** allows you to designate a specific person to assume authority for making health care decisions on your behalf should you be unable to do so. You may also give specific instructions regarding any aspect of your health care.

In the absence of *Advance Directive* the Mid-Columbia Center for Living will offer you the treatment and help your physician feels is appropriate. The forms included are for the use of the adult who wishes to complete an *Advance Directive*. The existence of or lack of an *Advanced Directive* does not determine and individual's access to care, treatment, and services.

Advance Directive forms do not require the assistance of an attorney to complete. If you would like more information, a booklet titled Making Healthcare Decisions is available by calling Oregon Health Decisions at 1-800-422-4805, or by contacting Mid-Columbia Center for Living Referral Coordinators at 541-386-5452 ext. 3236, or 541-386-2620 ext. 2103.

Advance Directives relating to your care at Mid-Columbia Center for Living must be on file in your medical record in our Medical Records Department for us to adhere to your wishes.