

SKAMANIA COUNTY COMMUNITY HEALTH
PO Box 1492
Stevenson, WA 98648
(509) 427-3850

REFERRED FOR: MENTAL HEALTH SUBSTANCE USE DISORDER

DATE _____ REFERRED BY _____

CLIENT NAME _____ BIRTH DATE ___/___/___ SSN _____

MAILING ADDRESS _____ WA Driver's License? Y N

PHYSICAL ADDRESS _____

HOME PHONE _____ OK to Leave Message? Y N

MESSAGE/CELL PHONE (circle one) _____ OK to Leave Message? Y N

PREFERRED CONTACT: Cell Phone Home Phone Mail

PLACE OF EMPLOYMENT _____

CHILDREN	Sex	Age	Grade in School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT _____ CITY _____ PHONE _____

PHYSICIAN _____ CITY _____ PHONE _____

MAJOR PROBLEM AREA Drugs Alcohol Sleep Mood Anxiety Other _____

REASON FOR VISIT _____

MEDICATIONS	Name	Dosage	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ANY ALLERGIES: _____

Have you or a family member received services here before? _____

DO YOU RECEIVE (check all that apply): Medical Coupons _____ Public Assistance \$ _____
Wages \$ _____ Social Security \$ _____ Other \$ _____

I consent and confirm that I have applied for and authorized treatment and understand my rights.

Consumer Signature Date



SKAMANIA COUNTY COMMUNITY HEALTH BEHAVIORAL HEALTH CLIENT DEMOGRAPHICS FORM

Client Name: _____

DOB: _____

REFERRAL SOURCE: <input type="checkbox"/> Legal/Probation <input type="checkbox"/> DOC <input type="checkbox"/> Guardian/Parents <input type="checkbox"/> Other Family Member <input type="checkbox"/> PCP <input type="checkbox"/> Self <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> School <input type="checkbox"/> Other Treatment Facility <input type="checkbox"/> Neighbor/Friend/Person in Community <input type="checkbox"/> DSHS/CPS			
GENDER AT BIRTH: <input type="checkbox"/> Female <input type="checkbox"/> Male	GENDER IDENTITY: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex: Person born with both <input type="checkbox"/> Transgender <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown	SEXUAL ORIENTATION: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Questioning <input type="checkbox"/> Unknown/Not Given	LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____
ETHNICITY: <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Some other Race <input type="checkbox"/> Vietnamese <input type="checkbox"/> Not Reported/Unknown	HISPANIC ORIGIN: <input type="checkbox"/> Cuban <input type="checkbox"/> General Hispanic <input type="checkbox"/> Mexican/Mexican-American/Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Spanish/Hispanic <input type="checkbox"/> Not Spanish/Hispanic <input type="checkbox"/> Unknown	LIVING SITUATION: <input type="checkbox"/> Permanent Housing - Unassisted <input type="checkbox"/> Permanent Housing - Assisted <input type="checkbox"/> Temporary Housing - Unassisted <input type="checkbox"/> Temporary Housing - Assisted <input type="checkbox"/> Temporary Housing - Dependent <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Foster Home <input type="checkbox"/> Adult Family Home <input type="checkbox"/> Residential Care <input type="checkbox"/> Institutional Setting <input type="checkbox"/> Crisis Residence <input type="checkbox"/> Jail/Juvenile Correction Facility <input type="checkbox"/> Homeless/Sheltered <input type="checkbox"/> Other: <input type="checkbox"/> Unknown	
SMOKING STATUS: <input type="checkbox"/> Every Day <input type="checkbox"/> Some Days <input type="checkbox"/> Former Smoker <input type="checkbox"/> Heavy Smoker <input type="checkbox"/> Light Smoker <input type="checkbox"/> Never <input type="checkbox"/> Unknown	EDUCATION: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not in Education <input type="checkbox"/> Unknown	MILITARY SERVICE: <input type="checkbox"/> Yes <input type="checkbox"/> No	EMPLOYMENT: <input type="checkbox"/> Full Time – Competitive employment <input type="checkbox"/> Part Time – Competitive employment <input type="checkbox"/> Not in Labor Force <input type="checkbox"/> Supp. Employment – Full Time <input type="checkbox"/> Supp. Employment – Part Time <input type="checkbox"/> Unemployed – Actively Job Searching <input type="checkbox"/> Unknown/Missing/Not Available
IMPAIRMENT KIND: <input type="checkbox"/> Alcohol/Drug Dependence <input type="checkbox"/> Communication Difficulties <input type="checkbox"/> Development/Intelligence <input type="checkbox"/> Hearing <input type="checkbox"/> Physical <input type="checkbox"/> Vision <input type="checkbox"/> Other Medical/Physical Disability <input type="checkbox"/> No Disability <input type="checkbox"/> Unknown	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/Annulled <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown		

Completed By: _____

Date: _____



SKAMANIA COUNTY COMMUNITY HEALTH
Authorization to Communicate and Share Personal Health Information

Authorization to Bill Insurance

I hereby authorize my consent for Skamania County Community Health to bill my insurance carrier(s) for any services rendered to myself and/or my dependents.

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, state provided insurance and any other health/medical plan, to issue payment check(s) directly to Skamania County Community Health for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

Insurers and managed care companies occasionally review medical charts to ensure compliance with company procedures. I understand that my chart may be selected for such review. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, my insurance carrier or other medical entity.

I further understand that my records may contain information regarding the diagnosis and treatment of HIV(Aids virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. A copy of this authorization will be kept on file by the organization, and may be revoked by myself at any time in writing.

Financial Policy

Skamania County Community Health will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that if I am on a sliding scale or self-pay for services, that I am expected to make payment in full when I am checking in for my appointment.

Signature _____ Date _____

Printed Name _____



**SKAMANIA COUNTY
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Rock Creek Center
710 SW Rock Creek Drive
PO Box 369
Stevenson, WA 98648
(509) 427-3850 Fax: (509) 427-0188
www.skamaniacounty.org

Skamania County Community Health

Acknowledgement of Receiving:

I, _____, do hereby acknowledge receiving a copy of:

- The Skamania County Community Health notice of Privacy Practices.
- The Skamania County Community Health Notice of Grievance Procedure.
- The Skamania County Community Health Consumer Rights.
- The Skamania County Community Health Code of Unprofessional Conduct.
- Ombuds Brochure
- Southwest Washington Behavioral Health Regional Support Network Information Booklet is available online at SWBH.org
- Washington Medicaid Mental Health Booklet available for review in office or online at <http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml>

Consumer or Legal Guardian Signature

Date



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Per DSHS website: Washington State Behavioral Health Benefits Booklet

The benefits booklet provides information to Medicaid recipients about:

- What number to call in your area if you are in a mental health crisis
- How American Indians and Alaska Natives access Medicaid covered behavioral health treatment
- Who is eligible for behavioral health services
- Who provides services covered under this booklet
- Who to contact for behavioral health services
- What happens at an intake evaluation or assessment
- What additional mental health care is covered by Medicaid
- If you will have to pay for mental health services
- What to do if you get a bill for mental health services
- What an Ombudsman is
- How to get transportation for care
- How to get care in an emergency
- Hospital coverage for behavioral health care
- What services are available
- How to find a recovery support group
- How to access medial care that is covered by Medicaid
- What is Early and Periodic Screening, Diagnosis and Treatment for Children
- When a child should get a checkup
- Rights as a person receiving publicly funded behavioral health services in the community
- What is a mental health advance directive and how to complete one
- What to do if you are not happy with your services and who can help you

<i>The Benefits Booklet is available in the following languages:</i>		
Cambodian	Chinese	English
Korean	Russian	Spanish
Vietnamese	Ukrainian	Somali

****Benefit booklets can be obtained online at:**

- https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO/Benefits_Book_English.pdf
- https://www.chpw.org/resources/Integrated_Managed_Care_Plan_information/2019_IMC_Member_Handbook.pdf
- https://www.molinahealthcare.com/members/wa/en-US/PDF/Medicaid/imc/IMC_Member_Handbook.pdf
- https://www.myamerigroup.com/wa/wawa_caid_imcmemberhandbook.pdf

A copy, in English, is retained in the waiting room for your reference.

 Consumer or Legal Guardian - signature

 Date

Skamania County Community Health

Your Privacy Rights as a Client

"We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it."

- A. **Access to Protected Health Information.** You have the right to inspect and obtain a copy of the protected health information Skamania County Community Health has regarding you, in the designated record set. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask Skamania County community Health staff for the appropriate request form.
- B. **Amendment of Your Record.** You have the right to request that Skamania County Community Health amend your protected health information. Skamania County Community Health is not required to amend the record if it is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask Skamania County Community Health staff for the appropriate request form.
- C. **Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures Skamania County Community Health has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment of health care operations. In addition, the account does not include disclosure made to you, disclosures made pursuant to a signed authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an account. To make a request, ask Skamania County Community Health staff for the request form.
- D. **Additional Restrictions.** You have the right to request additional restrictions on the use or disclosure of your health information. Skamania County Community Health does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask Skamania County Community Health staff for the appropriate form.
- E. **Alternative Means of Receiving Confidential Communications.** You have the right to request that you receive communications of protected health information from Skamania County Community Health by alternative means or at alternative locations. For example, if you do not want Skamania County Community Health to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask Skamania County Community Health staff for the appropriate request form.
- F. **Copy of this notice.** You have a right to obtain another copy of this Notice upon request.

Skamania County Community Health
Notice of Grievance Procedures

1. Skamania County Community Health encourages, but does not require, attempts to be made to resolve concerns, disagreements, or complaints through informal means and at the lowest possible level prior to initiating a grievance.
2. All grievances shall be filed in writing, dated and signed by the consumer, consumer representative, or Ombuds. If an oral request to file a grievance is received or if a consumer express his or her inability to prepare a written grievance, the grievant is immediately referred to the Southwest Washington Behavioral Health (SWBH) Ombuds Service for assistance in writing the request.
3. Consumers are asked to file a grievance within ten (10) days of occurrence of the grieved incident, although a grievance may be filed at any time. Consumers may request assistance or participation of persons of their choice in initiating a complaint or grievance. The grievant may request and receive assistance from his or her case manager, the SWBH Ombuds service, or another individual of their choice with all written and oral presentations throughout the grievance process. Each consumer has the right to receive, at no cost, written consumer information which they and/or their representatives (including Ombuds Service) may request for filing/resolving complaints and grievances. Grievance related materials shall not be disclosed to parties other than SWBH or agency staff without the consumer's permission except as necessary to resolve the grievance, or to the Washington State Mental Health Division (MHD) if fair hearing is requested on the matter grieved, or in order to comply with the provisions of the prevailing SWBH service agreement with the MHD.
4. A grievance is initially filed with the Clinic Director (or the Board of Commissioners if the Clinical Director is the subject of the grievance.)
5. The Clinic Director shall initially discuss the situation with both the grievant and the staff member responsible for the subject matter of the grievance and shall try to resolve the disputed issues to the satisfaction of both parties.
6. If grievance is not resolved within two (2) business days, an appeal board is designated to hear the grievance. The Board consists of the Chief Executive Officer of BMC or designee, a Corporate Board member, and a person chosen by the grievant. The appeal board shall schedule a hearing of the matter within nine (9) calendar days after the initial filing of the grievance.
7. After hearing the matter, the appeal board shall issue a written decision to all involved parties within a reasonable time period but no later than ten (10) calendar days after the grievance was filed by the consumer, unless an extension of the timeline is mutually agreed by all parties and evidenced in writing.
8. If the grievant is dissatisfied with the written response/decision, the matter is referred to SWBH for resolution in accordance with SWBH standards, unless otherwise directed by the consumer.
9. Contact information for parties involved or assisting in the grievance procedure is as follows:

Skamania County Community Health Director
509-427-3850; PO BOX 1492, Stevenson, WA 98648

SWBH Ombuds Office
(360) 606-1040 or (866) 666-5070



CLIENT COPY

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WAC 388-877-0600 Clinical—Individual rights.

(1) Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 70.96A, 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:

- (a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
- (b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
- (c) Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
- (d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
- (e) Be free of any sexual harassment;
- (f) Be free of exploitation, including physical and financial exploitation;
- (g) Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
- (h) Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;
- (i) Receive a copy of agency grievance system procedures upon request and to file a grievance with the agency, or behavioral health organization (BHO), if applicable, if you believe your rights have been violated; and
- (j) Lodge a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.

(2) Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:

- (a) Provided in writing to each individual on or before admission;
- (b) Available in alternative formats for individuals who are blind;
- (c) Translated to the most commonly used languages in the agency's service area;
- (d) Posted in public areas; and
- (e) Available to any participant upon request.

(3) Each agency must ensure all research concerning an individual whose cost of care is publicly funded is done in accordance with chapter 388-04 WAC, protection of human research subjects, and other applicable state and federal rules and laws.

(4) In addition to the requirements in this section, each agency providing services to Medicaid recipients must ensure an individual seeking or participating in behavioral health treatment services, or the person legally responsible for the individual is informed of their Medicaid rights at time of admission and in a manner that is understandable to the individual or legally responsible person.

(5) The grievance system rules in WAC 388-877-0654 through WAC 388-877-0675 apply to an individual who receives behavioral health services funded through a federal Medicaid program or sources other than a federal Medicaid program.

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

- 1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information and of the person's violation of the statute on which it is based. For the purpose of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under Chapter 9.96A RCW.
- 2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof.
- 3) All advertising which is false, fraudulent or misleading.
- 4) Incompetence, negligence or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.
- 5) Suspension, revocation or restriction of the individual's license to practice the profession by competent authority in any state, federal or foreign jurisdiction, a certified copy of the order, stipulation or agreement being conclusive evidence of the revocation, suspension or restriction.
- 6) The possession, use, prescription for use or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law or prescribing controlled substances for oneself.
- 7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.
- 8) Failure to cooperate with the disciplining authority by:
 - a) Not furnishing any papers or documents.
 - b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority.
 - c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceedings.
- 9) Failure to comply with an order issued by the disciplining authority or an assurance of discontinuance entered into with the disciplining authority.
- 10) Aiding or abetting an unlicensed person to practice when a license is required.
- 11) Violations of rules established by any health agency.
- 12) Practice beyond the scope of the practice as defined by law or rule.
- 13) Misrepresentation or fraud in any aspect of the business or profession.
- 14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk.
- 15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health.
- 16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service.
- 17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of the subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under Chapter 9.96A RCW.
- 18) The procuring or aiding or abetting in procuring a criminal abortion.
- 19) The offering, undertaking or agreeing to cure or treat disease by secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority.
- 20) The willful betrayal of a practitioner-patient privilege as recognized by law.
- 21) Violation of Chapter 19.68 RCW.
- 22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action.
- 23) Current misuse of:
 - a) Alcohol.
 - b) Controlled substances.
 - c) Legend drugs.
- 24) Abuse of a client or patient or sexual contact with a client or patient
- 25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards. [1989 c 270 33; 1986 c 259 10; 1984 c 279 18].



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WAC 388-877-0680 Individual rights specific to Medicaid recipients.

(1) Medicaid recipients have general individual rights and Medicaid-specific rights when applying for, eligible for, or receiving behavioral health services authorized by a behavioral health organization (BHO).

(a) General rights that apply to all individuals, regardless of whether an individual is or is not a Medicaid recipient, include:

- (i) All applicable statutory and constitutional rights;
- (ii) The participant rights provided under WAC 388-877-0600; and
- (iii) Applicable necessary supplemental accommodation services in chapter 388-472 WAC.

(b) Medicaid-specific rights that apply specifically to Medicaid recipients include the following. You have the right to:

- (i) Receive medically necessary behavioral health services, consistent with access to care standards adopted by the department in its managed care waiver with the federal government. Access to care standards provide minimum standards and eligibility criteria for behavioral health services and are available on the behavioral health administration's (BHA) division of behavioral health and recovery (DBHR) website.
- (ii) Receive the name, address, telephone number, and any languages offered other than English, of behavioral health providers in your BHO.
- (iii) Receive information about the structure and operation of the BHO.
- (iv) Receive emergency or urgent care or crisis services.
- (v) Receive post-stabilization services after you receive emergency or urgent care or crisis services that result in admission to a hospital.
- (vi) Receive age and culturally appropriate services.
- (vii) Be provided a certified interpreter and translated material at no cost to you.
- (viii) Receive information you request and help in the language or format of your choice.
- (ix) Have available treatment options and alternatives explained to you.
- (x) Refuse any proposed treatment.
- (xi) Receive care that does not discriminate against you.
- (xii) Be free of any sexual exploitation or harassment.
- (xiii) Receive an explanation of all medications prescribed and possible side effects.
- (xiv) Make a mental health advance directive that states your choices and preferences for mental health care.
- (xv) Receive information about medical advance directives.
- (xvi) Choose a behavioral health care provider for yourself and your child, if your child is under thirteen years of age.
- (xvii) Change behavioral health care providers at any time for any reason.



Behavioral Health Ombuds for Southwest Washington

SUPPORTING CLARK, SKAMANIA, AND KLICKITAT COUNTIES

What is an Ombuds?

Ombuds are people with lived experience in behavioral health who know services well and can help people navigate and resolve problems. Behavioral Health Ombuds services are available throughout the state. Ombuds can assist resolve issues with behavioral health services in both mental health and substance use. Ombuds services are primarily for individuals receiving Medicaid services.

What do Ombuds do?

Ombuds can help people resolve:

- **Complaints and grievances** — any dissatisfaction with services, written or verbal.
- **Appeals** — a reconsideration of denials, reduction or termination of services.
- **Administrative (Fair) Hearings** — a formal court procedure when all other avenues have been unsuccessful.

An Ombuds can help a person understand how to advocate for themselves effectively, or advocate on their behalf. They can advocate for adequate resolution and assist in setting up meetings and negotiations. The goal is always to resolve issues at the lowest level possible.

How do I contact my Ombuds?

If you live in Clark, Skamania, or Klickitat County, contact:

(800) 696-1401 or swbhombuds@gmail.com

Pathways HealthConnect

Your Local Connection to Good Health

What's Pathways HealthConnect?

Pathways HealthConnect is a free program that helps community members connect to the services and support they need to be healthy.

Who Can Participate?

- ✓ Adults 18+ with Medicaid (Apple Health) in Clark, Klickitat and Skamania counties
- ✓ People who need help connecting to services and support
- ✓ People with complex healthcare needs, including mental health or substance use disorder

What Services Can Pathways HealthConnect Connect You With?

- Medical, dental or mental health care
- Housing, transportation, food, clothing
- Transportation
- Substance abuse treatment
- Childcare and parenting education
- Utility help
- Financial help
- Education and employment
- Domestic violence
- And more!

How Does it Work?



What's a CHW/Peer?

CHWs/Peers are community members who know their way around healthcare, social services and other programs, and may have shared experience managing health conditions. CHWs help their neighbors and community members get the support they need.

My Pathways HealthConnect Contact

Skamania County Community Health
710 Rock Creek Drive
Stevenson, WA 98648
(509)427-3850

Questions? Contact us at 888-527-8406 (toll-free) or pathwayshealthconnect@southwestach.org

Pathways HealthConnect is currently operating as a pilot program. Enrollment will be determined through participating CCAs and/or our Pathways HUB coordinator. Contact us for more information.

A **SWACH** Program | 2404 E. Mill Plain Blvd. Suite B, Vancouver, WA 98661 | www.southwestach.org