



SKAMANIA COUNTY COMMUNITY HEALTH BEHAVIORAL HEALTH CLIENT DEMOGRAPHICS FORM

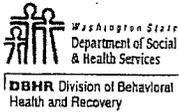
Client Name: _____

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	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	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	

Completed By: _____

Date: _____



DIVISION OF BEHAVIORAL HEALTH AND RECOVERY (DBHR)

**DBHR Target Data Elements
Gain Short Screening Setup**

ADMINISTRATION TIME	STAFF IDENTIFICATION	DATE	AGENCY NUMBER
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SECTION I CLIENT IDENTIFICATION

1. LAST NAME	2. FIRST NAME	3. MIDDLE NAME	4. OTHER LAST NAME
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5. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	6. DATE OF BIRTH	7. SOCIAL SECURITY NUMBER	8. WASHINGTON DRIVER'S LICENSE OR ID NUMBER
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9. WHICH RACE/ETHNICITY GROUP WOULD YOU IDENTIFY YOURSELF WITH (CHECK A MAXIMUM OF FOUR THAT APPLY)

<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Middle Eastern	
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native American	<input type="checkbox"/> Non – Federal Tribe
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Other Asian	
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Pacific Islander	Tribal Code (No. 1) _____
<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Race	
<input type="checkbox"/> Guamanian	<input type="checkbox"/> Refused to Answer	
<input type="checkbox"/> Hawaiian (Native)	<input type="checkbox"/> Samoan	Tribal Code (No. 2) _____
<input type="checkbox"/> Japanese	<input type="checkbox"/> Thai	
<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese	
<input type="checkbox"/> Laotian	<input type="checkbox"/> White/European American	

10. SPANISH/HISPANIC/LATINO (CHECK ONE)

<input type="checkbox"/> Cuban	<input type="checkbox"/> Not Spanish/Hispanic/Latino	<input type="checkbox"/> Puerto Rican
<input type="checkbox"/> Mexican, Mexican American, Chicano	<input type="checkbox"/> Other Spanish/Hispanic/Latino	<input type="checkbox"/> Refused to Answer

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

*The following questions are about common psychological, behavioral or personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions Yes or No.*

Mental Health Internalizing Behaviors (IDScr 1): During the past 12 months, have you had significant problems

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling sleep during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. when something reminded you of the past, you became very distressed and upset?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. with thinking about ending your life or committing suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Each yes answer is "1" point IDS Sub-scale Score (0 to 5)

Mental Health Externalizing Behaviors (EDScr 2): During the past 12 months, did you do the following things two or more times?

a. Lie or con to get things you wanted or to avoid having to do something?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have a hard time paying attention at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have a hard time listening to instructions at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Been a bully or threatened other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Start fights with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Each yes answer is "1" point EDS Sub-scale Score (0 to 5)

Substance Abuse Screen (SDScr 3): During the past 12 months, did.....

a. you use alcohol or drugs weekly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Each yes answer is "1" point SDS Sub-scale Score (0 to 5)



Skamania County Community Health

710 SW Rock Creek Drive
PO Box 1492
Stevenson, WA 98648
Ph: (509)427-3850
Fax: (509)427-0188

VOLUNTARY CONSENT FOR TREATMENT

I _____ voluntary consent to chemical dependency treatment and agree to:

GROUP REQUIREMENTS

1. Adopt the treatment goal of total abstinence from alcohol and drugs.
2. Submit to random urinalysis screenings.
3. No smoking or chewing in the building. No use or possession of alcohol or mood-altering chemicals. No assaultive or destructive behavior.
4. Meet financial obligations in order to be in good standing. Payment is required at the time of service if no medical coupon.

ATTENDANCE

1. To enhance the cohesiveness of the group, on time attendance is required for all sessions. Tardiness of more than 10 minutes will not allow admittance to the group and tardiness to an individual session will require rescheduling.
2. Absences are strictly limited to 3 total excused and unexcused absences in each phase of the program. A call must be made to the counselor prior to the group or scheduled individual appointment to be considered excused. Family and medical emergencies will be reviewed on a case-by-case basis.
3. Sessions missed must be made up at the end of the program. If more than 3 total sessions are missed, the patient must start that phase of the program over at the beginning.

CONFIDENTIALITY

All information discussed is strictly confidential and may not be discussed with others. Please be careful not to be overheard discussing group information. A breach of confidentiality can be grounds for immediate termination from the program.

FAILURE TO ADHERE TO ANY OF THESE RULES MAY RESULT IN THE FOLLOWING CONSEQUENCES:

1. Revision of treatment plan, which may include additional goals and objectives and may result in an increased level of care and the possibility of additional time and program requirements.
2. Reporting as appropriate to law enforcement, courts, probation and/or referral sources.
3. Immediate dismissal from the program or transfer to a more appropriate level of care.

Patient Signature

Date

Counselor Signature

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 Community Health Client-Pay Agreement

MH Clinicians
Annie Johns
Tamara Cissell
Jill Pariera
Leslie Khoury
Eli Galvan

Client Name: _____ DOB: _____

Primary Insurance:		Secondary Insurance:	
Primary Insurance ID:	Primary Group No:	Secondary Insurance ID:	Secondary Group No:

- Skamania County Community Health is considered an In Network/Out of Network provider with your insurance company. As of _____ your insurance deductible has been met. Your co-pay will be \$____ per visit.
- Skamania County Community Health is considered an In Network/Out-of-Network (circle one) provider with your insurance company. As of _____, your insurance deductible has **NOT** been met. You have a \$_____ deductible per year of which \$_ has been met. Your co-insurance will be _____ % of the contracted rate.
- Skamania County Community Health does not contract with your insurance provider. You will be responsible for payment for services received (see rates below).
- We show that you have coverage through Washington State (Molina, Community Health Plan of Washington, Amerigroup, Coordinated Care).
- You have insurance coverage through Medicare. As of _____, your insurance deductible has been met.
- You have insurance coverage through Medicare. As of _____, your insurance deductible has **NOT** been met. You will be responsible for the full cost of service (see rates below) until your deductible has been met.
- You have been approved to receive grant funding.
- You qualify to receive services on a sliding scale. You will be responsible to pay _____% of the cost of service for each visit (see rates below).

*** This quote of benefits from your insurance company does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, limitations, and exclusions of the member's contract at the time of service. Benefits and deductibles will be checked periodically. You will be responsible for any outstanding balance due.**

**The cost of treatment is outlined below and agreed to by the client as follows (unless income level meets criteria for Sliding Fee Scale):

<u>Mental Health</u>	
Psychiatric Intake	\$200.00
Medication Management	\$100.00 (1/2 hr.)
Assessment	\$145.00
Individual Session	\$130.00
Brief Session (1/2 hour)	\$65.00
Group Session	\$5.20 per 15 min.

<u>Chemical Dependency</u>	
Assessment	\$150.00
Admit	\$100.00 per hour
Individual Session	\$25.00 per 15 min.
Group Session (Adult)	\$12.00 per 15 min.
Group Session (Youth)	\$12.00 per 15 min.
Urinalysis	\$30.00

Fees are to be paid at the time of service.

Client

Date

Counselor

Date

SKAMANIA COUNTY COMMUNITY HEALTH

OATH OF CONFIDENTIALITY

As a condition of my employment or service relationship with Skamania County Community Health, I agree to the following:

I am bound by 42 Code of Federal Regulations (CFR) Part 2, federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records; by 45 CFR Parts 160 and 164, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and by Revised Code of Washington (RCW) 70.96A, Treatment of Alcoholism, Intoxication and Drug Addiction.

I certify not to divulge to any unauthorized third party any information concerning a client, other than to another Skamania County Community Health staff member, except when:

1. I have written authorized consent for the release of such information from the client.
2. I am reporting child abuse or neglect per RCW 26.44.
3. I am reporting information concerning a crime, which is threatened to be committed either at the program, or against any person who works for the program.
4. The disclosure is a requirement of a court order, or of federal or state laws and regulations.
5. I am reporting a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical attention.
6. I am ordered by a court order, which satisfies the requirements of 42 CFR Part 2.
7. I am reporting a crime a patient has committed on the premises of/or against agency personnel.
8. I have an executed data sharing agreement for research activity that has been approved by a recognized institutional review board (IRB).

I will consult management for direction anytime I am unclear as to the interpretation of confidentiality regulations or the legality of requests made of me for information.

I agree to be bound by procedures for safeguarding client information, including:

1. All charts, notes and other written materials will be stored in a secure room or locked up when not in use.
2. Discussions regarding clients will be held in staff offices or in other places providing assurance of privacy.
3. No privileged information will be shared with other agencies, professionals, friends or family members without prior written authorization from the patient.
4. I will deny requests for access to patient files by anyone not employed by the agency and refer such requests to the Director.

CONFIDENTIALITY OF CHEMICAL DEPENDENCY PATIENT RECORDS

Skamania County Community Health is bound by 42 Code of Federal Regulations (CFR) Part 2 Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records: by 45 CFR Parts 160 and 164, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and by Revised Code of Washington (RCW) 700.96A, Treatment of Alcoholism, Intoxication and Drug Addiction. 42 CFR Part 2 prohibits the release of any information identifying anyone as receiving or having received services for an alcohol and/or drug problem without written consent of the patient involved.

Specific situations where patient's written permission is not required are quite limited. Information concerning a patient will not be divulged to any unauthorized third party, other than to another Skamania County Community Health Staff member, except when:

1. There is a written consent for the release of such information signed and initialed by the patient.
2. When reporting child abuse or neglect per RCW 26.44.
3. When reporting information concerning a crime, which is threatened to be, committed either at the program, or against any person who works for the program.
4. The disclosure is a requirement of a court order, or of federal or state laws and regulations.
5. When reporting a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical attention.
6. There is a court order, which satisfies the requirements of 42 CFR Part 2.
7. When reporting a crime a patient has committed on the premises of/or against agency personnel.
8. There is an executed data sharing agreement for research activity that has been approved by a recognized institutional review board.
9. Audit and evaluation of contracted programs by State and Federal agencies.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Patient Signature

Date

Counselor Signature

Date

SKAMANIA COUNTY COMMUNITY HEALTH

COUNSELOR DISCLOSURE STATEMENT

Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of public health and safety. Registration of an individual with the Department does not include recognition of any practice standards or necessarily implies the effectiveness of any treatment. It is required that the following information be provided prior to commencing treatment.

All patients have the right, as individuals, to choose counselors who best suit their needs and purposes. The purpose of the counseling credential act is to provide protection for the public health and safety and to empower the citizens of the State of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Treatment Philosophy

This program provides treatment for substance use disorders. In the course of treatment, you will be treated for the physiological, psychological, social, behavioral, and spiritual effects of this disease. Our program requires abstinence from alcohol and all mood-altering drugs that are not prescribed by a physician. The treatment regimen will include, but is not limited to individual counseling, relapse/prevention counseling, group counseling, education, family counseling and discharge planning. Our program encourages recovery from addiction and participation in a 12-step program.

Counselor Confidentiality Statement

Your counselor cannot disclose the fact that you have signed the disclosure statement nor disclose any other information that you tell them unless you and/or your parent or guardian has given written permission. The law requires, however, the release of confidential information in the event of suspected child abuse or neglect and allows for such release when there is a high probability of suicide, medical emergency, and/or harm to another or psychiatric disability which is so severe that the individual is not capable of caring for his or her own needs. Professional staff may share patient information to coordinate case management activities with physicians, psychologists, psychiatrists, and counselors.

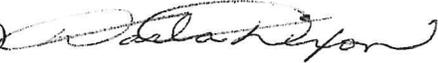
Counselor Education and Training

This treatment program is approved by the Department of Behavioral Health and Recovery to provide assessment services, treatment services for DUI and Deferred Prosecution, case management, treatment referral, outpatient treatment, and intensive outpatient treatment. As a state approved program, staff has met certain qualifications as set forth in WAC 440-22-240. The credentials of each counselor are monitored and regularly inspected by the Department of Behavioral Health and Recovery to verify that counselors continue to meet requirements.

Chemical Dependency Professionals (CDP) on staff at SCCH:

Tamara Cissell, LICSW, CDP (DOH credential LW60280965 and CP60199613) 

Sharon Bonge (AKA Penland), CDP (DOH credential CP00005224) 

Darla Dixon, CDP (DOH credential CP60907548) 

Patient Signature

Date

Skamania County Community Health

**Acknowledgement of Receiving:
Notice of Grievance Procedure
Consumer Rights
Unprofessional Conduct**

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

- 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.

Consumer or Legal Guardian Signature

Date

SKAMANIA COUNTY COMMUNITY HEALTH

SECTION I: TUBERCULOSIS HISTORY

- 1. Ever treated for TB? No ___ Yes ___ If yes, when _____ by _____
- 2. Ever had a test for TB? No ___ Yes ___ If yes, when _____ by _____
Results: Negative _____ Positive _____
- 3. Ever been exposed to TB? No ___ Yes ___ If yes, when _____ by _____
- 4. Family history of TB? No ___ Yes ___ If yes, when _____ by _____
- 5. Other symptoms / indicators: _____

SECTION II: ADMISSION SCREENING

- 1. Is person experiencing: Chronic cough with sputum? No ___ Yes ___
Fever? No ___ Yes ___
Weight Loss? No ___ Yes ___
Night Sweats? No ___ Yes ___
Chest pain (lung/breathing)? No ___ Yes ___
- 2. Other symptoms / indicators: _____
- 3. Is person presenting any symptoms / indicators (in Section I or II) of active tuberculosis?
No ___ Yes ___

SECTION III: TB TESTING, ADMISSION & PATIENT NOTIFICATION POLICY

WAC 440-22 requires that all patients are tested for TB. A negative test within 60 days of admission is acceptable. A negative test during the continuum of care is acceptable. A person who has been treated for TB (Section I #1) must provide evidence of treatment or a physician / healthcare professional report that the person is not infectious prior to admission. A person who has been exposed to TB (Section I #3) must show evidence of a negative test, treatment or a physician / healthcare professional report that the person is not infectious prior to admission. A person with a family history of TB will not be admitted until testing is accomplished or a physician / healthcare professional provides a report that the person is not infectious.

I CERTIFY THAT THIS POLICY HAS BEEN EXPLAINED TO ME

Patient Signature

Date

I will have the tuberculosis test administered within the next 30 days and I understand that I will not be allowed to participate in group treatment until Skamania County Community Health obtains the TB test results.

Patient Signature

Date

Counselor Signature

Date



Skamania County Community Health

710 SW Rock Creek Drive
PO Box 1492
Stevenson, WA 98648
Ph: (509)427-3850
Fax: (509)427-0188

RANDOM URINALYSIS POLICY

Patient Initials

I agree to participate in random UA's. _____

Refusing to participate in a random UA will be considered automatically positive. _____

I understand that I may be called to provide a random UA at any time. _____

If I don't show for the UA, it will be considered automatically positive. _____

If I am unavailable during a time when called for a random UA, a calendar schedule must be submitted in advance to my counselor. _____

I understand there is no way to appeal a laboratory report of UA results. _____

If UA results are needed for probation, the results will be disclosed to the Probation Officer. _____

Positive results are automatically reported to Probation with the proper Release of Information. _____

Actual laboratory reports with UA results cannot be redisclosed to a third party. _____

Client Signature

Date

Counselor Signature

Date

AIDS/HIV BRIEF RISK INTERVENTION

To Whom It May Concern:

I _____

hereby certify by my signature below, that I received prevention information concerning HIV/ AIDS. The information I obtained through consultation and provided literature was understandable and considered sufficient for purposes of prevention, especially as it pertains to behavior associated with psychoactive substance use, which suppresses inhibitions, judgment and reasoning.

I was further provided with phone number and address if I wish to obtain further information, testing or treatment.

Patient Signature

Date

Counselor Signature

Date

Consent for Release of Confidential Information

I, _____, authorize
(Name of Patient)

(Name or general designation of alcohol/drug program making disclosure)

to disclose to: Washington State Health Care Authority, Beacon Health Options and my current health plan (Community Health Plan of Washington, Molina, Amerigroup or Coordinated Care).
(Name of person or organization to which disclosure is to be made)

the following information: Identifying information, admission date, initial clinical assessment, program specific mental health and/or substance use disorder assessment, individual service plan, service encounter, anticipated discharge date, and discharge information if applicable.
(Nature and amount of the information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this is to: Support coordination of care, payment and health care operations.
(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
I have been provided a copy of this form.

Dated: _____

Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____



CLIENT COPY

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

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.

PATIENT RIGHTS

1. Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria;
2. Is reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
3. Is treated in a manner sensitive to individual needs and which promotes dignity and self-respect;
4. Is protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;
5. Has all clinical and personal information treated in accord with state and federal confidentiality regulations;
6. Has the opportunity to review their own treatment records in the presence of the administrator or designee;
7. Has the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the agency or by referral;
8. Is fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available;
9. Is provided reasonable opportunity to practice the religion of their choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. The patient has the right to refuse participation in any religious practice;
10. Is allowed necessary communication:
 - a. Between a minor and a custodial parent or legal guardian;
 - b. With an attorney; and
 - c. In an emergency.
11. Is protected from abuse by staff at all times, or from other patients who are on agency premises, including:
 - a. Sexual abuse or harassment;
 - b. Sexual or financial exploitation;
 - c. Racism or racial harassment; and
 - d. Physical abuse or punishment.
12. Is fully informed and received a copy of counselor disclosure requirements established under RCW 18.19.060;
13. Receives a copy of grievance procedures; and
14. In the event of an agency closure or treatment service cancellation, each patient must be:
 - a. Given thirty days notice;
 - b. Assisted with relocation;
 - c. Given refunds to which the person is entitled; and
 - d. Advised how to access records to which the person is entitled.



CLIENT COPY

**SKAMANIA COUNTY
COMMUNITY HEALTH**

710 SW Rock Creek Drive
PO Box 369

Stevenson, WA 98648

(509) 427-3850 Fax: (509) 427-0188

www.skamaniacounty.org

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.

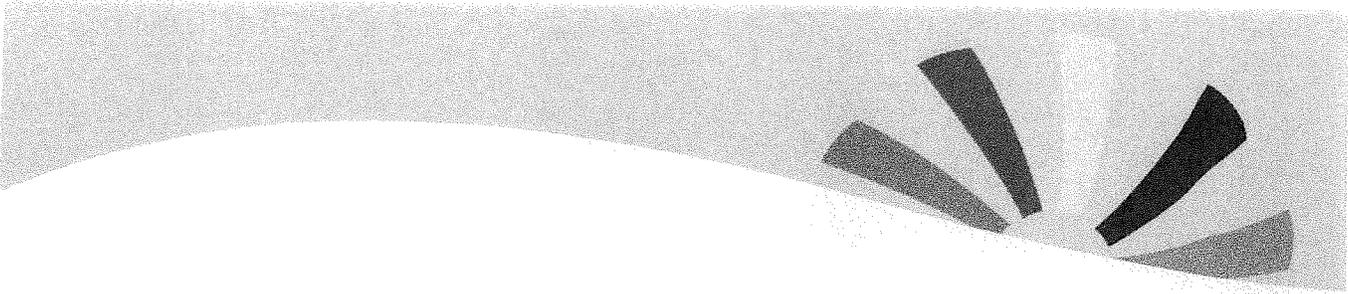
NOTICE OF GRIEVANCE PROCEDURE

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 and or by a Consumer's representative. If an oral request to file a Grievance is received or if a Consumer expresses his or her inability to prepare a written Grievance, the Grievant will be immediately referred to the Division of Behavioral Health and Recovery.
3. Consumers are asked to file a Grievance within ten (10) days of the occurrence of the 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 filing a Grievance. The Grievant may request and receive assistance from his or her representative or another individual of their choice for all written and oral presentations throughout the Grievance process. Each Consumer has the right to receive, at no cost, written Consumer information that they and/or their representatives may request for filing or resolving complaints and Grievances. Grievance related materials shall not be disclosed to parties other than Division of Behavioral Health and Recovery or Skamania County Community Health staff members without the Consumer's written permission. Except as necessary to resolve the Grievance, to the Division of Behavioral Health and Recovery if a Fair Hearing is requested on the matter grieved or in order to comply with the provisions of the prevailing service agreement with the DBHR.
4. A Grievance is initially filed with the Skamania County Community Health Director (or the Board of Commissioners if the Director is the subject of the Grievance).
5. The Director shall initially discuss the situation with both the Grievant and the staff member responsible for the subject matter of the Grievance and try to resolve the disputed issues to the satisfaction of both parties.
6. If the grievant is dissatisfied or declines to work toward resolution with Skamania County Community Health, the grievant shall contact the Complaint Manager at the Division of Behavioral Health and Recovery: (360) 725-3752.

RCW 18.130.180 Unprofessional Conduct

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].



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.

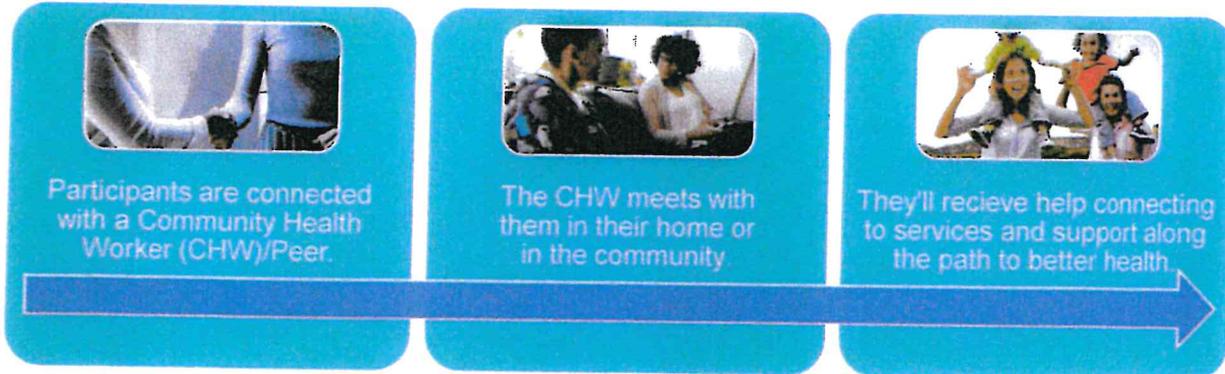
Who Can Participate?

- ✓ 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