Columbia Community Mental Health

Starting in Program (please circle) MED or A/D

Client Questionnaire/Application for Services

PLEASE READ*:** Columbia Community Mental Health is a private, nonprofit community mental health agency. Our professional staff is committed to providing quality counseling and case management services to the needs of all members of our community who are in mental or emotional distress. Most treatment is in the form of brief counseling and intervention. If we believe it would be helpful, we will refer you to one of a number of ongoing psychotherapy groups.A SPECIAL NOTE FOR PARENTS*:** We believe that ***parents are the most important members of their children's treatment team. Because of this, parents of children receiving treatment at Columbia Community Mental Health are required to participate in the treatment*** of their children. We cannot help your child without your active cooperation and participation.

Client ID # **Today's Date** *(Month/Day/Year):*	☐ Initial ☐ Status Update *(office use only)*	
Name *(First, Middle, Last):*	**Last Name at Birth**:	
Parents/Foster Parents names *(if client is a child):*	**DOB** *(Month/Day/Year):* **SSN:**	
Phone # information: **Home**_____ **Cell**_____ **Message**_____	**Gender:** *(please select one)* ☐ Female ☐ Male CCMH apologizes for the limitation of our software system for only having 2 choices. Please help us get to know you. How do you identify? _____	**Highest School Grade Completed:**
Residence Address: **Street** _____ **City**_____ **State**_____ **Zip Code**_____ **County of Residence**_____ **Mailing address if different:**	**Marital Status:** ☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐ Married Includes married couples, those living together as married, living with partners, or cohabitating.	**Veteran Status:** ☐ Yes, Veteran & not specified Branch of Service ☐ Yes, Veteran & Current or Former Active Duty Military ☐ Yes, Veteran & Current or Former Guard/Reserve Military ☐ No, but Current or Former Guard/Reserve Military ☐ No ☐ Unknown
	ODL / ID# *(if applicable, required for DUII):*	

Please list all household members: Name DOB Relationship to client

Person 1*(client):*_____

Person 2 _____

Person 3 _____

Person 4 _____

Person 5 _____

# of Dependents *(# of people dependent on client's household income, including yourself):*_____# of Child Dependents *(ages 0-17):*_____

Estimated Gross Household Monthly Income AND Source of Income / Support:	☐ Wages/Salary $_____ ☐ Disability/SSDI $_____ ☐ Unknown $_____ ☐ Other $_____	☐ Public Assistance (does not include Food Stamps) $_____ ☐ Retirement/Pension/SSI $_____ **Total Income** $_____	☐ No Income ☐ Prefer not to answer/Refuse
Employment Status:	☐ Full-time (35+ Hours) ☐ Part-time (Less than 35 Hrs) ☐ Student ☐ Homemaker ☐ Retired	☐ Disabled (unable to work for physical or psychological reasons) ☐ Hospital Patient or Resident of Other Institutions ☐ Other Reported Classification (e.g. Volunteers) ☐ Sheltered / Non-competitive Employment	☐ Unemployed (Looking for work during past 30 days or on layoff from job) ☐ Unemployed (Would like assistance) ☐ Not in Labor Force (Not actively looking for work) ☐ Unknown

Living Arrangement Status:

- ☐ Transient / Homeless
- ☐ Room & Board
- ☐ Oxford Home
- ☐ Prison
- ☐ Foster Home
- ☐ Jail
- ☐ Alcohol/Drug Free House
- ☐ Unknown
- ☐ Residential Facility
- ☐ Residential Facility (SUD)
- ☐ Residential Facility (BRS)
- ☐ Residential Facility (CSEC)
- ☐ Residential Facility (PRTS)
- ☐ Residential Facility (SCIP/SAIP)
- ☐ Residential Facility (SRTF for YAT)
- ☐ Residential Facility (RTH for YAT)
- ☐ Other Private Residence
- ☐ Private Residence (at home)
- ☐ Private Residence (with relative)
- ☐ Private Residence (with non-relative)
- ☐ Supported Housing
- ☐ Supportive Housing (Scattered Site)
- ☐ Supportive Housing (Congregate Setting)
- ☐ Secure Residential (SRTF Adult)
- ☐ Residential Sub-Acute Care Facility

Emergency Contact:

Name_____

Phone _____

Relationship_____

Primary Care Physician:

Name_____

Phone_____

Referred by:

Name_____

Phone_____

Primary Health Insurance:

- ☐ Medicare #_____
- ☐ Medicaid / OHP #_____
- ☐ Private Insurance / Managed Care Organization

_____

_____

- ☐ Other (Tricare, VA, Champus)
- ☐ None
- ☐ Unknown

Race *(Check all that apply):*

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

Ethnicity:

- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Specific Hispanic
- ☐ Hispanic – Specific Origin Not Specified
- ☐ Not of Hispanic Origin
- ☐ Unknown

Tribal Affiliation:

- ☐ Not Applicable ☐ Other
- ☐ Burns Paiute Tribe
- ☐ Confederated Tribes of Siletz
- ☐ Cow Creek Band of Umpqua Indians
- ☐ Confederated Tribes of Grand Ronde
- ☐ Confederated Tribes of Warm Springs
- ☐ Confederated Tribes of the Umatilla
- ☐ Coquille Indian Tribe
- ☐ Klamath Tribe
- ☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw

Interpreter Needed: ☐ None ☐ Hearing Impaired ☐ Foreign Language - Please specify language:

Tobacco Use: ☐ Yes ☐ No ☐ Unknown

Substance Use during Last 90 Days: ☐ Yes ☐ No ☐ Unknown

Are you pregnant? ☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

# of Arrests and Total Arrests can be left blank

# Of Arrests in Past Month: *(In Last 30 Days)*	**Total Arrests:** *(# of Arrests in Lifetime)*	**# of DUII Arrests in Past Month:** *(In Last 30 Days)*	**Total DUII Arrests:** *(# of DUII Arrests in Lifetime)*

Please describe briefly the problem you want help with:

_____

_____

_____

Signature_____ **Date**_____

(Client signature if 14 years of age or older)

COLUMBIA COMMUNITY MENTAL HEALTH
BRIEF MEDICAL DATA BASE

NAME:_____Age:_____Sex:_____Hgt:_____Wgt:_____Date:_____

Daytime phone # _____ Zip Code: _____

Family Physician:_____ Phone #_____

Current Medications Dose Frequency Prescribed by ***(name of physician.)***

Are you allergic to any medications? ☐Yes ☐No If yes please list name: _____
Symptoms of Allergy:

Hospitalizations:
Hospital name or address: Date Reason Physician

Are there any other notable medical conditions you would like to include?

INFECTIOUS DISEASE RISK ASSESSMENT FORM

Circle the answer for each question.

1. yes no don't know Have you seen a doctor or other health care provider in the past 3 months?

2. yes no don't know Do you live or have you lived on the street or in a shelter?

3. yes no don't know Have you ever been in jail/prison/juvenile detention?

4. yes no don't know Have you ever been in a long-term facility (nursing home, mental-health hospital, or other hospital)?

5. Where were you born?_____

6. yes no don't know In the past 3 years have you traveled/lived outside the U.S. (except Canada, Australia, New Zealand, Japan, Western Europe or Great Britain).

7. Yrs/Mos_____ How long have you been in the U.S.?

8. yes no don't know Are you a combat veteran?

9. yes no don't know In the past 12 months have you had a tattoo, ear/body piercing, acupuncture or come into contact with someone else's blood?

10. Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks:

_____ Nausea
_____ Fever
_____ Drenching night sweats that were so bad you had to change your clothes or the sheets on the bed
. _____ Productive cough
_____ Coughing up blood
_____ Shortness of breath
_____ Lumps or swollen glands in the neck or armpits
_____ Losing weight without meaning to
_____ Diarrhea (runs) lasting more than a week
_____ Brown tinged urine
_____ Women: Have you missed your last two periods?
_____ Extreme fatigue
_____ Jaundice (yellow skin) or yellow eyes

INFECTIOUS DISEASE RISK ASSESSMENT FORM

11. yes no don't know — Have you ever been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year?

12. yes no don't know — Have you ever had a positive skin test for TB? (A test where they gave you a shot in your forearm, and a few days later a hard lump appeared.)

13. yes no don't know — Have you ever been treated for TB?

14. Have you ever been told you have:

yes no don't know — Hepatitis A
yes no don't know — Hepatitis B
yes no don't know — Hepatitis C

15. yes no don't know — Have you **ever** used needles to shoot drugs?

16. yes no don't know — Have you **ever** shared needles or syringes ("rigs") to inject drugs?

17. yes no don't know — Have you ever had a job that put you in danger of needle stick injuries or other types of blood contact?

18. yes no don't know — Do you use stimulants? (cocaine/methamphetamine)

19. yes no don't know — In the past 12 months, have you, or anyone you have had sex with, had: syphilis, gonorrhea, herpes, chlamydia, `nongonococcal urethritis, other sexually transmitted diseases or hepatitis.

To help find out if you are at increased risk for HIV, the virus known to cause AIDS, or Hepatitis C Virus (HCV), please take a minute to answer the following questions.

20. yes no don't know — Did you receive a blood transfusion before 1992?

21. yes no don't know — Have you received blood products produced before 1987 for clotting problems?

22. yes no don't know — Was your birth mother infected with Hepatitis C virus during the time of your birth?

INFECTIOUS DISEASE RISK ASSESSMENT FORM

23. yes no don't know Have you been, or are you currently, on long-term kidney dialysis?

24. yes no don't know Have you had unprotected sex with someone who has the blood disease hemophilia?

25. yes no don't know Have you had unprotected sex with a person who injected drugs?

26. yes no don't know Have you had unprotected sex with a man who has sex with other men?

27. yes no don't know Have you had sex in exchange for money or drugs, or in order to survive?

28. yes no don't know Have you had sex with more than one person in the past 6 months? Any type of vaginal, rectal, or oral contact without protection (condom or other barrier) with or without your consent?

29. yes no don't know Have you had sex or shared needles to inject drugs with a person who has AIDS or who tested positive on the antibody test for AIDS?HIV disease or Hepatitis C?

30. yes no don't know Have you ever injected drugs, even once?

31. yes no don't know Have you ever been pricked by a needle or syringe that may have been infected with HIV or Hepatitis C?

32. yes no don't know Have you ever had a drinking problem that required medical care or counseling?

33. yes no don't know Have you ever been told or thought that you have a drinking problem?

* If you answered "no" to <u>all</u> the questions, you <u>are not</u> at increased risk for HIV/AIDS or Hepatitis C.

* If you answered "yes" or "don't know" to <u>any</u> question, you may be at risk for HIV/AIDS or Hepatitis C.

INFECTIOUS DISEASE RISK ASSESSMENT FORM

The following questions are asked to help with treatment planning. It is not required that you answer them to participate in assessment and /or treatment.

1.	Have you ever had a blood test for the HIV antibody?	yes	no
	If "no," would you like a blood test?	yes	no
	If "yes," have you been tested within the last six months?	yes	no
2.	Have you ever had a blood test for Hepatitis C virus?	yes	no
	If "no," would you like a blood test?	yes	no
	If "yes," have you been tested within the last six months?	yes	no

Document if client was assessed and if they were referred to the health department or other appropriate agency.

Columbia Community Mental Health (CCMH) Notice of Privacy Practices (Notice)

A. Compliance with HIPAA
As part of the Health Insurance Portability and Accountability Act (HIPAA), CCMH provides notice about your privacy rights and CCMH's privacy practices. The notice describes how protected health information may be used and disclosed, and how you can get access to this information.

At your first service, or in an emergency, as soon as feasible, we ask that you sign this notice to confirm your receipt.

Privacy Requirements
We are required by law to maintain the privacy and security of your protected health information. We will use and disclose the information you provide us as stated in this Notice.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

Revisions to the Notice
We may change the terms of this Notice at any time. The change will affect all Protected Health Information that we maintain, including any information created or received prior to publishing the new notice.

If we make material changes to this Notice, we will post the revised Notice on our website. We include a version number on this Notice consisting of the (year, month and day) it was last revised.

Your Health Information
CCMH collects health information about you and stores it in an electronic health record and in a paper chart. Collected health information may be generated by CCMH or received by CCMH from another provider. This is your health record. The health record is the property of this health practice, but the information in the health record belongs to you.

B. Uses and Disclosures of Health Information For Treatment, Payment and Health Care Operations
Use and disclosure of health information includes using the information to provide treatment to you, to receive payments for such treatment, and to conduct ongoing quality improvement activities. Our use and disclosure of your personal information (including health information) is limited as required by state and federal law.

1. Treatment
We may use your health information to provide you with treatment. We may disclose your information to staff prescribers, nurse practitioners, nurses, providers and other personnel involved with your care. We may also disclose your information to interns, who are supervised by staff, and who are involved in your care. Treatment includes (a) activities performed by staff providing care to you or coordinating or managing your care with third parties, (b) consultations with and between CCMH providers and other health care providers, and (c) activities of CCMH providers or other providers covering a CCMH practice by telephone or serving as the on-call provider.

For example, a provider might request records to see a complete health history in order to treat a behavioral symptom that is expressing as a physical symptom. They may also tell another provider about your information in order to plan a course of treatment.

2. Payment
We may use and disclose your health information so that we may bill and collect payment from you, an insurance company, or someone else for health care services you receive from CCMH. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

For example, we may submit a claim to an insurer in order to receive remuneration for the service.

3. Health Care Operations
We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance and business functions at CCMH.

For example, we may use your diagnosis information to analyze how often the diagnosis is used in a defined population and whether it is the appropriate diagnosis based on a normalized sample. Or, we may use your diagnosis to identify if a defined population would benefit from care coordination, and then use this information to refer you to another type of recommended treatment.

If CCMH engages a Business Associate to perform services on CCMH's behalf in order to fulfill CCMH's obligations, the business associate is required to sign a written contract whereby they agree to protect and secure your protected health information.

C. Appointments
We may use and disclose health information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

D. Check In/ Sign In Sheet
We may use and disclose health information about you by having you check in/sign in when you arrive at a location and check out/sign out when you leave that location. We may also call out your name when we are ready to see you.

E. Other Permitted Uses and Disclosures of Health Care Information
We may disclose your health information to any person performing audit, legal, operational, or other services for us. We will use information which does not identify you for these activities whenever feasible. Information disclosed to a contractor for operational purposes may not be re-disclosed to others by such a contractor, except as required for their business operations or by law.

We may disclose your health information when required to do so by a subpoena, court order, or search warrant. We may disclose your health information as we deem it appropriate to protect the safety of an individual or for an investigation related to public safety or to report an activity that appears to be in violation of law.

F. Research
We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

G. Marketing
We may contact you to give you information about products or services related to your treatment, case management or care

coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may also encourage you to maintain a healthy lifestyle, get recommended tests and tell you about government sponsored health programs. We will not be compensated for providing this information to you.

H. Fundraising
CCMH will not use your demographic information in order to contact you for our fundraising activities.

I. Uses and Disclosures You Can Limit
1. Family and Friends
Unless you notify us that you object, we may provide your health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your health information with these people and you don't stop us from doing so. There may also be circumstances when we can assume, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the provider's office during treatment.

Also, if you are not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement with your care. For example, we may tell someone who comes with you to the office, that you are being put on a hold, and provide an update on when we think the hold will be removed. We may also make similar professional judgments about your best interests that allow another person to remind you to take your medications and include what medications you are taking.

2. Health Care Facilities Directory
CCMH does not keep a directory of clients at its health care facilities.

J. Your Rights Regarding Your Health Information
1. Data integrity and correction
You may request to view, copy and correct your health record. The Privacy Officer will ask you to submit in writing what information you would like to view and whether you would like your information made available to you electronically.

If there is an inaccuracy in your record that we created, and you would like us to update your record, contact the Privacy Officer. We may refuse your request and will inform you of the appeal process. Data that was not created by us will need to be corrected with the originator of the information.

2. Accounting of Disclosures
You may obtain an accounting of certain disclosures of Protected Health Information. If you would like an accounting, contact the Privacy Officer.

3. Other requests to limit use and disclosure of your health information
State and federal laws may allow you to request that we limit our uses and disclosures of your health information for treatment, payment and health care operations purposes; however, by law, we do not have to agree to your request.

4. Confidential Communications
You may request, and we will accommodate any reasonable request for you to receive Protected Health Information by alternative means of communication or at alternative locations. If you would like to change your preferences, contact the Privacy Officer.

5. Copy of Notice
You may receive a paper copy of this Notice, even if you agreed to receive such notice electronically.

6. Breach
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

K. Types of Health Information that Require Written Authorization
1. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, HIV/AIDS identification/testing, genetic testing/results, and alcohol and drug information. CCMH will ask you to authorize the release of your alcohol and drug records as is necessary to treat you, receive payment for your treatment and perform health care operations. Alcohol and drug records are protected by 42 CFR Part 2.

L. Sale of Health Information
CCMH will not sell your health information.

M. Reciprocal Authorizations
Some authorizations have a check-box with the following wording, "marking this box means you authorize all the sending/receiving parties to exchange all the information listed below." If you mark the box, information will be shared by/between all the named entities. You do not need to mark the box if you want your authorization to be only one-way or asymmetrical.

N. Contact Us
If you have any questions about this Notice, our policies and practices concerning this Notice and your rights under this Notice you may call 503.397.5211 and ask to speak with the Privacy Officer.

O. File a Complaint
If you think we are not following our Notice, you may call 503.397.5211 and ask to speak with the Privacy Officer. If you are not satisfied with the manner in which the complaint is handled, you may submit a complaint to The Office of Civil Rights. Ask the Privacy Officer how. If you file a complaint CCMH will not retaliate against you.

_____

Client or Authorized Signee Signature

_____

Client or Authorized Signee Name (please print)

_____

Relationship of Authorized Signee (please print)

_____

Date

Columbia Community Mental Health
Alcohol & Drug Treatment Program

Confidentiality Agreement

Columbia Community Mental Health services seeks to abide strictly with all Federal and State confidentiality regulations. CCMH also seeks to respect the spirit of anonymity as expressed in the concept of Tradition Twelve of Alcohol Anonymous.

You have the right, by law, to anonymity during and after your treatment at CCMH. We honor this right by not informing anyone who is not associated with CCMH before, during or after your treatment, of your presence in our program unless:

You consent in writing; or
The disclosure is required by a court order; or
The disclosure is made to medical personnel in a medical emergency; or
To qualified personnel for research, audit, or program evaluation.

Exceptions: Federal law and state regulations do not protect information about:

Suspected child abuse or neglect;
Statements by the client of intention to harm themselves and/or others.

Confidentiality (Staff): Federal confidentiality regulations prohibit the disclosure of client names or their presence at CCMH without their express written permission. Staff may discuss each client's progress with other staff members.

Confidentiality (Clients): Do not disclose the name, presence, or personal history of other clients to anyone (family members, friends, etc.) during phone conversations, visiting hours, AA meetings, in correspondence, or after discharge.

Confidentiality (Group): Do not discuss other client's group disclosures. Staff will discuss each day's group sessions with other staff members.

Taking photographs of clients by other clients or visitors is prohibited.

_____
Client Signature Date

_____
Staff Signature Date

Columbia Community Mental Health
Consumer Rights, Complaints, Grievances, & Appeals, Fee Disclosure,
Non-Discrimination Policy, and Consent to Treatment

I. **Consumer Rights:** Rights, responsibilities and how to exercise them, shall be explained to the consumer, and if appropriate, guardian at intake.

In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

1. Not be discriminated against or denied service based on race, color, creed, sex, national origin, duration of residence, age or sexual preference. Furthermore, no qualified person shall, on the basis of handicap, be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination under any program or activity.
2. Not be denied services or be discriminated against on the basis of age, diagnostic or disability category, unless the Columbia Community Mental Health admission criteria for that program restricts the service to a specific age, diagnostic or disability category.
3. Not be denied services from Columbia Community Mental Health based on the ability to pay, if an emergent need.
4. Be treated with dignity and respect throughout the treatment process at Columbia Community Mental Health.
5. Not perform labor as a method of payment for services rendered. Any labor performed as a part of a treatment plan or a standard program expectation shall be agreed to in writing by the client.
6. Choose from available services and supports, those 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 the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence.
7. Be treated with dignity and respect;
8. 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 to receive a copy of the written Service Plan;
9. Have all services explained, including expected outcomes and possible risks;
10. 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.
11. 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;
12. Inspect their Service Record in accordance with ORS 179.505;
13. Refuse participation in experimentation;
14. Receive medication specific to the individual's diagnosed clinical needs;
15. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
16. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
17. Have religious freedom;
18. Be free from seclusion and restraint;
19. Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;
20. 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;
21. Have family and guardian involvement in service planning and delivery;
22. Make a declaration for mental health treatment, when legally an adult;
23. File grievances, including appealing decisions resulting from the grievance;
24. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
25. Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority;
26. Exercise all rights described in this rule without any form of reprisal or punishment.

II. **Non-Discrimination Policy:** As a recipient of Federal financial assistance, Columbia Community Mental Health will not deny access of services to any qualified person on the basis of race, color, religion, political party, national origin, gender, sexual orientation, insurance status, or on the basis of disability or age from participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity, or employment therein, whether carried out by Columbia Community Mental Health directly or through a subcontractor, or any other entity with whom Columbia community Mental Health arranges to carry out its programs and activities.

III. **Complaints, Grievances, & Appeals:** Any individual receiving services, the parent or guardian of the individual receiving services, or a community partner may file a complaint or grievance with CCMH, the individual's managed care plan or with the Addictions and Mental Health Division [the Division].

Staff will assist individuals and parents, guardians or community partners, as applicable, to understand and complete the complaint/grievance process, and notify them of the results and basis for the decision as appropriate. CCMH will encourage and facilitate resolution of the complaint/grievance at the lowest possible level.

Individuals may communicate a complaint verbally or in writing. If communicated verbally, the receiving staff member will document the complaint to the extent possible. If the individual wishes to remain anonymous, staff will not include identifying information. While individuals have the right to communicate their complaint to any individual at CCMH, if the individual is uncomfortable communicating with the person they are seeing, they may communicate with another staff member to document their complaint, per their preference.

Any complaint related to an allegation of abuse or neglect will be referred to the CCMH Abuse Investigator for screening as soon as possible.

Any other complaint will be investigated by the Supervisor, Program Manager, Compliance Officer, or designee to determine:

1. The sequence of events that contributed to the complaint.
2. The outcome preferred by the complainant.
3. Options available for resolving the complaint.

The investigation may include the following, if applicable:

1. Contact with the individual or party who communicated the complaint.
2. Clinical chart review.
3. Contact with other witnesses or collaborating parties.

The provider or providers who are the subject of the complaint will be provided with an opportunity to respond to the allegation. If the investigation determines that a lack of quality of care contributed to the complaint, a peer or supervisor with equal or greater credentials will be consulted in order to determine the validity of any quality of care allegation.

Disciplinary action will not occur without the provider being given the opportunity to present information in response to the complaint.

The investigation will be completed within 30 calendar days.

Expedited Grievances/Complaints: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in this policy are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator will review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

Retaliation: A grievant, witness or staff member of CCMH will not be subject to retaliation by CCMH for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

Appeals: Individuals and their legal guardians, as applicable, have the right to appeal entry, transfer and grievance decisions as follows:

1. If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CCMH Executive Director or to the Division as applicable;
2. If requested, program staff will be available to assist the individual;

3. The CCMH Executive Director will provide a written response within ten working days of the receipt of the appeal; and
4. If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the Director.

IV. **Fee Disclosure:** I have received a schedule of fees for services provided by Columbia Community Mental Health, and understand that I may apply for a "sliding scale fee: exceptions based on my income circumstances. I agree to pay the fees established for me.

V. **Voter Registration:** I have been offered an opportunity to register to vote (if 18 years old or older).

VI. **Consent to Treatment:** I, _____ have read, discussed with the intake worker and understand the above information. I hereby consent to participate in the services provided by **Columbia Community Mental Health**.

_____ _____
Signature Date

For clients under 14 years of age, or legally unable to contact:
After having read and agreed to the above treatment conditions, I hereby give my consent to provide

Services to_____ under the conditions stated above.

_____ _____
Signature of parent or legal Guardian (indicate which) Date

COLUMBIA COMMUNITY MENTAL HEALTH
CLIENT RIGHTS LIMITATIONS AND RESPONSIBILITIES

This form is to let you know what is expected of you and what you may expect during your treatment at Columbia Community Mental Health.

1. Services may not be denied to any person on the basis of race, color, religion, sex, national origin, sexual orientation, duration of residence, handicap, or age. Each person shall be treated with dignity and respect.
2. Each person shall be protected from sexual abuse or contact, and physical punishment and abuse are prohibited.
3. Each person shall have the right to the highest quality of services. There may be a fee for services dependent on income criteria. Failure to maintain your fee agreement may result in your referral back to the originating agency. You will also be expected to pay for sessions not attended and for which you did not arrange to miss ahead of time. You have the right to know the cost of treatment in advance.
4. In general, information and records obtained in the course of treatment shall be kept confidential and will only be used within Columbia Community Mental Health. Records will be released to people outside of Columbia Community Mental Health if you give us written permission by signing a release of information form. If you wish to cancel the release, you must do so verbally or in writing.

There are several special situations in which we would not keep information confidential. They include:

a. if a judge orders us to disclose information to a court,
b. if we have cause to suspect child or elder abuse,
c. if we believe that a client will do harm to themselves or others,
d. if crimes are committed against Columbia Community Mental Health or staff, and
e. if a non-custodial parent of a child thirteen years old or under 0requests information about his/her child's treatment (unless there is a court order blocking release of information).

5. It is expected no one will arrive for his/her appointment after consuming alcohol or other unprescribed substances.
6. Parents and guardians are primary caregivers of children and the involvement of caregivers is critical in most treatment of children. Parents will be contacted during treatment and attempts will be made to involve them unless there is a court order restricting contact or unless it is believed that significant harm, such as abuse, will occur to the child or adolescent.
7. If we do not believe that treatment will benefit you or your family, we will tell you and suggest changes in treatment, which may help. These suggestions may include other treatment services or other methods of treatment.
8. Please talk with you therapist if you have any questions about the treatment you or your family are receiving at Columbia Community Mental Health.
9. You have the right to file a grievance with CCMH if dissatisfied with treatment. The exercise of that right will not jeopardize further treatment. If the outcome of your grievance is unsatisfactory to you; you have the right to file a grievance with your Managed Care Organization, and/or the Division of Addictions and Mental Health[i].

_____ _____

Signature of Client Date

Columbia Community Mental Health

Therapy Attendance No Show Policy

In order to provide the most effective services available, it is essential that you attend therapy sessions as scheduled. If you consistently miss appointments you will receive an inquiry letter and your scheduled appointment times may be reassigned. If your mental health services are terminated, you may reapply at any time. Your application for services will be treated as a new intake. If you have any questions about this policy, please speak to the Clinical Director or your therapist before signing below.

I have read and understand the above statement. If it becomes necessary for me to miss a scheduled appointment, I will call as soon as possible to cancel.

Client/Guardian Signature_____Date_____