IDAHO DEPARTMENT OF
HEALTH & WELFARE

APPLICATION FOR MENTAL HEALTH SERVICES

Effective January 1, 2013

DBH-0050
(1/13)

Completion of this application serves as your request for Mental Health services through the Idaho Department of Health and Welfare. Following completion, this application will be reviewed by a Mental Health clinician and you will be contacted regarding the possible next steps in your, or if applicable, your child's eligibility for services.

I, _____, do hereby apply for Mental Health Services for
(Name of Applicant OR Parent/Guardian)
myself (or my child) from the Department of Health and Welfare as indicated below:

Name	
Address	
Phone Number	
Parent/Guardian's Name	

I am seeking services for myself (or my child) to address the following concerns:
(Please print)

_____

_____

_____

_____

_____

_____

(Please attach additional paper if needed)

By signing below, I am requesting mental health services. I understand that this application for services is not a guarantee of services. Further, I give consent for the Department to conduct a mental health assessment that could bring up potentially uncomfortable thoughts or feelings; I have been given the opportunity to ask questions about this consent. I have read and understand the above.

_____ _____
(Applicant's Signature) (Date)

_____ _____
(Parent or Guardian Signature) (Date)

MENTAL HEALTH CLIENT PROFILE

Name: _____ _____ _____ Date: _____
First Last MI

Date of Birth: _____ SSN (Optional): _____ Primary Phone #: (_____)_____

Street Address: _____ City _____ Zip Code_____

Mailing Address (if different): _____

Parent or Emergency Contact Name:_____ Phone: (_____)_____

Address: _____

Gender

- ☐ Female
- ☐ Male
- ☐ Refused
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Unknown

Ethnicity

- ☐ Cuban
- ☐ Hispanic or Latino - specific origin not specified
- ☐ Mexican
- ☐ Other Specific Hispanic or Latino
- ☐ Not of Hispanic or Latino Origin
- ☐ Puerto Rican
- ☐ Unknown/Refused

Race

- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Other
- ☐ Pacific Islander
- ☐ White/Caucasian
- ☐ Unknown/Refused

Special Needs

- ☐ Developmental Impairment/ Intellectual Disability
- ☐ Moderate to Severe Medical Problems
- ☐ None
- ☐ No Response
- ☐ Organically Based Problem
- ☐ Other
- ☐ Physical Impairment (manipulation and/or mobility)
- ☐ Severe Hearing loss or Deaf
- ☐ Traumatic Brain Injury
- ☐ Visual Impairment or Blind
- ☐ Unknown

Veteran Status

- ☐ Active Duty
- ☐ Never in Military
- ☐ Veteran
- ☐ Unknown/Refused

Marital Status

- ☐ Cohabitating
- ☐ Divorced
- ☐ Married
- ☐ Never Married - Single
- ☐ Separated
- ☐ Widowed

Household Composition

- ☐ Client Lives Alone
- ☐ Client Lives with Adolescents
- ☐ Client Lives with Children
- ☐ Client Lives with Non-relatives
- ☐ Client Lives with Relatives
- ☐ Other

Number of People Living with Client _____

Living Arrangement

- ☐ Adolescent living independently
- ☐ Adolescents (under 18) living with parents, relatives, or guardians
- ☐ Adult living with parents, relatives, or guardians
- ☐ Foster Home/Foster Care
- ☐ Jail/Correctional Facility
- ☐ Dependent Living
- ☐ Institutional Setting
- ☐ Residential Care
- ☐ Independent Living
- ☐ Other
- ☐ Other Residential Status
- ☐ Crisis Residence
- ☐ Adult Foster Care
- ☐ Homeless - Hotel, boardinghouse, SRO
- ☐ Homeless - Long Term Shelter
- ☐ Homeless - Outdoors
- ☐ Homeless - Short Term Shelter
- ☐ Homeless - Someone else's home
- ☐ Private Residence - living arrangements not known

School Attendance in last 30 days

- ☐ Attending School Regularly: 5 days or Less Absent
- ☐ Home Schooled
- ☐ Not Applicable
- ☐ Not Available
- ☐ Not Attending School Regularly: 6 days or More Absent

Highest Level of Education Completed

_____

Currently Enrolled in Vocational Rehab.

_____ Yes _____ No

Preferred Method of Contact

- ☐ Phone (_____)_____
- ☐ Text (_____)_____
- ☐ Letter
- ☐ Email

Email Address_____

_____

Employment Status

- ☐ Disabled
- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Homemaker
- ☐ In the Armed Forces
- ☐ Other
- ☐ Resident/Inmate
- ☐ Retired
- ☐ Seasonal Emp.; In-Season
- ☐ Seasonal Emp.; Out of Season
- ☐ Student
- ☐ Unemployed

Name of Employer _____

_____

Health Insurance

- ☐ Blue Cross/Blue Shield
- ☐ Health Maintenance Organization (HMO)
- ☐ Medicaid
- ☐ Medicare
- ☐ Other (e.g., TRICARE)
- ☐ Private Insurance (other than BCBS or HMO)

Policy # _____

Group # _____

Number of Arrests in past 30 Days _____

Number of Arrests in past 12 Months _____

Total Months Employed in Last 6 Months _____

Number of Employers in past 12 Months _____

Is Client Under Court Supervision

Yes _____ No _____

Supervising Jurisdiction _____

Revised July 2019

**The Social Security Number (SSN) is collected for the purpose of identification of the participants, prevention of duplication of benefits and information. The Department will not disclose an individual's SSN without the consent of the individual to anyone outside of the Department except as mandated by law. 31 CFR 1.32; 42 CFR §435.910.*

Medical Health Intake Form

Name: _____ DOB: _____ Date: _____

Current Treatment

Primary Physician: _____ Location: _____

Date of last appointment: _____ Phone Number: _____

Are you current on your immunizations? ☐ Yes ☐ No ☐ I don't know

What surgeries have you had? _____

_____

Have you ever been screened for HEP C/HIV, or other communicable diseases? _____

If female, when was your last PAP? _____ Mammogram? _____

Are you currently on birth control? ☐ Yes ☐ No What method? _____

Who is your dentist? _____ Location: _____

Date of last appointment: _____ Phone Number: _____

Family Health History (s=self/f=family)

Do you, or a member of your family, have a family history of any of the following? (Check one or both)

S☐F☐ Cancer	S☐F☐ Diabetes	S☐F☐ Thyroid	S☐F☐ Other
S☐F☐ Stroke	S☐F☐ Asthma	S☐F☐ Vision concerns	
S☐F☐ Heart Disease	S☐F☐ Tuberculosis	S☐F☐ Hearing concerns	
S☐F☐ Lung Cancer	S☐F☐ Arthritis	S☐F☐ Traumatic Brain Injury	

If other please explain: _____

Substance History

Do you smoke, vape, or use any form of smokeless tobacco? ☐ Yes ☐ No

How much per day/week? _____ When did you start? _____

Are you interested in quitting? ☐ Yes ☐ No

Do you use illegal substances? ☐ Yes ☐ No

How much per day/week? _____ When did you start? _____

Do you drink alcohol? ☐ Yes ☐ No

How much per day/week? _____ When did you start? _____

Current Medications (Over the Counter, Herbal, and Prescription)

_____

_____

_____

_____

Allergies? _____

_____

Vital Signs (to be completed by nursing staff) Name of RN:

Blood Pressure: _____ Pulse: _____ Pulse Ox: _____

Ht: _____ Weight: _____ BMI: _____ Abdominal Girth: _____

Have you had any labs drawn recently? _____ If yes where? _____

☐ Glucose ☐ Thyroid ☐ Lipid Panel ☐ Hep Panel

Medical concerns/referrals/follow-up:

Please see the Idaho Standard Mental Health Assessment for any reported history or current mental health needs.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Behavioral Health

INFORMED CONSENT FOR TREATMENT

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de interprete sin costo alguno. Llame at 2-1-1 al 1-800-926-2588 para obtener la syuda de un intprete.

I, _____, authorize and choose the Idaho Department of Health and Welfare, Division of Behavioral Health (IDHW-DBH) to provide examination, treatment, and/or diagnostic procedures, including prescription of medication, which now or during my care as a participant/client are advisable. The frequency and type of treatment will be decided between myself, my Prescriber, Clinician, Nurse, and/or Mental Health Worker.

_____ I understand there are potential risks and benefits to accessing mental health treatment. I understand that (IDHW-DBH) will work with me to achieve maximum benefit, but there is no guarantee that my mental health will improve; however, a maximum benefit of improved mental health and increased functioning is most likely to occur with consistent participation in treatment.

- I understand and agree that treatment will include a mental health assessment which includes a clinical interview and other available resources to gather clinical information to determine eligibility for Mental Health services, identify issues, strengths, and service needs.
- I understand and agree I will be involved in creating an individualized treatment plan that identifies strategies for providing services to meet the needs identified in my assessment, creating specific treatment goals, and criteria for determining when those goals and needs have been met. The specific services to be included on the treatment plan will be discussed in detail while the treatment plan is being made. I understand I have the right to accept or reject mental health services offered by the Department, unless imposed by law or court order.
- If my services include medication management, I understand that a prescriber, who is licensed in the State of Idaho, will review which medications are being prescribed and the risks and benefits of taking each medication. In general, benefits of medications may include improved mental health functioning and decreased symptoms. Risks of medications may include side effects which will be described to me by the prescriber. I understand and agree I will address with my prescriber any side effects from prescribed medications.
- I understand and agree that I will receive services from a number of (IDHW-DBH) staff with various credentials and experience. I understand there are many different types of therapy and treatment techniques that may be used to assist me on my journey to recovery. I have the right to ask about the type of therapy or treatment I will receive and what the staff's credentials and experience are.

- I understand the benefits of consistent participation in Mental Health services may include improved mental health, functioning in the community, quality of life, and awareness of strengths and limitations, as well as decreased symptoms of my mental illness.

- I understand the risks of treatment may include uncomfortable feelings or memories, and there may be periods of increased anxiety or uncertainty. I understand it is impossible to predict the extent to which I might experience these feelings. I understand and agree I will discuss any concerns or issues related to treatment with my Clinician, Nurse, or Mental Health Worker.

_____ I understand that my records are kept electronically and/or in a paper file folder. IDHW-DBH employees have access to these files, however, it would be unethical for anyone other than those involved in my services to access them. I understand that the service team members I am assigned to will have access to my records and they will be staffing my case as appropriate to aid in treatment.

_____ I understand that I have the right to refuse services at any time and that there are other providers in the community or through telehealth services, in certain parts of the state, that can assist me with my mental health needs. By signing below, I acknowledge that I have been fully informed that I have a choice of providers and may ask for a list of local mental health providers at any time.

_____ I understand that my communication and records are confidential, however, there are exceptions when the law mandates that information is revealed or when ethical guidelines of protection are enforced. The following situations may be cause for disclosure of confidential information without your signed consent:

- Reporting child or vulnerable adult abuse
- Disclosing information to protect others from harm
- Disclosing information to protect you from suicidal risk
- Reporting AIDS/HIV infection and possible transmission
- Criminal prosecutions
- Child custody cases
- Suits which the mental health of a party is an issue
- In a negligence suit brought by you against the Department
- Fee disputes between you and the Department
- Filing of a complaint with a licensing board or other state or federal regulatory authority

_____ I understand the purpose of these procedures will be explained to me.

_____ I understand that IDHW-DBH staff may be cheerful and friendly when working with me, however, they must abide by professional and ethical standards which prohibit the development of personal friendships out of the office or any sexual intimacy.

____ I understand that a clinician or social worker cannot provide services to personal friends, family associates, social or organizational acquaintances, political associates or family members.

____ I understand I can access 24-Hour Crisis Services by calling the Regional Crisis Line that can be found at my Regional office.

____ I understand that I can access advocacy services by calling Disability Rights Idaho at 1-866-262-3462 (TDD/Voice) and can access legal assistance through Idaho Legal Aid; regional numbers can be found at www.idaholegalaid.org.

Date: _____ Client Signature: _____

Date: _____ Parent/Guardian Signature: _____

Date: _____ Witness: _____

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Behavioral Health
CLIENT TEXT MESSAGE & EMAIL INFORMED CONSENT

You may let Idaho Department of Health and Welfare, Division of Behavioral Health (IDHW-DBH) staff contact you by text message (also called SMS) and email. This form tells you about the risks of these types of communication, things to do or not do with these types of contact, and how we use these types of communication.

1. How we will use text messaging and email: We use text messages and email to talk only about things that are not urgent or serious, like reminding you of appointments. All contact to or from you may be added to your IDHW-DBH electronic health record (your "chart"). You have the right to request that information in your health record just like you can request everything else in your record.

2. Risk of using text messages and email: Using text messages and email has some risks that you should keep in mind. These are some of the risks, but there might be other risks too:
    a. Texts and emails can be shown to other people.
    b. People can easily send messages to the wrong person accidentally.
    c. People can save copies of texts and emails even if you delete them on your phone or computer.
    d. Employers and on-line services have the right to look at texts and emails sent through their company systems.
    e. Texts and emails can be read, changed, or sent to other people without you knowing it or giving permission.
    f. Texts and emails can be used as evidence in court.
    g. Text messaging and emails may not be secure, so someone else might be able to see them.
    h. Someone could find out about anything said in text and email messages, such as which services you get through us.

3. Rules for using text messaging and email: Because of the risks talked about above, IDHW-DBH cannot guarantee, but will do our best to keep all messages private. To use email and text with us, you have to read and agree to these rules:
    a. **IN AN EMERGENCY DO NOT USE TEXT OR EMAIL. CALL 911!** Do not text or email us for urgent problems. If you have an urgent problem during regular business hours, please call the main office or 911. Call us if you need to tell us something that cannot wait.

b. Text messages and email may be added into your health record.
c. Clinical staff will not forward your identifiable texts and email.
d. If you or someone else lets someone else see the messages, IDHW-DBH is not responsible for that.
e. It is your responsibility to follow up with your staff person if needed.

4. Withdrawal of consent: I understand that if I don't want IDHW-DBH to use text messaging or emails with me anymore, I can say so in a letter at any time. If I don't want to use text messaging or email with IDHW-DBH anymore, I will still be able to get the treatment or services that I am qualified for.
5. Client Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks of using text messaging and email as a way to talk with IDHW-DBH staff. I agree to the rules in this form, and any other rules about text message or email that IDHW-DBH may tell me.

Print Name	Signature	Date

Phone Number: _____ Email: _____

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Notice of Privacy Practices

Effective September 23, 2013

HW-0320
Revised 08/2013

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

- If you have any questions about this Notice, please contact the Idaho Department of Health and Welfare's Privacy Office at 208-334-6519 or by email at PrivacyOffice@dhw.idaho.gov.
- You may request a copy of this Notice at any time. Copies of this Notice are available at the Department of Health and Welfare offices. This Notice is also available on the Department of Health and Welfare's website at http://www.healthandwelfare.idaho.gov.

PURPOSE OF THIS NOTICE

This Notice of Privacy Practices describes how the Idaho Department of Health and Welfare (Department) handles confidential information, following state and federal requirements. All programs in the Department may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The Department may also share your confidential information with others outside of the Department as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the Department. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.
We are required to:

- Use and disclose confidential information as required by law;
- Maintain the privacy of your information;
- Give you this Notice of our legal duties and privacy practices for your information; and
- Follow the terms of the Notice that is currently in effect.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. **Right to Review and Copy**
   You have the right to ask to review and copy your information as allowed by law.

   If you would like to ask to review and copy your information, a "Records Request" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

   If you ask to receive a copy of the information, we may charge a fee.

   You will be told if there is information we are legally prevented from disclosing to you.

2. **Right to Amend**
You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask the Department to change your information, a "Request to Amend Records" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request within 10 days.

We may deny your request if you ask us to change information that:

- Was not created by the Department;
- Is not part of the information kept by or for the Department;
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. **Right to Restrict Health Information Disclosures**
You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask the Department to not share your information, a "Request to Restrict Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request in writing.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction. In situations where you or someone on your behalf pays for an item or service, and you request that information concerning said item or service not be disclosed to a health insurer, we will agree to the requested restriction.

4. **Right to an Alternate Means of Delivery**
You have the right to ask that we communicate with you by alternative means or at alternative locations. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery for your information, a "Request for Alternate Means of Delivery" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request if it is denied for some reason.

We will not ask you the reason for your request. Reasonable requests will be approved.

5. **Right to a Report of Health Information Disclosures**
You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request to Receive a Report of Health Information Disclosures" form is available at Department offices or its website. You must complete this form and return it to the Department. The Department will respond to your request according to the Idaho Public Records Act and the federal HIPAA Laws.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are charged to you.

HOW THE DEPARTMENT MAY USE AND SHARE YOUR INFORMATION

Times when your permission is not needed

- **For Treatment.** We may use and share your information to give you benefits, treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs in the Department may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the Department who are involved in your care or payment of care, such as family members, informal or legal representatives, or others that give you services as part of your care.

- **For Payment.** We may use and share your information so that the treatment and services you receive through the Department can be paid. For example, we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.

- **For Business Operations.** We may use and share your information for business operational purposes. This is necessary for the daily operation of the Department and to make sure that all of our clients receive quality care. For example, we may use your information to review our provision of treatment and services and to evaluate the performance of our staff in providing services for you.

Times when your permission is needed

- **For reasons other than Treatment, Payment or Business Operations.** There may be times when the Department may need to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example, if the Department is asked for information from your employer or school that is not part of treatment, payment or business operations, the Department will ask you for a written authorization permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time, if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.

- **Individuals that are part of your care or payment for your care.** We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to say yes or no to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster so that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- For Appointment Reminders
- For Treatment Alternatives
- As Required by Law
- For Public Health Risks
- To Law Enforcement
- For Lawsuits and Disputes
- To Coroners, Medical Examiners, Funeral Directors
- For Organ and Tissue Donation
- For Emergency Treatment
- To Prevent a Serious Threat to Health or Safety
- To Military and Veterans Organizations
- For Health Oversight Activities
- For National Security and Intelligence Activities
- To Correctional Institutions

SPECIAL REQUIREMENTS

Information that has been received from a federally funded substance abuse treatment program or through the infant and toddler program will not be released without specific authorization from the individual or legal representative.

Affected individuals will be notified following a breach of unsecured health information.

CHANGES TO THIS NOTICE

The Department has the right to change this Notice. A copy of this Notice is posted at our Department offices or at http://www.healthandwelfare.idaho.gov. The effective date of this Notice is shown at the top of each page. If the Department makes any changes to this Notice of Privacy Practices, the Department will follow the terms of the Notice that is currently in effect.

COMPLAINTS

If you believe your confidential information privacy rights have been violated, you may file a written complaint with the Idaho Department of Health and Welfare. All complaints turned in to the Department must be in writing on the "Privacy Complaint" form that is available at Department offices or its website. To file a complaint with the Department, submit your completed Privacy Complaint form to:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

If you believe your health information privacy rights have been violated, you may also file a complaint with the U. S. Department of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Region 10
Office for Civil Rights
U. S. Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

For all complaints filed by e-mail send to OCRComplaint@hhs.gov.

A complaint filed with either the Idaho Department of Health and Welfare or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.

Adult Mental Health Client Information & FAQs About Idaho Health Data Exchange (IHDE)

Beginning September 3, 2019, certain client data will be transmitted from the Division of Behavioral Health (DBH) electronic health record system to the IHDE system to improve service coordination and delivery for clients served by DBH.

What is the Idaho Health Data Exchange (IHDE)?

IHDE is a secure statewide internet-based health information exchange with the goal of improving the quality and coordination of health care in Idaho. IHDE enables healthcare providers and medical staff quick, secure access to important health information about their patients at the point of care.

How does sharing health information improve patient care?

Physicians and their medical staff need your current and past history to accurately diagnose and treat you. Each physician who treats you may have just a portion of your medical record. When providers access each other's records through the IHDE, they have more complete health information and make informed decisions that ultimately lend to better care for their patients.

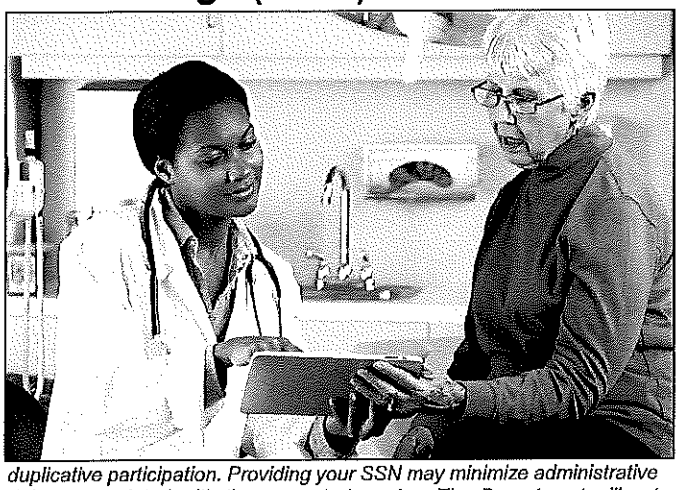
What information from my DBH record may be viewable by IHDE authorized users?

The following information from the DBH regional electronic health record system will be available to authorized users of IHDE:

- Last Name
- First Name
- Social Security Number*
- Birth Date
- Gender
- Race
- Address
- Phone Number
- Marital Status
- Primary Care Physician Information
- Behavioral Health Services Information
    - Location where services are provided
    - Service Date
    - Service Type (behavioral health codes)
- Admission Date
- Discharge Date
- Allergies
- Medication dispensed by Idaho Department of Health and Welfare Division of Behavioral Health
- Insurance Plan coverage information

*The Social Security Number (SSN) does not display in the IHDE portal but is collected for the purpose of identification of the participants, and prevention of duplication of benefits and information. The SSN is a fundamental component for case management and care coordination activities.

The Department of Health and Welfare is authorized to collect and use the SSN to determine Medicaid eligibility, verify information, and prevent duplicative participation. Providing your SSN may minimize administrative delays associated with the requested service. The Department will not disclose an individual's SSN without the consent of the individual to anyone outside of the Department except as mandated by law.; 5 U.S.C. 552a; IDAPA 16.05.03.103; 42 CFR §435.910.



Why would I want my information available through IHDE?

By using IHDE, physicians and medical staff can quickly access information such as lab test results that another provider may have ordered. Making this information available to a physician treating you enables them to make more informed decisions regarding your care.

Having access to this information may also reduce the number of tests that are ordered which can help save you time and money.

With the information provided through IHDE, your physician and medical staff can review current medications. This can help ensure you are not given medications to which you are allergic or that should not be taken with another medication.

Through IHDE, emergency physicians and staff can get vital medical information to treat you in case of an emergency when you might not be able to communicate.

How does my information get into the IHDE?

DBH client information is transmitted securely from the DBH electronic health record system to the IHDE on a daily basis.

Who will have access to my information in IHDE?

Health care providers, this includes physicians, clinical, and medical staff in Idaho who are enrolled to participate in IHDE. These participants may ONLY access data for purposes of treatment, payment, and healthcare operations which promote efficiency of communication in care, patient safety, and enhance patient health. These participants also must abide by the IHDE programs and policies which include privacy, security and HIPAA standards. Use of the IHDE system for any other reason is strictly prohibited. You can obtain a current list of IHDE participants by visiting www.idahohde.org.

(continued next page)

How is my health information shared between providers without the IHDE?

Without use of the IHDE, your health information is shared between providers by telephone, fax, mail carrier, or through limited computer networks. These processes take time, are costly and may impose a burden on you or your provider. IHDE allows a participant such as a physician, to locate records from another data source participant, such as a hospital, in a matter of minutes. It can result in your provider having a more complete an accurate health record.

What if I don't want my information to go to the IHDE?

You may request to opt-out of having your health information transmitted to the IHDE by using the Request to Restrict Disclosure Form. You will need to complete, sign, and submit the form on your own. The DBH staff can provide the opt-out form to you, but they are not allowed to submit it for you.

- Fax to: (208) 803-0031
  ATTN: Idaho Health Data Exchange, **OR**
- Mail to: Idaho Health Data Exchange
  PO Box 6978
  Boise, ID 83707

If you opt-out, your health information will not be viewable or useable in IHDE. Only your name, date of birth, and gender will be available.

If I opt-out, can I change my mind later?

Yes. If you opt-out of having your health data transmitted, you can change your mind and opt back in and revoke your request to opt-out. You can call IHDE or visit the IHDE website to find out how to revoke the request. Your signature on a request to revoke a restriction must be notarized. When you revoke a request to restrict, all the information that has been gathered since you made your request will be available through IHDE.

How is my privacy protected?

Information shared through the IHDE is mandated to meet specific technical protections under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA regulates the use and/or disclosure of your personal health information for purposes of treatment, payment, and operations.

IHDE and participating providers use a combination of safeguards to protect your health information. Technical safeguards include encryption, password protection, and audit logs that track every participant's use of the system. Administrative safeguards include written policies that require limited access to information through IHDE. All participating providers must agree to follow these policies. All participating providers are also regulated by HIPAA, and other federal and state privacy laws. They must have their own policies and other safeguards in place, including policies to train their staff and limit access to those who have a need to know.

Where can I get more information on IHDE?

For help understanding the benefits of IHDE and for more information, please contact IHDE at:

- Phone: (208) 803-0030
- E-mail: info@idahohde.org
- Website: www.idahohde.org

Have questions not covered by this flyer or have concerns?

Please speak with your local Idaho Department of Health and Welfare Mental Health office.

healthandwelfare.idaho.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Acknowledgement of Receipt of the Notice of Privacy Practices and Idaho Health Data Exchange Client Information

(For Division of Behavioral Health use only)

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.
Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name_____
(Please Print your First Name, Middle Initial and Last Name)

By the signature below, I acknowledge that I have received the Notice of Privacy Practices provided by the Idaho Department of Health and Welfare and the Idaho Health Data Exchange (IHDE) Client Information and Frequently Asked Questions (FAQs) specific to Adult or Children's Mental Health.

Your Signature: _____ Date: _____

HW-0735
Rev. 3-10-09

DEPARTMENT OF HEALTH AND WELFARE
MENTAL HEALTH SERVICES
FEE DETERMINATION

SECTION I – CLIENT/RESPONSIBLE PARTY INFORMATION:

Client's Name: _____ SSN: _____
Medicaid Number: _____

Responsible Party: _____ Relationship: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____

Do you have Insurance: ___Yes ___No Name of Insured: _____
Insurance Company: _____ Telephone: _____
Address: _____
Group Number: _____ Subscriber Number: _____

Does your spouse have Insurance: ___Yes ___No Name of Insured: _____
Insurance Company: _____ Telephone: _____
Address: _____
Group Number: _____ Subscriber Number: _____

Section II – FEE DETERMINATION:
(Your income, minus allowable deductions and the number of dependents in your household will be used with our sliding fee scale to determine what percentage of our fees you will be required to pay.)

Gross Monthly Income for **Adult** Clients:

1. Self _____
2. Spouse _____
3. Other _____
4. Total _____

Gross Monthly Income for **Child** Clients:

1. Self _____
2. Father _____
3. Mother _____
4. Other _____
5. Total _____

Number of Dependents in Household: _____

Allowable Monthly Deductions:
1. Court Ordered Obligations: ..... _____
2. Dependent Support: ..... _____
3. Child Care Expenses Necessary for Parental Employment: ..... _____
4. Medical Expenses: ..... _____
5. Transportation: ..... _____
6. Extraordinary Rehabilitative Expenses: ..... _____
7. State and Federal Tax Payments (including FICA taxes): ..... _____
8. Total Monthly Deductions: ..... _____

(Office Use Only)

Sources of Income/Deduction Verification: _____

Total Monthly Income: ..... _____
Allowable Monthly Deductions: - _____
Adjusted Monthly Income: ..... _____ X 12 = _____ Adjusted Annual Income.

SECTION III – PAYMENT AGREEMENT:

Under Sections 16-2433, 19-2524, 20-520(i), 20-511A, and 39-3137, Idaho Code, the Director is authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers. Under Section 39-309, Idaho Code, the Board of Health and Welfare is authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers.

Based on your adjusted annual income and the number of dependents, it has been determined that your financial responsibility will be _____ percent of the fees charged for services. This includes any portion of your fees not covered by insurance, CHAMPUS, or services not covered by Medicaid.

I affirm that the statements made by me herein are true and correct to the best of my knowledge.

I understand that I am responsible for the total amount due by me and agree to pay at the time of service or on a monthly basis as per prior arrangements. If it becomes necessary for the Department to initiate collection action to recoup unpaid fees, I understand that I am responsible for all cost incurred by the Department.

_____ _____

Client/Parent/Responsible Party Signature Date

I affirm that I have requested verification of income and allowable monthly deductions from the family. I have accurately and completely documented all information made available to me, attached copies of all available documents verifying income and monthly expenses, and used information provided to me to calculate the family's financial responsibility according to Division of Behavioral Health rules.

_____ _____

Staff Signature Date

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Behavioral Health
CLIENT'S RIGHTS AND RESPONSIBILITIES

In accordance with IDAPA 16.07.33-Adult Mental Health Services, each individual Client receiving adult mental health services through the Department must be notified of their rights and responsibilities prior to the delivery of adult mental health services. At a minimum, the Client has the following rights:

1. The right to impartial access to treatment and services, regardless of race, creed, color, religion, gender, national origin, age or disability.

2. The right to a humane treatment environment that ensures protection from harm, provides privacy to as great a degree as possible with regard to personal needs and promotes respect and dignity for each individual.

3. The right to communication in a language and format understandable to the individual client.

4. The right to be free from mental, physical, sexual, and verbal abuse, as well as neglect and exploitation.

5. The right to receive services within the least restrictive environment possible.

6. The right to an individualized treatment plan, based on assessment of current needs.

7. The right to actively participate in planning for treatment and recovery support services.

8. The right to have access to information contained in one's record, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan.

9. The right to confidentiality of records and the right to be informed of the conditions under which information can be disclosed without the individual client's consent.

10. The right to refuse to take medication unless a court of law has determined the client lacks capacity to make decisions about medications and is an imminent danger to self or others.

11. The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.

12. The right to refuse to participate in any research project without compromising access to program services.

13. The right to exercise rights without reprisal in any form, including the ability to continue services with uncompromised access.

14. The right to have the opportunity to consult with independent specialists or legal counsel, at one's own expense.

15. The right to be informed in advance of the reason(s) for discontinuance of any service provision, and to be involved in planning for the consequences of that event.

16. The right to receive an explanation of the reasons for denial of service.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Behavioral Health
ACKNOWLEDGEMENT OF RECEIPT OF CLIENT'S RIGHTS AND RESPONSIBILITIES

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de interprete sin costo alguno. Llame at 2-1-1 al 1-800-926-2588 para obtener la syuda de un intprete.

By the signature below, I _____ acknowledge that I have
(Print Name)

received the Client's Rights and Responsibilities provided by the Idaho Department of Health and Welfare, Division of Behavioral Health.

Date: _____ Client Signature: _____

Date: _____ Parent/Guardian Signature: _____

Date: _____ Witness: _____

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Behavioral Health
Notice of Administrative Appeal Rights

The Division of Behavioral Health provides formal and informal opportunities for clients to have input regarding the care they are provided. The Division of Behavioral Health encourages resolution of any complaints or concerns be addressed informally whenever possible.

You should be aware of rules governing contested case proceedings, noted below. However, if you have a complaint or concern about services you or your child received from a state-operated Regional Clinic, you may want to first talk to the clinic staff or managers where services were received. If a concern still exists, you may bring it to the attention of the Regional Behavioral Health Program Manager.

If your concern is about a decision notice by the Behavioral Mental Health Program, and it remains unresolved, then you have the right to pursue an administrative appeal under IDAPA 16.05.03.

How to ask for an appeal:

Step 1:
Under IDAPA 16.05.03.101.01, appeals must be filed by you or your representative and must include:

- Name (if this is a service provided for your child, please put the name of your child)
- Address
- Phone number
- Copy of the decision notice that is the subject of the appeal and the reason for the disagreement with the decision
- Remedy requested
- Any evidence you want to be considered

Step 2:
Mail, fax, or deliver your appeal to: 450 West State Street 10th floor
P.O. Box 83720, Boise, ID 83720-0036
Phone: (208) 334-5564
FAX: (208) 639-5741

The time limit for filing an appeal is twenty-eight (28) days from the date the decision is mailed. An appeal is filed when it is received by the Department, or if mailed, when it is postmarked within the time limits provided in the decision notice. IDAPA 16.05.03.101.02.

Idaho Department of Health & Welfare
Authorization for Disclosure

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Information

Client Name_____ Date of Birth _____Telephone _____
(First, MI, Last)

Mailing Address _____State_____Zip Code_____

Requestor Information
(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority).

Requestor Name (if different than client) _____Telephone _____

Mailing Address _____State_____Zip Code_____

Authorization Details

I authorize the following individual, organization or business _____

_____

to disclose my confidential information to: Name_____

Address:_____ State_____Zip Code_____

for the purpose of _____

*Please describe in detail the information to be disclosed*_____

_____

_____

_____

This authorization will expire in 6 months unless another date or event is specified here_____

_____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to a Department of Health and Welfare office. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

Your signature _____**Date** _____

Your signature must be notarized if we are unable to verify your identity and you submit this request by mail.