



**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)



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 español. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 al 1-800-926-2588 para obtener la ayuda de un intérprete.

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.



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- 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.



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____ 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.



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- 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: _____



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

Effective 09/23/2013

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.

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

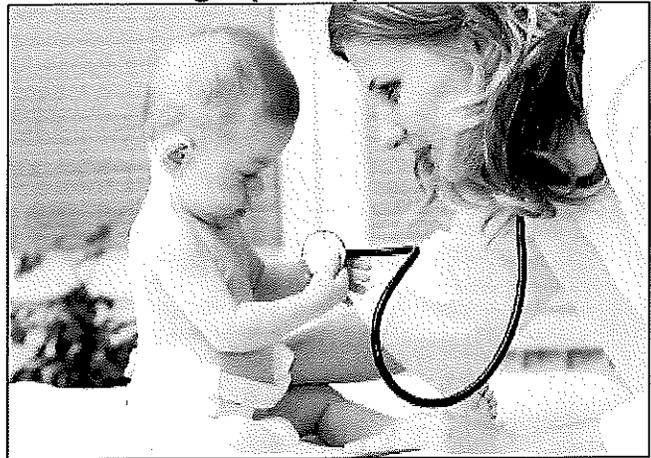
What information from my child's DBH record may be viewable by IHDE authorized users?

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 child's 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 your child enables them to make more informed decisions regarding your child's 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 child's physician and medical staff can review current medications. This can help ensure your child is not given medications to which they are allergic or that should not be taken with another medication.

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

How does my child's 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 child's 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 child's health information shared between providers without the IHDE?

Without use of the IHDE, your child's 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 child's provider having a more complete and accurate health record.

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

You may request to opt-out of having your child's 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 child's health information will not be viewable or useable in IHDE. Only your child's 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 child's 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 child's 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 personal health information for purposes of treatment, payment, and operations. IHDE and participating providers use a combination of safeguards to protect your child's 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



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 español. 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: _____

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:

Gross Monthly Income for Child Clients:

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

- 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

FAMILY EDUCATION AND SUPPORT SERVICES AUTHORIZATION FOR RELEASE OF INFORMATION

The Idaho Department of Health and Welfare contracts with Idaho Federation of Families for Children's Mental Health to provide education and support services to the families that are served by the Department's Children's Mental Health Program. By completing this form, you are authorizing the Department of Health and Welfare to release the information contained on this form to the Idaho Federation of Families. If at any time you, as the parent/guardian, wish to revoke your authorization or terminate your relationship with the Idaho Federation of Families, you may do so by contacting the Department of Health and Welfare or the Idaho Federation of Families.

I, _____, do hereby authorize the **Department of Health and Welfare** to release the information contained on this form to the Idaho Federation of Families.

Name of Person Completing this Form	_____
Family Address	<i>Clinician's Signature</i> _____ <i>Street Address</i> _____ <i>City</i> _____ <i>State</i> _____ <i>Zip Code</i> _____
Mailing Address <i>(If Different)</i>	_____ <i>Mailing Address</i> _____ <i>City</i> _____ <i>State</i> _____ <i>Zip Code</i> _____
Phone Number	() - _____
Email Address	_____
Name of Child	_____

By signing below, I understand that the Idaho Federation of Families will:

(Check preferences)

- Place my name on their mailing list to receive information on training and family support services.
- Contact me directly to offer education and support services to me and my family or provide training on how I can advocate for myself and other families in Idaho.

(Parent or Guardian Signature)

(Date)

INITIAL HISTORY QUESTIONNAIRE

Form Completed by: _____ Date Completed: _____

Name of Child: _____ Age: _____

Date of Birth: _____ M F

FOR OFFICE USE ONLY

WITS ID #: _____

Priority Population #1 #2 #3

Household

Please list all those living in the child's home

Name	Relationship to child	Birth date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent(s) not in the home? _____

Physician: _____ Last Seen _____

Dentist: _____ Last Seen _____

Birth History

Birth weight _____

Was the delivery Vaginal? Cesarean?

Was the baby born at term? Yes Early? Late?

If cesarean, why? _____

If early, how many week's gestation? _____

Did the baby have any problems right after birth?

Yes No Explain _____

Prenatal Care

Did mother have any illness or problem with her pregnancy?

Yes No Explain _____

Was initial feeding Breast? Bottle?

During pregnancy, did mother

Smoke Yes No Drink alcohol Yes No

Did the baby go home with mother from the hospital?

Use drugs or medication Yes No

Yes No Explain _____

What _____ When _____

General

Do you consider your child to be in good health? Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? Yes No Explain _____

Has your child had any surgery? Yes No Explain _____

Has your child ever been hospitalized? Yes No Explain _____

Is your child allergic to any medicine or drugs? Yes No Explain _____

Development

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

Is your child in school? Yes No Home schooled

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? Yes No If yes explain _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes, or has an IEP? Yes No If yes explain _____

Child's Past History

Does your child have, or has he/she ever had?

Chickenpox Yes No When _____

Frequent ear infections Yes No Explain _____

Problems with ears or hearing Yes No Explain _____

Nasal allergies Yes No Explain _____

Problems with eyes or vision Yes No Explain _____

Asthma, bronchitis, bronchiolitis, or pneumonia Yes No Explain _____

Any heart problem or heart murmur Yes No Explain _____

Child's Past History (cont.)

Does your child have, or has he/she ever had?

Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Bladder or kidney Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
(For girls) Has she started her menstrual periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When _____
(For girls) Are there problems with her periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Convulsions or other neurological problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Thyroid or other endocrine problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Any other significant problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____

Family History

Please indicate if any of the child's family members have had any of the following:

Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Heart attack (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
High blood pressure (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Liver disease (Hepatitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Diabetes (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Epilepsy or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Mental retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Involvement with law enforcement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Additional family history	_____		

Child's Emotional / BehavioralHas your child's behavior, thinking, and/or feelings made a turn for the worse since being on a particular medication, developing a physical illness or physical trauma? Yes No If yes, explain _____

Do you suspect that your child uses alcohol or drugs?

- No, I know for sure that my child doesn't use any of those things
 I am not sure, sometimes I wonder if my child uses alcohol or drugs
 Yes, I know for sure that my child uses alcohol or drugs

Does your child act as if he or she is hearing voices that only he/she can hear?

- I don't know
 No
 Yes, some of the time
 Yes, most of the time
 Yes, all of the time

Child's Emotional / Behavioral (cont.)

Does your child act as if he/she is seeing things that only he/she can see?

- I don't know
- No
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Please rate each the following emotions

- | | | | |
|---|---|---|---|
| My child seems <i>happy</i> | My child seems <i>sad</i> | My child seems <i>anxious</i> | My child seems <i>irritated</i> |
| <input type="checkbox"/> All of the time |
| <input type="checkbox"/> Most of the time |
| <input type="checkbox"/> Some of the time |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Rarely | <input type="checkbox"/> Rarely | <input type="checkbox"/> Rarely |
| <input type="checkbox"/> None of the time |

Does your child have significant sleeping problems (for example: he sleeps too much or too little, or his sleep is often interrupted)?

- No
- Yes, but rarely
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Does your child seem no longer interested in doing things that he/she usually enjoys (for example: talking to friends, fishing) ?

- No
- Yes, but rarely
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Does your child ever talks about suicide or attempted suicide before? Yes No If yes explain _____

Does your child seem to worry too much about any particular member of your family's well being for no apparent reason?

- Yes No If yes, explain _____

Does your child complain about feeling sick or having an illness or disease that you know doesn't exist?

- Yes No If yes, explain _____

Does your child have trouble being apart from you or your home to the point that he/she becomes excessively worry?

- Yes No If yes, explain _____

Does your child fear being humiliated in social setting or situations?

- Yes No If yes, explain _____

Please indicate which of the following strong fears, if any, your child displays. These are fears that would usually cause him/her to feel very nervous, make him cry, throw tantrums, freeze, or cling to an adult.

- A particular animal such as dogs No fears
- A particular insect such as spiders
- Objects in the natural environment such as storms
- Seeing blood or an injury or receiving an injection
- Specific situation such as tunnels, heights, flying, etc.

Has your child ever experienced a trauma or shock in his lifetime that still bothers him/her?

- Yes No If yes, please explain _____

Child's Emotional / Behavioral (cont.)

Please rate the following behaviors

My child pays attention very well

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child has respect for rules or for authority

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child is as active as any other child of his/her age

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child plays well with others

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

My child has consideration for the rights of others

- All of the time
- Most of the time
- Some of the time
- Rarely
- None of the time

Does your child have any history of sexual abuse as a

Victim Yes No Perpetrator Yes No

Does your child have any history of physical abuse as a

Victim Yes No Perpetrator Yes No

Has your child had any contact with law enforcement, Department of Juvenile Corrections, or Juvenile Probation before?

Yes No If yes, please explain _____

Does your child have any odd or unusual behavior that concerns you very much? Yes No If yes, explain _____

Please provide a list of your child's strengths:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

Please provide a list of child's weaknesses:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

By the signature below, I acknowledged that I have read and understood this questionnaire and provided information to the best of my knowledge and ability.

Signature/Date

THANK YOU!



Client Information and FAQs About ICANS

What is ICANS?

ICANS is an electronic, internet-based system used to administer and manage the Children and Adolescent Needs and Strengths (CANS) Assessments in Idaho.

Why would I want my child's information available in ICANS?

The Child and Adolescent Needs and Strengths (CANS) is a tool for measuring your child's needs and strengths, as well as the family's. The CANS will be used in Idaho to help determine a child or youth's level of functional impairment and guide treatment planning decisions. In Idaho, the ICANS will also help clinicians and other providers of children's mental health services to recommend, and plan for the appropriate level of care. Identification of functional impairment and informing treatment decisions are key pieces to the use of the ICANS in Idaho.

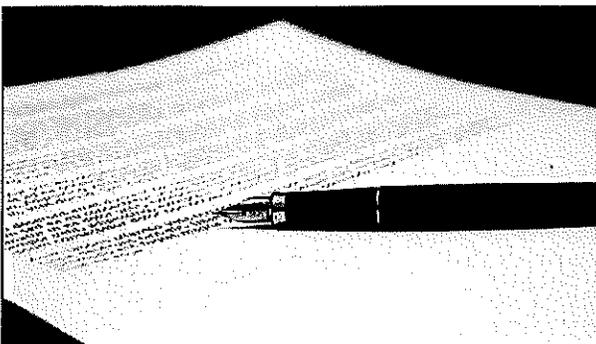
Permitting your child's information to be entered into the ICANS allows it to be available to authorized providers and staff to make more informed, collaborative decisions regarding your child's mental health services and care.

To participate in or receive certain state-funded programs, such as the Youth Empowerment Services (YES Program), a child/youth will need to complete a CANS Assessment.

ICANS is the state-approved platform to administer and score the CANS. By not allowing your child's information to be available in ICANS your child may not be able to access certain state-funded services or programs.

Who will have access to your child's information in ICANS?

Only authorized users will have access to your child's information in ICANS.



Examples of potential authorized users may include, but are not limited to:

- Division of Behavioral Health Children's Mental Health staff.
- Division of Family and Community Services (FACS) staff, including Developmental Disabilities and Child Welfare if your child is involved in their programs.
- Medicaid and/or Optum staff who are responsible for the coordination, payment, and quality management of behavioral health services in Idaho.
- Independent Assessment providers, who are contracted by Medicaid, who will assess children for eligibility for some state-funded children's mental health services.

ICANS users must also abide by the ICANS policies and procedures which include Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy and security standards. Use of the ICANS system for any other reason is strictly prohibited.

What is an authorized user?

An authorized user is an individual designated by a provider agency or Idaho Department of Health and Welfare Division of Behavioral Health needing to access ICANS for their job.

Who may input my child's information in ICANS?

The agency that you have named at the top of the informed consent has permission to add your child's information to ICANS.

What information may be viewable by ICANS authorized users?

It is important for you to know what information entered into ICANS is viewable to all authorized users. It is also important for you to know that not all information entered into the ICANS system is shared with authorized users.

Only the following information in the ICANS system may be shared with authorized users:

- Last Name
- First Name
- Birth Date
- Social Security Number*
- Gender
- Race
- Ethnicity
- Address
- Identifiers (other numbers such as Medicaid ID number)

*The Social Security Number (SSN) is collected for the purpose of identification of the participants, prevention of duplication of benefits and information. The SSN is a fundamental component for case management and care coordination activities.

The following information in the ICANS system is not shared with authorized users:

- Diagnosis(s)
- Any information related to Substance Use.
- Ratings on any of the CANS items.
- Comments entered into ICANS related to the CANS scoring.
- Recommended Level-of-Care outcomes

Why do I need to complete and sign the informed consent?

By completing and signing the informed consent release form, you allow the agency listed to release, use, receive, exchange, communicate with, and disclose information with authorized agencies and/or users with access to ICANS.

Without the completed and signed informed consent release form, your provider cannot enter your child's information in ICANS.

Can I revoke the informed consent release form?

You may revoke the informed consent release form at any time. This will prevent any future use on ICANS but will not change any action that has already taken place using the informed consent release form.

After the informed consent release form has been revoked, the informed consent release form is no longer valid from that date forward. Copies or exact reproduction

of the completed and signed informed consent release form will have the same force and effect as the original.

How is my child's privacy protected?

Information shared through ICANS is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; 45 C.F.R. Parts 160 & 164; and the Medicaid Act, 42 C.F.R. Part 431, Subpart F.

The ICANS system and participating providers use a combination of safeguards to protect your child's health information.

Technical safeguards include encryption, password protections, and audit logs that track every participant's use of the system.

Administrative safeguards include written policies that require limited access to information through ICANS. All participating providers must agree to follow these policies. The ICANS Security Safeguards can be found online at: <http://icans.dhw.idaho.gov/ResourcesandUserGuide/tabid/4105/Default.aspx>

All participating providers are also regulated by HIPAA, and other federal and state privacy laws. Providers must also 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.



Have questions not covered by this flyer or have concerns?

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

healthandwelfare.idaho.gov



IDAHO DEPARTMENT OF
HEALTH & WELFARE



ICANS Informed Consent

I, _____ (*parent's name*), am the parent or legal guardian of

_____ (*minor client's name*).

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency _____ (*name of provider/agency/organization*) to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.

I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.

I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

EXPIRATION

This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT

I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	Relationship to Client	Date
Full Legal Signature of Parent or Legal Guardian – <i>Required if Client is under 16 years of age, but only after signed by client.</i>	Relationship to Client	Date
Full Legal Signature of Witness (Agency Employee)	Initiating Agency Name	Date



IDAHO DEPARTMENT OF
HEALTH & WELFARE

To file a complaint or concern at the Regional Clinic
level please call:

Region 1	Coeur d'Alene/Kellogg Sandpoint/Ponderay	208-769-1406 208-769-1406
Region 2	Grangeville Lewiston Moscow	208-983-2300 208-799-4440 208-882-0562
Region 3	Caldwell/Nampa Payette	208-459-0092 208-642-6416
Region 4	Boise/Mountain Home	208-334-0981
Region 5	Twin Falls Burley	208-732-1630 208-677-5390
Region 6	Pocatello	208-234-7900
Region 7	Idaho Falls/Rexburg Salmon Blackfoot	208-528-5700 208-785-5871

Telephone: Non-Emergency Line for
Central Office:
1-855-643-7233
Local 208-334-6870

Address: 450 W State St. 3rd Floor
Boise, ID 83702

Email: yes@dhw.idaho.gov

Visit the websites for more information:

www.yes.idaho.gov

[http://healthandwelfare.idaho.gov/Medical/MentalHealth/
ChildrensMentalHealth](http://healthandwelfare.idaho.gov/Medical/MentalHealth/ChildrensMentalHealth)



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Behavioral Health
Children's Mental Health

CONCERN & COMPLAINT

RESOLUTION PROCESS

- ◆ Idaho's child serving mental health system of care respects the right of any family and youth to complain about any aspect of mental health service delivery.
- ◆ Families and youth have a right to be informed of their right to express and report their complaints to have them reviewed, investigated, and resolved promptly.
- ◆ The decision of a family and youth to file a complaint will not interfere with the quality of care and continued services.

Concern and Complaint Resolution Process

The Division of Behavioral Health provides formal and informal opportunities for families and youth to have input regarding the care they are provided.

The Division of Behavioral Health has adopted the following standards in pursuit of this goal:

- * *Caring*
- * *Competence*
- * *Communication*
- * *Convenience*

Resolving Concerns and Complaints Informally

The Division of Behavioral Health encourages resolution of concerns and or complaints informally whenever possible. If you have a concern or complaint about services you received from a State operated Regional Clinic (See the list of clinics on the back page of this brochure) you may want to talk first to the staff or managers of the clinic where services were delivered.

This type of concern or complaint can be made by telephoning, mailing, or emailing the CMH Regional Clinic listed on the back page.

Step 1 Filing a Formal Complaint

Formal complaints can be made by telephoning, mailing, or emailing the following:

Telephone: Toll Free Non-Emergency Line:
1-855-643-7233
or 208-334-6870 (Local)
Address: 450 W State St. 3rd Floor
Boise, ID 83702
Email: yes@dhw.idaho.gov

You will be asked to provide the following information:

1. Name, DOB
2. Contact Information (phone number, address)
3. Explanation of the Complaint
4. Are you wanting services to be continued (if applicable)
5. How you would like the issue resolved

The Complaint will be forwarded to a designated Complaints Committee. The goal is to ensure that complaints are addressed efficiently and effectively and that complainants have confidence in the our agency to meet their needs and concerns.

Step 2 Acknowledgment of the Complaint

All formal complaints will be responded to with an acknowledgement letter of receiving the complaint within five days.

Step 3 Investigating the Complaint

The Complaints Committee will review the complaint to make recommendations for a resolution. The Complaints Committee will be composed of at least three individuals, none of which would be directly involved in the complaint.

Step 4 Resolution of the Complaint

Within 30 days, following a review of the complaint, a written response will be sent to you. The response will include a summary of the investigation and findings. While transparency is the goal, nonetheless, when providing the findings of the complaint, consideration is given to any confidential or privacy information that may not be available for release.

Note for complaints about Medicaid services please call the Optum Member line at 1-855-202-0973.



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 español. Proveenmos 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.