Sierra County Health and Human Services

Social Services	Public Health	Behavioral Health	HHS Satellite Office
P.O. Box 1019	P.O. Box 7	P.O. Box 265	P.O. Box 38
Loyalton, CA 96118	Loyalton, CA 96118	Loyalton, CA 96118	Downieville, CA 95936
202 Front Street	202 Front Street	704 Mill Street	22 Maiden Lane
(530) 993-6720	(530) 993-6700	(530) 993-6746	(530) 289-3711
Fax (530) 993-6767	Fax (530) 993-6790	Fax (530) 993-6759	Fax (530) 289-3716
Lori McGee, INT Director	Rhonda Grandi, INT Director	Sheryll Prinz-McMillan, Director	

Thank you for making your first appointment with Sierra County Behavioral Health.

In order for us to provide services, please fill out the entire intake packet prior to your first appointment. At this time, please provide a valid picture ID, Sierra County Medi-Cal card and proof of residence such as a utility bill showing your physical address and your name. If the packet is not filled out in full or you have forgotten to bring it with you, we will need to reschedule your appointment. This may cause a delay in you receiving services.

Should you need assistance in filling out the paperwork, call our office at 530-993-6746 during normal business hours and we will be glad to assist you. You may request alternative formats. Our office is opened: M-F 8am-5pm; closed 12pm-1pm for lunch and on major holidays. For after-hours you can also call our toll free access line **1-888-840-8418.**

If you feel you are in crisis, please call our office during normal business hours. For after hours and weekends, call our 24-hour crisis line **1-833-723-2968 or 988** to speak with an on-call crisis worker.

Thank you for the opportunity to work with you,

Behavioral Health Front Desk.

Placer/Sierra County Systems of Care

Distribution of Mental Health Plan (MHP) Informing Materials

Check all that apply	Informing Materials Provided also available on our website: *http://sierracounty.ca.gov/181/Behavioral-Health*
ALL ☐	**Notice of Privacy Practices (HIPAA 03)** The Notice of Privacy Practices tells you how the Placer County and/or Sierra County may use or disclose information about your physical and/or mental health. The county is required by federal law to give you this notice.
ALL ☐	**Systems of Care (SOC) Client & Family Information Brochure** The Client & Family Information Brochure is a brief, easy to ready summary of all the services available in the Systems of Care with quick contact numbers.
ALL ☐	**Systems of Care (SOC) Grievance Form and Procedure (CARE-020)** The SOC Grievance Form is a tool to help you file a complaint about your services if you need to at some point. The procedure tells you how to file the complaint.
ALL ☐	**Informed Consent (CARE-440)** The Informed Consent Form outlines the expectations regarding the treatment you will receive. It also explains that the risks, benefits, and alternatives to treatment have been explained to you.
ALL ☐	**Formal Request for Change of Provider Form/Request for Second Opinion (CARE-084)** The Formal Request to Change a Provider/Request for Second Opinion Form is a tool to help you to change the person who is providing your service or to receive a consultation from a second provider.
Medi-Cal ☐	**Placer/Sierra County MHP "Guide to Medi-Cal Mental Health Services"** The MHP "Guide to Medi-Cal Mental Health Services" contains information on how a person is eligible for mental health services through Medi-Cal. It also explains how to access those services, what services are available, what your rights and responsibilities are, and how to file a grievance or file for a state fair hearing. The guide contains important phone numbers regarding our Mental Health Plan (MHP). *Download a copy at: http://sierracounty.ca.gov/181/Behavioral-Health*
Medi-Cal ☐	**MHP Provider List – Placer County or Sierra County** The MHP Provider List is a list of providers who are contracted by the MHP to provide mental health services through Medi-Cal for our Placer and Sierra County residents. Non-emergency services must be pre-authorized.
ALL Over Age 18 ☐	**Voter Registration Card** and **Voter Preference Form (CARE-126)** The National Voter Registration Act requires handing you these forms at entry to services and every year thereafter. You may receive help filling out these forms. You may ask for new forms every time you change address
ALL **Over Age 18** ☐	**Advance Health Care Directive Brochure** The Advance Health Care Directive Brochure explains your right to make decisions about your medical treatment. It includes how to appoint a person who can make health care decisions for you when you are unable (Health Care Agent). It tells you how to change your directive at any time.
	Do you already have an Advance Health Care Directive or a Durable Power of Attorney for Health Care? ☐ **Yes** ☐ **No**
	If yes, will you provide a copy for our medical record? ☐ **Yes** ☐ **No**

☐ Distributed face-to-face by: _____ (MHP Staff)

☐ Distributed via US mail by: _____ (MHP Staff)

Date given to client or posted: _____

Name of Client: Type text here _____ **Client #:** _____

Client #_____

Sierra County Behavioral Health Department
Demographic Form

Referral Source: Self Other_____ Referral Phone_____

Legal Name: Last Name:_____ First Name:_____ Middle:_____

Birth Name (If different from above) Last Name_____ First_____ MI_____

Alias (es): Last Name_____ First_____ Middle_____

Physical Address:_____

City: _____ State: _____ Zip+4: _____-_____

Mailing Address:_____

City: _____ State: _____ Zip+4: _____-_____

Home Phone: _____ **Cell Phone**:_____ **Work Phone**:_____

Driver's License/State Id: O Yes O No State_____ No._____

Social Security #:_____ Reason SSN Not Provided_____

Gender: _____ **DOB:**_____ O Actual O Estimated

Born in U.S. O Yes O No If No, what Country:_____

State:_____

County - if born in *California*:_____

Marital Status: O Married O Divorced O Separated O Widowed O Never Married

Mother's First Name:_____

Ethnicity: O Not Hispanic O Hispanic O Other Hispanic_____

Race: O Caucasian O African American O Native American O Other_____

Primary Language: O English O Spanish O Other_____

Communication Method: O Verbal O Translator O Sign Language O Other_____

Language Preferred (Individual):_____ (Caretaker):_____

Interpreter Needed? O Yes O No

Employment Status: O Full-time Job O Part-time Job O Actively looking for work O Homemaker
O Student O Volunteer Worker O Retired O Other_____

Living Arrangement: O House or Apartment O Foster Home O Adult Residential Facility
O Homeless O SNF/ICF/IMD for psych O Other_____

Number of Children under the age of 18 the Client cares for/responsible for 50% or more of the time_____

Number of Dependents age 18 or older the Client cares for/responsible for 50% or more of the time_____

Education: (highest grade completed)_____ **Special Education:** O Yes O No

Disability: O None O Developmentally Disabled O Mental Health O Hearing O Mobility
O Speech O Vision O Other Disability_____

Smoking Status: O Every Day O Some Days O Heavy O Light O Former O Never

Veteran: O Yes O No Branch:_____

Emergency Notification Information:

Name:_____ Relationship:_____

Address:_____ Home Phone:_____

Work Phone:_____ Employment Place:_____

Legal Information:

Responsible person:_____ Relationship:_____

Address:_____ Phone:_____

Medical Information:

Primary Care Physician:_____ Phone:_____ FAX:_____

Address:_____

Pharmacy:_____ Phone:_____ FAX:_____

Hospital Preference:_____

Advance Directive Given? O Yes O No

Notice of Privacy Practices Given? O Yes O No **Form Signed Date**:_____

Client Contact Information:

May we leave message at:
Home? O Yes O No
Work? O Yes O No
Cell? O Yes O No
Text? O Yes O No
May we leave message via **emergency contact**? O Yes O No
May we contact you by **email**? O Yes (email)_____ O No
May we contact you by **mail**? O Yes O No

Preferred Method of Contact:_____

Sierra County Behavioral Health Services

Client Name

BEHAVIORAL HEALTH INFORMED CONSENT

In the interest of assuring that you are informed of the conditions of involvement with our services, please be informed the following:

1. PARTICIPATION IN SERVICES

Treatment is most effective when there are occasional discussions about your progress and counseling experience. You will develop a treatment plan collaboratively with your counselor, and participate in periodic reviews of your treatment and progress.

If you feel your treatment isn't helping you, please inform your counselor, so that your treatment plan can be revised to most effectively meet your needs.

Your time is reserved for you. If you must cancel, please provide a courtesy **24** hour notice. Individual sessions generally last fifty to sixty minutes. If you do not call to cancel your appointment by **8AM** on the day of your appointment and fail to show, this could incur a missed appointment fee of up to **$15** for each no show.

If you are more than ten minutes late for a session, this could be considered a "no show". If you arrive late, your appointment will still end at the designated time.

A returned check fee of **$25** will be applied to your bill for all returned checks.

If you do not have insurance or your Medi-Cal should lapse for any reason, you will be required to pay the Uniform Method of Determining Ability to Pay (UMDAP) calculated by your income. You can set up monthly payments with the front office staff.

After 30 days or 3 repeated absences/failure to participate in services may result in discontinuation of services.

If you are not scheduling sessions and/or arriving for sessions for a continuous period, we will assume you are voluntarily terminating services with us, and your client file will be closed. Should your file be closed, you will be eligible to participate in another intake and assessment process, and this would be considered a new admission.

2. DIAGNOSIS

If you are eligible for services through Sierra County Behavioral Health, you meet criteria for a qualifying diagnosis. We are required to give a diagnosis to document that you meet criteria for services. Your clinician will discuss your diagnosis with you, and how you meet criteria for the diagnosis.

Note a diagnosis is a representation of presenting issues and is something that is experienced on a continuum. You may meet criteria for a diagnosis during one stage of your life, and not meet criteria at another. It is estimated that a majority of people will meet criteria for a mental health diagnosis at some point in their lives.

3. LIMITS OF CONFIDENTIALITY

a. In accordance with State and Federal laws, Behavioral Health staff are legally obligated to make a report to the appropriate entities if they have reason to suspect the following.

- ⇨ A **child** is in danger of abuse or neglect.
- ⇨ An **elder** (65 years or older) is in danger of being abused or neglected. (Note, for elders, financial abuse is considered a form of abuse).
- ⇨ Someone appears to be in **imminent danger** of harming themselves or others.

b. Your mental health record can be subject to a **legal subpoena** in a legal proceeding.

c. If you are paying for services through your **insurance company**, we are obligated to let your insurance company know your diagnosis and, in some cases, details of your treatment, as a condition of insurance reimbursement.

4. SOCIAL CONTACT WITH MENTAL HEALTH STAFF

Note it is against professional Codes of Ethics to engage in social relationships with clients or former clients. If your counselor or another mental health employee sees you in public, you are welcome to initiate a conversation. They may avoid initiating a conversation with you, in order to protect your privacy.

If you wish to discuss your case, you are encouraged to contact your counselor at the office during regular business hours. We avoid discussing confidential matters in public.

5. GRIEVANCES

You may file a grievance if you are dissatisfied with our service. The information described below regarding filing grievances is posted in our waiting room.

You may call any of the following entities to register a complaint:

- **Sheryll Prinz-McMillan Behavioral Director** 530-993-6746.
- **Jamie Franceschini QI/QA** 530-993-6770
- **The Patient Rights Advocate** 530-886-5419 or 1-800-488-4308 ext 5419.

You may use the provided addressed envelopes and mail your concern(s) to any of the entities listed above, C/O P.O. Box 265, Loyalton, CA 96118. Addressed envelopes are available for you in the waiting room of the mental health department.

- **The Patient Rights Advocate** can assist you with registering a formal grievance.
- Your complaint or grievance will be **confidential.**
- **You will not be discriminated against** or penalized for filing a grievance.
- You will receive **notification** that we received your grievance, provided we have your contact information.
- You will receive a **written decision** on your grievance within 60 calendar days after your grievance has been received.

6. CLIENT RIGHTS

Your rights as a client of Sierra County Behavioral Health include the following:

1. The right to be treated with **respect** and with due consideration for your **privacy.**
2. The **right to receive information** on available treatment options and alternatives presented in a manner understandable to you.
3. The right to **participate in decisions** regarding your health care, including the right to refuse treatment.
4. The right to **file a grievance** or appeal a decision without being subject to discrimination or penalty.
5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
6. The right to request and receive a **copy of your health Information.**
7. The right to request that your health record be **amended.**

7. CAUSE FOR DISCHARGE

- ⇨ If it appears that the services we offer are **not beneficial for you**, a decision could be made to discontinue services.
- ⇨ Failure to treat other clients and staff with **respect** can result in discharge from program services.
- ⇨ **Failure to maintain the confidentiality** of others accessing services can result in discontinuation of services.
- ⇨ Sierra County Behavioral Health reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without good cause.

8. WEAPONS

Individuals are prohibited from possessing guns, knives (other than kitchen utensils), or other weapons (except for law enforcement officers acting in the line of duty) while at Sierra County Human Services.

9. FOLLOW-UP

Upon discharge from the program, someone from Sierra County Human Services may attempt to contact you to participate in a follow-up client satisfaction survey, with your permission. These surveys assist us with maximizing the effectiveness of our services. If you are willing to participate in a follow-up contact, please initial one of the following:

I am willing to participate in a follow up contact, following discharge from services _____

I am **not** willing to participate in a follow up contact, following discharge of services ____

CLIENT CONSENT TO SERVICES

I have read and understand all conditions set forth in this Informed Consent. I consent to participate in Sierra County Behavioral Health Services.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

GUARDIAN CONSENT FOR MINOR

I have read and agree with the conditions set forth in the Informed Consent. I agree to allow my minor child _____ (name of minor) to participate in Sierra County Behavioral Health Services.

_____ _____
Parent Signature Date

_____ _____
Minor Signature Date

_____ _____
Witness Signature Date

Sierra County Behavioral Health Services
Consent for Treatment Using Teleconferencing Equipment

Your Sierra County Behavioral Health program has agreed to provide Mental Health and Substance Use services utilizing teleconferencing equipment.

Nature of Telehealth Consultation: Teleconferencing is a simple technology. It requires the use of a monitor and/or television and a small camera to talk to another person over secured data lines, much like a face-to-face contact and in real time. This service is confidential. This is not a satellite or broadcast service; it is a video signal sent over dedicated data lines in what is referred to as a "site-to-site connection." This is a standard considered the most secure and confidential.

Tele-counseling will use this same technology to provide you with your MH/SUD care. You will see your counselor for regular visits, crisis evaluations, and treatment planning, just as you would if your counselor were in the office. You will sit and talk with the counselor as you would if the counselor were in the office. Your treatment should not change significantly, except to receive more trained, specialized, and accurate treatment without waiting or driving for significant periods of time. You would have the opportunity to discuss your needs and have them resolved to the best of our ability.

Associated Risks: Reasonable and appropriate efforts have been made to reduce the risks associated with Telehealth consultation, and all existing confidentiality protections in compliance with CFR 42, and under Federal and California laws apply to information disclosed during this Telehealth consultation. Despite these measures and protections, there remains a risk that: the transmission of information could be disrupted or distorted by technical failures in transmission; the transmission of information could be intercepted by unauthorized persons; and/or the electronic storage information generated by this Telehealth consultation in one or more databases could be accessed by unauthorized persons. In addition, Telehealth consultation may not be as complete as face-to-face care.

Rights: Using Telehealth consultation is voluntary and in no way diminishes your rights as a client and you continue to have the right to withhold or withdraw your consent to Telehealth consultation at any time without affecting your right to future care or treatment and without risking the loss of your health insurance coverage. You have the option of using a face-to-face visit with a counselor/clinician/doctor. You will need to ask your agency for this information if you wish to pursue this option. As a Medi-Cal beneficiary, you have the right to request transportation to and from your appointments when other available resources have been exhausted.

The laws which protect the confidentiality of Mental Health and Substance Use Disorders information apply to Telehealth consultation. No information or images from the Telehealth consultation which identify you will be disclosed to researchers or other entities without your consent.

I have read and understand the above and give my consent to participate in Telehealth services using teleconferencing equipment.

Client Name (PLEASE PRINT)	Guardian Name (PLEASE PRINT)
Signature of Client or Guardian	Date

I **do not agree** to participate in Telehealth treatment using teleconferencing equipment.

Client Name (PLEASE PRINT)	Guardian Name (PLEASE PRINT)
Signature of Client or Guardian	Date

Date : _____ Client Name: _____

C.I.N. #: _____ SS#: _____ DOB: _____

Placer-Sierra County Systems of Care

Behavioral Health Services Financial Form

Information from: ☐ Patient ☐ Responsible Person ☐ New ☐ Readmit ☐ Update

Financial Type: : ☐ Individual ☐ Family Program: ☐ Mental Health ☐ Substance Abuse ☐ Both

Name: _____ Relationship: _____

Billing Address: _____ City/Zip: _____

Home Phone #:_____ Cell Phone :_____

Employer: _____ Work Telephone #: _____

Other Source of Income: _____

Primary Insurance Company: _____ Veteran: _____ Claim No.: _____

Secondary Insurance Company : _____

Family Members In Treatment:

- _____
- _____
- _____

Income			Expenses		
Gross Monthly Income			**Allowable Expenses**		
Self	$	_____. 00	Court Ordered	$	_____. 00
Spouse	$	_____. 00	Child Care	$	_____. 00
Other: SS, Public Assist	$	_____. 00	Med. Exp. in excess of 3%	$	_____. 00
Unemployment, Disability			Mandated Deductible	$	_____. 00
Sub-Total (A)	$	_____. 00	Total (B)	$	_____. 00

Number of Dependents: _____

UMDAP Valid _____Through_____
(Uniform Method of Determining Ability to Pay)

Payment Plan Agreed Amount: $_____

Per : ☐ Month ☐ Visit

FOR OFFICE USE ONLY

Calculation of Annual Deductible Income

A. Subtotal - Gross Mo. Income	$	_____. 00
B. Total Allowable Expenses	$	_____. 00
E. Total Income (A-B)	$	_____. 00
F. MH Annual Liability	$	_____.00
G. Substance Abuse Sliding Scale	$	_____. 00

******Agreement to Pay Amount Due******

I affirm that the statements made herein are true to the best of my knowledge. I understand and accept my annual deductible and agree to pay the amount due on a timely basis.

******Assignment of Benefits-Release of Information******

I hereby assign all Behavioral Health Benefits to which I am entitled including Medi-Cal, Medicare, to Sierra County Department of Health and Human Services. This assignment will remain in effect until revoked by me in writing or until such time as I am no longer receiving Sierra County Behavioral Health Services. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible to pay any deductible amount referred to above if charges are not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ **DATE:** _____

Patient or Responsible Person

S.O.C. Representative: _____ **DATE:** _____

HEALTH QUESTIONNAIRE/MEDICAL HISTORY

Name:_____ Date:_____

Date of Birth:_____ Client ID#:_____

This questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

Section 1

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.
   No ☐ Yes ☐ Date:
   Do you have any of the following symptoms?
   1. A cough lasting for 3 weeks or longer? No ☐ Yes ☐
   2. Coughing up Blood? No ☐ Yes ☐
   3. Fever or night sweats? No ☐ Yes ☐
   4. Unexplained weight loss? No ☐ Yes ☐
2. Have you ever had a stroke? If yes, please give details.
   No ☐ Yes ☐ Date:
3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.
   No ☐ Yes ☐ Date:
4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.
   No ☐ Yes ☐ Date:
5. Have you experienced or suffered any chest pains? If yes, please give details.
   No ☐ Yes ☐ Date:

Section 2

6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.
   No ☐ Yes ☐ Date:
7. Do you take any medications for a heart condition? If yes, please give details.
   No ☐ Yes ☐ Date:
8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.
   No ☐ Yes ☐ Date:
9. Have you ever had high blood pressure or hypertension? If yes, please give details.
   No ☐ Yes ☐ Date:
10. Do you have a history of cancer? If yes, please give details.
    No ☐ Yes ☐
11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.
    No ☐ Yes ☐

Section 3

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If yes, please give details.
    No ☐ Yes ☐ Date:
13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.
    No ☐ Yes ☐ Date:
14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.
    No ☐ Yes ☐ Date:
15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.
    No ☐ Yes ☐ Date:
16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.
    No ☐ Yes ☐ Date:
17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.
    No ☐ Yes ☐ Date:

18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder? If yes, please give details.
No ☐ Yes ☐ Date:

19. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details including any ongoing pain or disabilities.
No ☐ Yes ☐ Date:

20. Please describe and date any surgeries or hospitalizations due to illness or injury that you have had.

_____

_____

_____

21. When was the last time you saw a physician? What was the purpose of the visit?

_____

22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).
No ☐ Yes ☐

23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it.
No ☐ Yes ☐

24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.
No ☐ Yes ☐

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.
No ☐ Yes ☐

26. When was your last dental exam? Date:_____

27. Are you in need of dental care? If yes, please give details.
No ☐ Yes ☐

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.
No ☐ Yes ☐

29. Are you pregnant? No ☐ Yes ☐ Due Date:

30. In the past seven days what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

31. In the past year what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

32. Please list current medications:

Type of Medication	Dosage

33. Do you have a Primary Care Physician? No ☐ Yes ☐ _____

Date of last visit and reason why _____

I declare that the above information is true and correct to the best of my knowledge:

Client Signature:_____ Today's Date:_____

Counselor Signature:_____ Today's Date:_____

Sierra County Health and Human Services

Notice of Behavioral Health Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES. PLEASE REVIEW THIS INFORMATION CAREFULLY.

1. Your Rights under Federal Privacy Standards

Your agency health record typically contains your history, current symptoms, progress notes, examination and test results, diagnoses, treatment, and planned care or treatment. Although your record is the physical property of the agency, you have the following rights:

A. The right to request restriction on uses and disclosures of your health information for treatment, payment, and health care operations: We do not have to agree to a requested restriction on disclosures of information. If we do agree to the request, we will adhere to it unless you request otherwise or we give you advance notice.

B. The right to ask us to communicate with you by alternate means: If the method of communication is reasonable, we will grant the alternate communication request.

C. The right to obtain a copy of this Notice of Information Practices: You have a right to receive a copy of this Notice of Information Practices upon request.

D. The right to inspect and copy your health information: In certain situations, such as if access could cause harm to you or somebody else, we can deny access. If we deny access to your health information, we must provide you a review of our decision to deny access.

E. The right to request amendment/correction of your health information: We will be unable to grant the request if the record is accurate and complete, or we did not create the record. If the party that created the record amends or corrects the record, we will put the corrected information into our records.

   If your request is denied, you can attach a statement of disagreement to your records and you can appeal the decision. If we grant the request, we will make the correction and distribute the correction to those who need it.

F. The right to obtain an accounting of uses and disclosures of your information: We must provide the accounting within 60 days. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

G. The right to revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

2. Examples of How Your Information may be Disclosed

Sierra County Behavioral Health has an ethical and legal obligation to protect the confidentiality of your information; however there are situations in which information obtained during the course of your care may be disclosed without your permission.

A. Child or Elder Abuse: If we have reason to believe that a child below the age of 18 or elder person (age 65 or older) is subject to abuse, neglect, or exploitation we are mandated by law to notify the appropriate authorities.

B. Duty to Protect: If we have reason to believe somebody is in imminent danger of harm from themselves or another, we are required to take appropriate action necessary to protect somebody from harm. This can include notifying law enforcement or notifying an intended target.

C. Disclosure for Payment: With your consent, we will use your health information for payment. For example, we may send a bill to you or to a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnosis and treatment received.

D. Business Associates**:** We may at some time provide some services through contracts with business associates. Business associates are required to comply with the same federal security and privacy rules as we do.

E. Appointment Reminders: We may call you using contact information you provide to give appointment reminders or to attempt to schedule an appointment.

F. Public Health: Where required by law, we may disclose information to authorities charged with preventing or controlling disease.

G. Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents health information necessary for your health or the health and safety of other individuals.

H. Legal Entities: We may disclose health information as required by law or in response to a valid subpoena or court order.

I. Other Health Care Providers: We may share information with other health care providers as needed to coordinate your care.

Your signature below serves as acknowledgement that you have read this Notice of Information Practices and any questions you have about Sierra County Behavioral Health Information Practices have been adequately answered.

_____ _____

Signature Date

CLIENT NAME:_____

Your Rights & Responsibilities

You are entitled to:

⇒ Be treated with consideration and respect;

⇒ Have your services provided in a safe environment;

⇒ Participate in the planning of your service & treatment;

⇒ Request a change of case manager or therapist;

⇒ Receive interpreter services as needed free of charge. Family members will not be expected to interpret or provide an interpreter;

⇒ Receive services that are sensitive to cultural differences, religious preferences, sexual orientation, or disabilities.

If you are receiving Mental Health Services through Medi-Cal, you are entitled to:

⇒ Choose your therapist, when possible. A list of providers is available by calling 530-993-6747

⇒ Request a second opinion to determine medical necessity for services.

You have the responsibility to:

⇒ Exhibit considerate & respectful behavior to staff & providers;

⇒ Take an active part in getting well;

⇒ Work on goals that you develop with your provider;

⇒ Respect the rights, property, and environment of all staff, providers, and other clients;

⇒ Provide complete, accurate information;

⇒ Keep appointments on time and if unable to do so, notify the service provider;

⇒ Pay for services if required.

Mission Statement

In partnership with our community members and their families, Sierra County Behavioral Health strives to promote the wellness of the whole - person by providing comprehensive and appropriate supports and services.

Privacy

We will respect your right to privacy. In order to provide your services, we may share information as needed within our agency. However, we will request your written permission to share information with outside agencies.

SierraCounty Adult System of Care
Mental Health Services

Loyalton Office 704 Mill Street, Loyalton, CA 96118
Downieville Office 22 Maiden Lane, Downieville 95936

Sierra County Health & Human Services Adult System of Care

Mental Health Services Brochure

To request mental health services call:

Loyalton Behavioral Health

(530) 993-6747

Downieville

(530) 289-3711

Mental Health Services Available

The following is a list of Mental Health Services available through Adult System of Care. All Mental Health Services are "needs-based" and some services have income eligibility requirements.

* Assessment of individual needs
* Mental Health Support Services
* Mental Health Crisis Response
* Psychiatric Medication Services
* Support groups for current clients
* Wellness Center

Obtaining Services

If you are a current client, most Mental Health Services can be obtained by contacting your current Service Coordinator. If you are new or a returning client you can request services by calling (530) 993-6747

Problem Resolution

If you are dissatisfied with your service, you can file a grievance/appeal at any time. The grievance/appeal forms are located in the Loyalton and Downieville waiting rooms. After you have exhausted all internal County procedures for a grievance/appeal, you may file for a State Fair Hearing. You will not be subject to any penalty or discrimination for filing a grievance/complaint and you have the right to appeal the decision.

- You are encouraged to discuss issues regarding your services directly with your service provider.
- If you cannot resolve the issue through your service provider, you should ask to speak to his/her supervisor or program manager.
- To file a formal grievance/appeal form, the forms are located in the Loyalton and Downieville waiting rooms.

Medi-Cal State "Fair Hearings"

- If you have received a denial, reduction, or termination of Medi-Cal Mental Health Services you have the right to file for a State Fair Hearing within 10-days of the decision from the problem resolution process, this will keep services in place.

- Information on how to file for a State Hearing is available on the *Notice of Action* form that should be sent to you when denied or a change to coverage occurs. If you have not received a form with these instructions, please call the Managed Care Unit or the Sierra County Patients' Rights Advocate.

Status of Complaints

To find out the status of your grievance/appeal, please call the Sierra County Quality Improvement Coordinator at (530)- 993-6770

Providers in Sierra County

Dr. Gould, MD **Mon**
Psychiatrist Services
CA License #C161437
530-993-6746 or 530-289-3711

Danielle Deen, PA **Thur**
Psychiatrist Services
CA License #PA55046
530-993-6746 or 530-289-3711

Oliver Ocskay, Ph.D **Tues, Wed, Thur**
Clinical Psychology Services
CA License #PSY6480
530-993-6746 or 530-289-3711

Mary Lowe, LMFT **Mon, Tues, Thur**
Marriage and Family Therapist
CA License #MFC36473
530-993-6746 or 530-289-3711

Alisha Woods, Ph.D **Mon, Tues, Wed**
Clinical Psychology Services
CA License #PSB94022660
530-993-6746 or 530-289-3711

Robert Szopa, CAODC II **Mon-Fri**
SUD Program Manager
Substance Use Counselor
CA Certificiate #Aii051700218
530-993-6746 or 530-289-3711

Sheryll Prinz-McMillan, LMFT **Mon-Fri**
Behavioral Health Director
CA License #32944
530-993-6746 or 530-289-3711

National Suicide and Crisis Lifeline
988

Treatment Centers

Progress House
Residential/Transitional Services
530-626-9240

Aegis Treatment Centers, LLC
Hub & Spoke Provider for MAT
818-206-0381 Fax

Wellspace Health
Detoxification/Residential Service
916-921-6598

Granite Wellness
Detox/Residential/Transitional Service
530-273-9541

Interpretation Services

Telelanguage
Interpretation Services
1-800-514-9237

NorCal
Services for deaf & hard of hearing
916-349-7500

24 Hour Crisis Line

7 Days a week

833-723-2968

24 hour Access Line

888-840-8418

Sierra County Systems of Care
COMPLAINT PROCESS

Clients who are dissatisfied with their services may file a complaint. Complaints are divided into two categories: informal complaints and formal complaints (grievances). Clients will not be subject to any penalty or discrimination for filing a complaint or grievance and may appeal decisions.

INFORMAL COMPLAINT

- Clients are encouraged to discuss issues regarding their services directly with their case manager or service provider.
- Clients who cannot resolve the issue through the case manager should ask to speak to the case manager's supervisor or program manager.
- Clients may call the S.O.C. Managed Care Unit or the Patient's Rights Advocate to file an informal complaint at any time.

FORMAL COMPLAINT (GRIEVANCE)

- Clients can call or write a letter to the Managed Care Unit or the Patient's Rights Advocate to file a formal complaint at any time. The Patient's Rights Advocacy staff is available to assist in completing the form upon request.
- Clients may authorize a person to act on their behalf during the formal complaint process or in the State Fair Hearings process.
- Clients may obtain an official complaint form at any System of Care office, Network Private Provider office, or by calling the S.O.C. Managed Care Unit.
- Clients will receive a written response to a formal complaint within 30 days. The decision can be appealed.

MEDI-CAL STATE "FAIR HEARINGS"

- Medi-Cal beneficiaries who disagree with the denial, reduction or termination of their Medi-Cal Mental Health services have the right to file for a State Hearing at any time.
- Instructions on filing for a State Hearing are available on the *Notice of Action* forms or by calling the S.O.C. Managed Care Unit or the Patient's Rights Advocate.

For assistance for all or any of the above procedures, contact any of the following:

Patients' Rights Advocate
(530) 886-5419
Or
Managed Care/Quality Improvement Coordinator
(530) 886-5440

24-hour telephone number for complaint/grievance procedure information: 1-888-886-5401

Programas de Auxilio
del Condado de Sierra
COMO PRESENTAR UN RECLAMO

Aquellos clientes que estén insatisfechos con sus servicios pueden entablar un reclamo. Estos se dividen en dos categorias: reclamos extraoficiales y reclamos oficiales. No resultarán sanciones ni descriminación a los clientes por entablar un reclamo y pueded apelar la decisión.

RECLAMO EXTRAOFICIAL

- Se anima al cliente a considerar cuestiones en cuanto a sus servicios directamente con su administrador de caso o su proveedor.
- Aquel cliente que no puedan resolver la cuestión mediande su administrador de caso deberia hablar con el supervisor de su administrador de caso o con el administrador del programa.
- El cliente también pueden llamar a la Unidad de Cuidado de Salud Administrativo o el Partidiario para Derechos de Pacientes para entablar un reclamo a cualquier momento.

RECLAMO OFICIAL

- El cliente puede llamar o escribir una carta a la Unidad de Cuidado de Salud Administrativo o al Partidiario para los Derechos de Pacientes para entablar un reclamo a cualquier momento.
- El cliente puede autorizar otra persona para ser su representante en sus reclamos formales o durante el proceso con su audencia con el estado.
- El cliente puede obtener un formulario de reclamo oficial en cualquier oficina de Programa de Auxilio, oficina de un Proveedor Participante, o llamando la Unidad de Cuidado de Salud Administrativo de S.O.C.
- Dentro de 30 dias, el cliente recibirá por escrito una respuesta a su reclamo oficial. Esta decision puede ser apelada.

AUDIENCIAS ESTATALES DE MEDI-CAL

- El beneficiario de Medi-Cal que no concuerde con la negación, reducción o descontinuación de sus servicios de Salud Mental mediante Medi-Cal tiene el derecho de entablar una Audencia Estatal a cualquier momento.
- Los formularios *Notificación de Acción* facilitan las intrucciones para entablar una Audiencia Estatal o puede pedirlas llamando a la Unidad de Cuidado de Salud Administrativo de S.O.C. o al Partidiario de Derechos de Pacientes.

Para asistencia con este o cualquier otra processo, comuniquese con uno de los siguientes:

Abogar de Derechos de Pacientes
(530) 886-5419
o
Cuidado de Salud/Administrador de Mejoria de Calidad
(530) 886-5440

Numero de telefono (24 horas) para information sobre el proceso de quejas.

Will I still be treated if I don't make an Advance Health Care Directive?
Absolutely. You will still get medical treatment. We just want you to know, if you become too sick to make decisions, someone else will have to make them for you.

What are the parts of the Advance Healthcare Directive form?
They are:
Part 1 – Power of Attorney for HealthCare
Lets you name another individual as your healthcare agent to make medical treatment decisions for you if you become unable to make those decisions.

Part 2 – Instructions for Healthcare
Lets you express your wishes about your future healthcare treatment.

Part 3 – Donation of Organs at Death (optional)

Part 4 – Primary Physician (optional)
Lets you designate a primary doctor, if you wish.

Part 5 – Signature
Sign and date the form. You will need two witnesses to your signature.

Where do I get the Advance Healthcare Directive form?
You should ask your physician or physical health care office for an Advance Healthcare Directive form. A printable form is available on-line at: http://www.calhealth.org/public/pubs/frmspstrs.html.

How can I get more information about making an Advance Healthcare Directive?
Ask your primary medical doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an Advanced Healthcare Directive for you or you can complete one yourself by filling in the blanks on a form. Instructions are included on the form. Additional resource information is included on the back of this brochure.

Important Contacts and Resources

Patients' Rights Advocate
(530) 886-5419

Placer/Sierra County MHP
SOC Managed Care Unit
(530) 886-5400

For further assistance:
Legal Services of Northern California
190 Reamer St.
Auburn, CA 95603
(530) 823-7560

Additional information on-line:
Office of Attorney General
www.ag.ca.gov/consumers/general/adv_hc_dir.htm

California Medical Association
www.cmanet.org/publicdoc.cfm/7

You may file a complaint regarding noncompliance with the Advance Medical Directive requirements to:

California Department of Human Services Licensing and Certification
P.O. Box 997413
Sacramento, CA 95899-1413
Or call
1-800-236-9747

Sierra County
Mental Health Plan (MHP)

Advance Healthcare Directive

You have the right to make decisions about your medical treatment

What is an Advance Health Care Directive?
An Advance Health Care Directive is the best way to make sure that your physical health care wishes are known and considered if for any reason you are unable to make decisions on your own.

Do I have to wait until I am sick to express my wishes about health care?
No. In fact, it is better to decide before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatments you want. These documents are called "Advance" because you prepare one before healthcare decisions need to be made. They are called "Directives" because they tell who you want to speak for you and what kind of treatment should or should not be done.

Who can make an Advance Directive?
Anyone over 18 years of age (or an emancipated minor) who is capable of making his/her own medical decisions can make an Advance Health Care Directive. You do not need a lawyer.

Who decides about my treatment?
Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment that you don't want - even if the treatment might keep you alive longer.

How do I know what I want?
Your doctor must tell you about your medical condition and about what different treatment and pain management options are available. Your doctor must also inform you of any side effects from treatment or medications. At times, more than one treatment might help you. Your doctor can advise you about different options. You can discuss options with your family and friends. Ultimately, it is your decision.

Can I choose a relative or friend to make healthcare decisions for me?
Yes. You may appoint them to be your health care "Agent" by completing Part 1: Power of Attorney for Health Care on the Advance Health Care Directive.

What if I become too sick to make my own decisions?
If you have named an agent, he/she will make medical decisions on your behalf. If not, your doctor will ask your closest relative or friend to decide what is best for you. Most of the time that works, sometimes everyone cannot agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you cannot speak for yourself.

Who may I appoint as my health care agent?
You may appoint any adult to be your agent. It is important that you talk to the person first to make sure that he/she understands your wishes and is willing to accept the responsibility.

How does my agent know what I would want?
After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make and it truly helps if your agent knows what you want. Writing down your health care wishes will be helpful for your agent. You can also write specific health care wishes in your Part 2: Instructions for Health Care of the Advance Health Care Directive.

When does my agent begin making my medical decisions?
Usually a healthcare agent will make decisions only after you lose the ability to make them yourself. But if you wish, you can state in the Power of Attorney for Health Care, that you want the agent to begin making decisions immediately.

What if I don't want to name someone to make my healthcare decisions (an agent)?
You can write down your wishes for healthcare treatment without naming an agent. You can say that you want to have your life continued as long as possible, or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment. Even if you do not complete the form, you can discuss your wishes with your doctor and ask your doctor to list those wishes in your medical record. You can also discuss your wishes with family members or friends. But it will probably be easier to follow your wishes if you write them down.

What happens when someone else makes decisions about my treatment?
The same rules apply to anyone who makes healthcare decisions on your behalf – a healthcare agent, a person whose name you gave to the doctor, or a person appointed by a court to make decisions for you. All are required to follow your Health Care Instructions or your general wishes about your treatment, including stopping treatment. If your treatment wishes are not known, the person who makes the decisions on your behalf must try to determine what is in your best interest. The people providing your health care must follow the decisions of the person you designated unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the health care provider must make a reasonable effort to find another healthcare provider to take over your treatment.

What if I change my mind? You can change or cancel your Advance Healthcare Directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.