VailPlace
23 - 9th Avenue South, Hopkins, MN 55343
952.938.9622 • fax 952.938.7934 • www.vailplace.org
Cultivating hope and inspiring change to promote mental health recovery.

Referral Packet
Vail Care: a Behavioral Health Home
Fax: (952) 945-4257
Attn: Kristina Swanberg

Client Name	**Date of Birth**
Social Security Number	**Insurance (must have Medical Assistance)**
Address	**Phone (please list secondary number if needed):**

Please note: ***to be eligible for Vail Care Behavioral Health Home Services, an individual must; have a SMI/SPMI, live in Hennepin County, have active Medical Assistance, have a recent Diagnostic Assessment & WHODAS (within the past 12 months), and cannot be receiving case management or care coordination services at the same time as Behavioral Health Home Services.***

***An ideal candidate for Vail Care will have stable and/or consistent housing.**

PLEASE REVIEW REFERRAL CHECKLIST BEFORE FAXING:

- ☐ Completed Diagnostic Assessment & WHODAS included (completed within the last 12 months)
  - ☐ *If there isn't a recent DA & WHODAS, check here if one can be completed within the next 2 weeks*
- ☐ Signed Release of Information forms for:
  - ☐ Referral Source
  - ☐ County of Financial Responsibility
  - ☐ Mental Health provider
  - ☐ Primary Care Clinic
- ☐ Signed Behavioral Health Home Services Rights, Responsibilities and Consent form

For questions about Vail Care services please call
Julie Plante RN, Nurse Manager-Integrated Care at (952) 807-6337

VAIL PLACE AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

1) CLIENT INFORMATION:

Client Full Name (Please Print)	Previous Names or Aliases
Date of Birth	Social Security Number (last 4 digits only) XXX-XX-

2) I AUTHORIZE VAIL PLACE TO:

☒ **RELEASE MY RECORDS/INFORMATION TO** ☒ **OBTAIN MY RECORDS/INFORMATION FROM**

Organization or Individual's Name (required)	Address		
Specific health care facility, location or professional's name (optional)	City	State	ZIP
Contact Type Referral Source	Phone	Fax	

3) THIS CONSENT IS VALID FOR COMMUNICATION WITH EMPLOYEES ASSOCIATED WITH VAIL PLACE PROGRAMS.

Primary Vail Place Contact:	**Please direct written communications to:**
Vail Care Staff	23 9th Avenue S, Hopkins MN 55343
Phone: 952-945-4225	**FAX:** 952-945-4257

4) THE INFORMATION SHARED MAY INCLUDE: (select ONLY the information you are authorizing to be released or obtained)

☒ **Release or obtain all information/records (*see description in instructions*)**

- OR - ONLY RELEASE MY HEALTH INFORMATION IN THE FOLLOWING CATEGORIES:

☐ Intake Summary	☐ Chemical Health Information	☐ Housing Information
☐ Discharge or Closing Summary	☐ Progress Reports/Treatment Records	☐ Civil Court Records
☐ Clinical Diagnostic Assessment	☐ Medical History/Physical Exam	☐ Criminal Court Records
☐ Psychiatric Assessment/Evaluation	☐ Medication Records	☐ Income & Economic Benefits
☐ Chemical Dependency Evaluation	☐ Treatment Plan	☐ Medical Insurance

☐ Other:_____

☐ **Specific dates/years of treatment:**_____

Disclosing the following information requires special consent by law. Even if you indicate **all information**, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program information *(see instructions)* ☐ Psychotherapy notes *(see instructions for more information)*

5) REASONS FOR RELEASING OR OBTAINING INFORMATION: (select all that apply)

☒ To determine eligibility for services ☒ To coordinate services ☒ To provide services ☒ At client's request

☐ Other:

_____

6) I UNDERSTAND AND AGREE:

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- A copy of this authorization is as valid as the original.
- If I have questions about the privacy of my records, I may ask Vail Place staff for more information.
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- I may stop this consent at any time by contacting Vail Place verbally or in writing. If information has already been disclosed based on my consent, my request to stop will not work for that information.
- This information may be disclosed to other parties who are entitled to it by law and is therefore no longer protected under the privacy rule.
- **If I do not identify a specific expiration date or event below, this consent will end one year from the DATE SIGNED at the bottom of this form.**

7) CLIENT SIGNATURE AND/OR LEGALLY AUTHORIZED REPRESENTATIVE:	**DATE SIGNED:**

****OPTIONAL** AUTHORIZATION IS VALID UNTIL:**

SPECIFIC END DATE: _____ **OR** **SPECIFIC EVENT:** _____

If not signed by subject of disclosure, specify basis for authority to sign.

☐Guardian ☐Other authorized representative (describe): _____

***Documentation verifying authority to sign must be obtained and added to client record prior to signing consent.**

FOR INTERNAL USE ONLY: A copy of this consent was offered to the individual or representative.

☐ Individual received copy ☐ Individual declined copy ☐ **Copy will be mailed to individual**

Form version date: 12/07/16

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- It is important to follow the directions for each section carefully to be sure this form is valid. **An incomplete form might not be accepted.**
- A fee may be charged for the release of the health information.
- Please type or print as clearly and completely as possible.
- If you have any questions about the release of your health information or this form, contact Vail Place staff for assistance.

1) CLIENT INFORMATION:

- Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information.
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2) I AUTHORIZE VAIL PLACE TO:

- In this section, state who you want to release or obtain your health information.
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  - **Selecting both Release and Obtain** allows two-way communication between Vail Place and the individual/organization
- **Please be as specific as possible.** Providing location information may help clarify your request.
- If you want to limit the disclosure, you can name a specific facility (i.e. Main Street Clinic) or a specific professional (i.e. Dr. John Jones).

3) This consent is valid for communication with employees associated with the following Vail Place program(s):

- Members or clients may be involved with more than one program at Vail Place. If you choose "**All Vail Place Programs**", this authorization will be valid for and may be used by representatives of any of our programs as necessary to provide services to you.
- You may limit the program areas at Vail Place permitted to release or obtain your health information by selecting the options listed.
- **In an emergency,** Vail Place staff associated with other programs may use this authorization even if you choose specific programs.

4) THE INFORMATION SHARED MAY INCLUDE:

- Indicate what health information you want shared. **Select ONLY the information you are authorizing to be released or obtained.**
- If you select **Release or Obtain all information/records**, this will include all information in your record, including mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.
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- It is Vail Place's policy to only re-disclose written information we receive from other sources (such as a Diagnostic Assessment) if needed to provide services or for referral purposes. We will not re-disclose this information unless you specifically authorize us to do so. **If you wish to have information from your record re-disclosed, please note the specific information on the line provided.**

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5) REASONS FOR RELEASING OR OBTAINING INFORMATION: (select all that apply)

- Please indicate the reason(s) for releasing or obtaining the health information.
- You must select at least one option.

6) I UNDERSTAND:

- *By signing this consent form, I am giving permission for written, verbal or electronic communication between Vail Place and the organization or individual identified in this consent.*
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  - **Please refer to Vail Place's Notice of Privacy Practices for more information**
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Client Full Name (Please Print)	Previous Names or Aliases
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☒ **RELEASE MY RECORDS/INFORMATION TO** ☒ **OBTAIN MY RECORDS/INFORMATION FROM**

Organization or Individual's Name (required)	Address		
County Economic and Financial Assistance			
Specific health care facility, location or professional's name (optional)	City	State	ZIP
Contact Type: County of Financial Responsibility	Phone	Fax	

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Primary Vail Place Contact:	**Please direct written communications to:**
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Organization or Individual's Name (required)	Address		
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Contact Type Mental Health Provider	Phone	Fax	

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Primary Vail Place Contact: Vail Care Staff	**Please direct written communications to:** 23 9th Avenue S, Hopkins MN 55343
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Form version date: 12/07/16

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Organization or Individual's Name (required)	Address		
Specific health care facility, location or professional's name (optional)	City	State	ZIP
Contact Type Primary Care Physician & Care Team	Phone	Fax	

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_____

6) I UNDERSTAND AND AGREE:

- By signing this consent form, I am giving permission for **written, verbal or electronic communication between Vail** Place and the organization or individual identified in this consent.
- A copy of this authorization is as valid as the original.
- If I have questions about the privacy of my records, I may ask Vail Place staff for more information.
- I am not required to sign this authorization. Vail Place may not be able to provide services if they cannot verify I am eligible for services.
- I may stop this consent at any time by contacting Vail Place verbally or in writing. If information has already been disclosed based on my consent, my request to stop will not work for that information.
- This information may be disclosed to other parties who are entitled to it by law and is therefore no longer protected under the privacy rule.
- **If I do not identify a specific expiration date or event below, this consent will end one year from the DATE SIGNED at the bottom of this form.**

7) CLIENT SIGNATURE AND/OR LEGALLY AUTHORIZED REPRESENTATIVE:	**DATE SIGNED:**

****OPTIONAL** AUTHORIZATION IS VALID UNTIL:**

SPECIFIC END DATE: _____ **OR** **SPECIFIC EVENT:** _____

If not signed by subject of disclosure, specify basis for authority to sign.

☐Guardian ☐Other authorized representative (describe): _____

***Documentation verifying authority to sign must be obtained and added to client record prior to signing consent.**

FOR INTERNAL USE ONLY: A copy of this consent was offered to the individual or representative.

☐ Individual received copy ☐ Individual declined copy ☐ **Copy will be mailed to individual**

Form version date: 12/07/16

VAIL PLACE AUTHORIZATION TO RELEASE INFORMATION INSTRUCTIONS:

By signing this form, you are giving permission for Vail Place to obtain your health information from others, or share information on your behalf.
We encourage you to read all instructions and information before completing and signing the form. Please note the following:

- It is important to follow the directions for each section carefully to be sure this form is valid. **An incomplete form might not be accepted.**
- A fee may be charged for the release of the health information.
- Please type or print as clearly and completely as possible.
- If you have any questions about the release of your health information or this form, contact Vail Place staff for assistance.

1) CLIENT INFORMATION:

- Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information.
- Your Date of Birth and Social Security Number are used to identify your health information and to make certain that only your information is disclosed. **If you do not want to provide your complete Social Security Number, please provide only the last four digits.**

2) I AUTHORIZE VAIL PLACE TO:

- In this section, state who you want to release or obtain your health information.
  - **Release information to:** selecting this option allows Vail Place to disclose information to the organization or individual listed
  - **Obtain information from:** selecting this option allows the individual or organization to disclose information to Vail Place
  - **Selecting both Release and Obtain** allows two-way communication between Vail Place and the individual/organization
- **Please be as specific as possible.** Providing location information may help clarify your request.
- If you want to limit the disclosure, you can name a specific facility (i.e. Main Street Clinic) or a specific professional (i.e. Dr. John Jones).

3) This consent is valid for communication with employees associated with the following Vail Place program(s):

- Members or clients may be involved with more than one program at Vail Place. If you choose "**All Vail Place Programs**", this authorization will be valid for and may be used by representatives of any of our programs as necessary to provide services to you.
- You may limit the program areas at Vail Place permitted to release or obtain your health information by selecting the options listed.
- **In an emergency,** Vail Place staff associated with other programs may use this authorization even if you choose specific programs.

4) THE INFORMATION SHARED MAY INCLUDE:

- Indicate what health information you want shared. **Select ONLY the information you are authorizing to be released or obtained.**
- If you select **Release or Obtain all information/records,** this will include all information in your record, including mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.
- If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.
- It is Vail Place's policy to only re-disclose written information we receive from other sources (such as a Diagnostic Assessment) if needed to provide services or for referral purposes. We will not re-disclose this information unless you specifically authorize us to do so. **If you wish to have information from your record re-disclosed, please note the specific information on the line provided.**

Important: There are certain types of health information that require special consent by law.

- **Chemical dependency program** information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial this option in Section 4.
- **Psychotherapy notes** are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 2.**

5) REASONS FOR RELEASING OR OBTAINING INFORMATION: (select all that apply)

- Please indicate the reason(s) for releasing or obtaining the health information.
- You must select at least one option.

6) I UNDERSTAND:

- *By signing this consent form, I am giving permission for written, verbal or electronic communication between Vail Place and the organization or individual identified in this consent.*
  - **If you want to limit communication to written/electronic format only, please note this using the "Other" option in Section 4.**
- *This information may be disclosed to other parties who are entitled to it by law and is therefore no longer protected under the privacy rule.*
  - **Please refer to Vail Place's Notice of Privacy Practices for more information**
- *If I do not identify a specific expiration date or event below, this consent will end one year from the DATE SIGNED at the bottom of this form.*
  - **Authorizations to Release Information are typically valid for one year unless you choose a different date or event.**
  - **If you do not want the consent form valid for one year, you must add a specific end date or event below your signature.**

7) CLIENT SIGNATURE AND/OR LEGALLY AUTHORIZED REPRESENTATIVE: **DO NOT SIGN ON INSTRUCTIONS PAGE**

- Please sign and date this form using today's date.
- ***OPTIONAL** AUTHORIZATION IS VALID UNTIL:*
  - **The end date can be any date after today. If you don't add an end date, the consent will expire one year from the date signed.**
  - **Instead of an end date, you can choose to end the authorization after a specific event occurs. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."**
- If you are a legally authorized representative of the client, please sign, date and indicate your relationship to the client. You may be asked to provide documents showing that you are the client or the client's legally authorized representative.

DEPARTMENT OF HUMAN SERVICES

DHS-4797B-ENG 3-17

Behavioral Health Home (BHH) Services Rights, Responsibilities and Consent

Purpose of this form

The purpose of this form is to explain what behavioral health home (BHH) services are, what your responsibilities are if you choose to participate in behavioral health home services and to get your consent to review your eligibility for services. To determine if you are eligible for services, the behavioral health home provider must review your diagnostic assessment. If you choose to participate in the program, your provider will give you a separate form to get your permission to share your protected health information (PHI) with your other medical and service providers. You don't have to give your permission to share your PHI, but if you don't it will affect the services you can get from your behavioral health home provider.

The goals of behavioral health home services are that an individual:

- Has access to and utilizes routine and preventative health care services
- Has consistent treatment of mental health and other co-occurring health conditions
- Gains knowledge of health conditions, effective treatments and practices self-management of health conditions
- Learns and considers healthy lifestyle routines
- Has access to and uses social and community supports to assist the individual with the individual's goals

Individual Responsibilities

I understand that:

- In order to receive behavioral health home services, a certified BHH provider must conduct a diagnostic assessment, or review my current diagnostic assessment to determine if I am eligible for services.
- I must maintain regular communication with my behavioral health home team, this means:
  - I will tell a member of my BHH team if I go to the emergency room or if I am admitted to the hospital.
  - I will return phone calls, email or other communications from my BHH team.
- I must work with my behavioral health home team to identify my health and wellness goals and to complete my health wellness assessment and health action plan.
- I understand that I will not be able to get the following case management or care coordination services at the same time I am getting BHH services:
  - Assertive Community Treatment (ACT)
  - Mental Health Targeted Case Management (MH-TCM)
  - Health Care Home care coordination services

Individual Rights

I understand that I have the following rights:

- Behavioral health home services are voluntary. I can stop receiving services at any time.
- If I decide to stop receiving behavioral health home services, I will continue to receive my other health care services covered under Medical Assistance.
- If I am a minor child, my parents or legal guardian might have access to some of my PHI even if I do not give them permission.
- If I have concerns about the behavioral health home services that I am receiving, I can contact DHS at Behavioral.Health.Home.Services@state.mn.us.
- The behavioral health home provider must tell me in writing if the provider determines that I am ineligible for BHH services. The provider must also tell me the reasons why I am not eligible for BHH services in writing.

Provider Responsibilities

To provide behavioral health home services, a provider must:

- Be enrolled as a Minnesota health care programs provider.
- Meet the certification standards for behavioral health home service providers.
- Assist participants to find answers to questions about the participant's health and wellness.
- Assist participants to obtain available services and supports to meet the participant's health and wellness goals.
- Ensure that the participant's primary care provider and behavioral health provider understands and is working to achieve the participant's health and wellness goals.
- Follow all state and federal laws regarding private health information.

I have discussed this information with the certified behavioral health home provider listed below. I understand that by signing this form, I am giving the provider permission to determine if I am eligible for BHH services. If the provider determines that I am eligible for BHH services, I want to participate in the program, and I understand my rights and responsibilities.

INDIVIDUAL'S FIRST NAME	MI	LAST NAME		DATE OF BIRTH
SIGNATURE				DATE
NAME (Print)		RELATIONSHIP TO PARTICIPANT		PHONE NUMBER
ADDRESS		CITY	STATE	ZIP CODE

BHH PROVIDER			PHONE NUMBER
Vail Place - Vail Care			952-938-9622
ADDRESS	CITY	STATE	ZIP CODE
23 9th Avenue S.	Hopkins	MN	55343

800-657-3739

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ: ካለምንም ከፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မိတခါအံၤန္ဉာ်,ကိးဘဉ်လီတဲစီနီါ်လၢထးအံၤန္ဉာ်တကွ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA1 (9-15)

ADA Advisory

For accessible formats of this publication or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service.