VAIL PLACE NOTICE OF PRIVACY PRACTICES

This document is adapted from U.S. Department of Health and Human Services Model Notice of Privacy Practices that includes an overlay of Minnesota's additional legal requirements. It is intended to be adapted by health care providers to suit their individual needs. *Minnesota's legal requirements* are in *italic* text.

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

Your rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. If you have questions, please talk to staff or the Privacy Official, Shelly Zuzek at (952) 945-4250 or szuzek@vailplace.org.

Copy of medical record

Receive an electronic or paper copy of your medical record

- You can ask to see or copy an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information within a reasonable time.
- *If you ask to see or receive a copy of your record for purposes of reviewing current medical care, we may not charge you a fee. [Minn. Stat. § 144.292 subd. 6]*
- *If you request copies of your patient records of past medical care, or for certain appeals, we may charge you specified fees. [Minn. Stat. § 144.292 subd. 6]*

Request to amend medical record

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

Request for us to contact you confidentially

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Request to limit use/ sharing of TPO

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations (TPO). We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. *Minnesota Law requires consent for disclosure of treatment, payment, or operations information. [Minn. Stat. § 144.293 subd. 2]*

List of those with whom we've shared information

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Copy of this privacy notice

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

File a complaint

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington, D .C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

Request us not to share

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us NOT to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Will never share without permission

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Minnesota Law also requires consent *for most other sharing purposes.*

Fundraising

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

Our uses and disclosures for TPO

How do we typically use or share your health information?

We typically use or share your health information in the following ways. *We need your consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent due to your condition or the nature of the medical emergency. [Minn. Stat. § 144.293, subd. 2 and 5]*

Treat you

In general, we can use your health information and share it with other professionals who are treating you *only if we have your consent.*

Example: Vail Place staff coordinate services with other organizations on your behalf, when you provide consent by signing an Authorization

to Release Information form. In some situations we are able to share information without your consent with Hennepin County to coordinate services on your behalf.

In some cases, we may need to release your health information to other professionals or involved parties *without your consent* if it is an emergency and you are unable to provide consent due to the nature of the emergency. *We may also share your health information with other Vail Place staff or affiliates. [Minn. Stat. § 144.293, subd. 2 and 5]*

Example: We don't need your written permission to provide health information to emergency personnel if you are experiencing a medical or psychiatric emergency.

Run our organization

We can use and share your health information to run our programs and services, improve your care, and contact you when necessary. *We are required to obtain your consent before we release your health records to other providers for their own health care operations. [Minn. Stat. § 144.293, subd. 2 and 5]*

Example: We will use your health information to manage your care and services at Vail Place.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities only if we obtain your consent. [Minn. Stat. § 144.293, subd. 2 and 5]

Example: We will ask you to sign our Consent to Receive Services form which gives us permission to share billing information with health plans.

Other uses and disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Public health and safety

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Research

Do research

We can use or share your information for health research *if you do not object. [Minn. Stat. § 144.295 subd. 1]*

Comply with the law

To Comply with the Law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. *[Minn. Stat. § 144.293 subd. 2]*

Organ and tissue donation

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations *only with your consent. [Minn. Stat. § 525A.14]*

Medical Examiner

Work with a medical examiner or coroner

We can share health information with a coroner and medical examiner when an individual dies. *We need consent to share information with a funeral director. [Minn. Stat. § 390.11 subd. 7 (a)]*

Workers' comp, law enforcement, government

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or *with a law enforcement official with your consent, unless required by law. [Minn. Stat. § 144.293, subd. 2]*
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services *with your consent, unless required by law. [Minn. Stat. § 144.293, subd. 2]*

Respond to legal actions

Respond to law suits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena. In some cases a court order may be required. *[Minn. Stat. § 144.293 subd. 2]*

Other state law	**Comply with other state laws** In Minnesota, we need your consent before we disclose protected health information for treatment, payment, and operations purposes, unless the disclosure is to a related entity, or the disclosure is for a medical emergency and we are unable to obtain your consent. We will never share any substance abuse treatment records without your written permission. *[Minn. Stat. §§ 13.386, 254A.09]*

Our Responsibilities

Maintain privacy & security	We are required by law to maintain the privacy and security of your protected health information.
Inform of breach	We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
Follow notice practices	We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

Changes to the Terms of this Notice	We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

Effective Date	January 15, 2016 (replaces February 1, 2015 version)
Name and contact of Privacy Official	Shelly Zuzek, MSW, LICSW 952-945-4250 szuzek@vailplace.org. VAIL PLACE 23 - 9th Avenue South Hopkins, MN 55343 www.vailplace.org

How Vail Place uses or shares your private information.

Vail Place staff working at our facilities and site-based projects/ partnerships follow this Notice of Privacy Practices.
We create and access your private information to provide and to coordinate your care. Information we receive from others and documents we create will be stored in our secure electronic health record or in a locked cabinet. We have developed safeguards to keep your information private. The information in your file will be accessible to staff who need it to provide services to you and to do their jobs.

We will share your private information as defined in this notice or as required to comply with external business contracts. Vail Place may use or disclose your information to related entities to coordinate care, make reports, respond to audits, evaluate our programs, and follow up on complaints. Program funders, including Hennepin County, may access your file for the sake of evaluation or complaint investigation.

Our Case Management program has a partnership with Hennepin County. Two county employees are part of our work team and may have access to some of your information, but do not have access to your health record.

Vail Place Consent to Receive Services

Revised 12/01/2019

Welcome to Vail Place Services! This document contains important information about our services and policies. Please read it carefully and ask staff any questions you might have. When you sign that you have received this document, it represents an agreement between you and Vail Place for services.

Program Services: Vail Place offers a variety of services that are designed to help you on your recovery journey including Clubhouse program, case management, vocational, housing, benefits assistance, health and wellness and other services related to your needs. Staff will encourage and support you in developing recovery goals. Services will be provided at Vail Place, in the community or in your home.

Eligibility: For ***some*** Vail Place programs, we are required to obtain a Diagnostic Assessment to verify that you have a mental illness and are eligible to receive services. Service eligibility is regularly reviewed and you will be sent a notice if you are determined to be no longer eligible for services.

Confidentiality: Protecting the privacy and confidentiality of your health information is very important to Vail Place. We will get your permission before sharing your information except in an emergency or when required by law. Our ***Notice of Privacy Practices*** **outlines your privacy rights. You have the right to read Notice before you sign that you agree to the information in this Consent form.**

Communication: The preferred mode of communication with staff is in person or by phone. Texting and email are not secure ways to communicate with staff. Staff will respond to messages during regular business hours, excluding nights, weekends and holidays. If you have an emergency you are advised to contact COPE at 612-596-1223 or 911. Staff will generally reply to messages within 24-48 hours**.** You may receive text notifications for appointments with staff. These texts do not contain private information and you may choose to opt out.

Benefits and Risks: There are many benefits to receiving Vail Place services. You will have help identifying and accomplishing your goals, receive resource information, and help to access other services. A potential risk to receiving services is that there may be times when you share information with others that could bring up difficult issues for you. Staff can assist you in locating a therapist if needed.

Alcohol, Illegal Substance, and Tobacco-free Grounds:

Vail Place grounds are alcohol, illegal substance, and tobacco free. If you are under the influence of alcohol or illegal substances you will be asked to leave. We kindly ask you to respect our tobacco free grounds. Individuals who do not comply may be asked to leave. If staff are meeting you in your home, it is requested that you not smoke 30 minutes prior to and during appointments. If you do not comply with the request your appointment may be rescheduled.

Emergency Procedures: Staff are trained to manage crisis or emergency situations:

- If you are experiencing a psychiatric crisis, staff may contact Community Outreach for Psychiatric Emergencies (COPE) at 612-596-1223 or call 911. COPE provides community crisis intervention. Staff will work with COPE or emergency professionals and provide information needed to help you.
- Vail Place is required by law to make a report if you or other persons are in physical danger.

Qualifications of Staff: Most staff are Mental Health Practitioners or Professionals and have diverse education and training backgrounds. All receive ongoing training in the area of mental health.

Alternatives: There are other providers in Hennepin County. We can assist you in contacting other providers or Hennepin County's Intake and Assessment if you do not want to receive services from Vail Place.

Access to records: You have a right to review your file or request a copy of it. Please talk with staff who will connect you with a supervisor to begin the process.

Tennessen Warning: The Information you provide is generally private. You are not required to answer the questions asked, but we may not be able to help you if you don't provide us with some information. The information you provide may be shared with other staff in the state system whose jobs require access and with staff in this or other agencies as provided by law.

Required Reporting: Vail Place staff are mandated to report suspicion of physical or sexual abuse, financial exploitation or neglect to the proper authorities. If we suspect you (or another vulnerable person or child) are being abused in any of these ways, we are required to report it right away to make sure you (or others) stay safe.

Non-Discrimination: Vail Place does not discriminate against anyone seeking services in accordance with all laws, rules and regulations. **If at any point you feel you have been discriminated against or have not received the services you feel you should, please follow the Grievance Policy that you have received and contact a supervisor.** As an agency, Vail Place is an equal-opportunity employer that values the diversity of its community, both in our staff and in those whom we serve. In our work with people, we strive for respectful relationships that honor the differences in who we are. Just as we do not tolerate discrimination of any kind towards you, we expect the same respect in return. We do not allow sexual harassment, use of racial/homophobic slurs, or any other abusive behavior. Any type of prejudice or harassment experienced by staff will be addressed and may result in changes to your service at Vail Place.

Payment for Services: Vail Place is reimbursed for providing some services, such as Case Management, Vail Care (Behavioral Health Home) or Vail House (Group Residential Housing). By signing acknowledgment of this form, you are giving permission for Vail Place to request reimbursement from Medical Assistance providers, Hennepin County, or the State of Minnesota for services you receive. In order to get reimbursed, we must share some private information, such as your name, address and date of birth.

> ***For Vail Care Enrollees****: if you have Medical Assistance with a spenddown, you will be responsible for paying any part of the cost for Vail Care services not covered by MA.*
>
> ***For Vail House Residents****: based on your countable income, service funding rules may require you to pay part of the costs for your housing.*

Vail Place engages in service partnerships with some health systems and associated clinics. If you are referred to Vail Place by one of our community partners, the staff who work in these programs may have limited access to your health information. This access is used to help coordinate your services and care. This information will be held confidential in the same way as your Vail Place record.

I, the client (or guardian), understand I have the right to not to sign that I received this form, however I may not be able to access services if I don't. My signature indicates that I understand this information. If I have questions about any of the items in this form, I will ask staff.

If acknowledgement is not captured in the electronic record, please sign on a paper Signature Page form.

Welcome to Vail Place: Program Review and Expectations
04/01/2016

The Clubhouse is an intentional community centered on providing a ***safe and welcoming environment*** for all members, staff and visitors. The program offers a variety of services including: employment; supported education; social programming; health and wellness; housing; crisis assistance; individual recovery goal planning and referrals to other programs.

Your participation is voluntary and you may attend as frequently as you want. "Once a member, always a member". Vail Place is required to determine if you are eligible to receive services bases on your diagnosis and to update this information every three years. We ask that you sign an **Authorization to Release Information** form so that we may get this information. If you don't sign this form we will not be able to offer services to you. This information will be kept confidential and is only accessible to staff. We may ask you to give permission so that we may request or share information with others involved in your recovery to coordinate services to assist you.

Confidentiality in the Clubhouse setting: Vail Place is dedicated to protecting your private information and takes precautions to keep your information confidential. However, due to philosophy of the Clubhouse others may have more access to your information than at other programs. The environment of the Clubhouse is a semi-public community where one will need to be aware of what and to whom you share your personal information. You may decide this is not acceptable and you want to access services elsewhere.

- Some of your personal information that **will be accessible** to members may include: your first and last name, your birthdate, sign-in sheets or your phone number.
- Information that other members **will not have access** to would be your social security number, your diagnosis, your address, and information in your individual record.
- The telephones are answered by staff and members and are trained in procedures to help protect your privacy. However, there is a risk that someone could accidently disclose that you attend Vail Place. We will try to make sure this doesn't happen, but we are unable to guarantee this.

Clubhouse Expectations:

- Maintain good personal grooming and hygiene and wear clothes that are appropriate for the workplace. Staff will help you if you need it, however you may be asked to leave if it is an ongoing problem.
- Please do not **borrow** cigarettes or money from others or **ask** for rides from members who have cars. However the **offering** from one member to another these items is allowed.
- In providing a safe community sexual harassment or the solicitation of sexual favors is not permitted.
- Do not sell or give prescription medications, drugs or alcohol to other members.
- Do not use alcohol or illegal drug use on-site. If you come to Vail Place under the influence, staff will evaluate your situation to determine if you need medical attention. This may involve calling 911. If you do not need medical attention, staff will ask you to leave the Clubhouse. If you appear to be under the influence and you attempt to transport yourself in your car, staff must call 911 to alert them of your condition. If you need help with your substance use, staff will assist you to locate services.

Activity Agreement: Vail Place offers activities that occur in the community. We take measures to ensure the safety of members. Vail Place will not be held responsible for medical or other expenses if an accident occurs during a Vail Place sponsored activity. If you chose to drive your vehicle and transport members, Vail Place will not be liable and will not assume responsibility for any damages or injuries that occur as result of an accident. The responsibility rests with vehicle owner and their personal vehicle insurance coverage.

If acknowledgement is not captured in the electronic record, please sign and date below:

Printed name: _____

Signature: _____

Date: _____

Grievance Policy and Procedure

Policy: Vail Place will use a formalized process for handling grievances.
Purpose: To outline the steps for grievances and grievance resolution, and procedures of documentation.
Scope: This policy and procedure applies to individuals served by Vail Place.

Procedures:

1.0 Individuals will be informed of the Grievance Procedure at the time of initial involvement.

2.0 Before filing a formal grievance, the individual with the grievance is encouraged to make every effort to communicate/resolve the issue(s) with their staff advocate or case manager.

3.0 Grievance forms are given to individuals at the time of intake and are available from staff and supervisors or upon request from the Compliance Officer.

3.1 The individual will write his or her grievance on the form, or dictate it to another person if unable to write it out.

3.2 The person filing the grievance will sign and date the form.

3.3 Grievances will be first submitted to the direct supervisor, who will review and contact the individual within two business days to acknowledge receipt of the Grievance form.

3.4 The supervisor will complete the Grievance Response section within seven (7) business days and will share the response with the person filing the grievance.

3.5 The supervisor will then forward the grievance to the Compliance Manager for review.

3.6 The Compliance Officer will review the form; add comments if necessary and sign. If the Compliance Officer is unable to review the grievance, the Executive Director will assume the responsibility.

4.0 If, at this point, the grievance is not resolved to the satisfaction of the person filing it, he or she may request that the grievance be forwarded to the Executive Director.

4.1 If the grievance remains unresolved after the Executive Director provides a response, the individual may request the Executive Director forward the grievance to the Board of Director's Executive Committee.

5.0 Individuals with a grievance are encouraged to seek resolution through the above procedures; however, they may at any time present the grievance directly to the Minnesota Department of Human Services, the Minnesota Department of Human Rights or Hennepin County.

5.1 The phone numbers for resources available to help resolve complaints are as follows:

- Hennepin County 612-879-3350
- Minnesota Human Rights Commission 763-535-1051
- State Mental Health Ombudsman 651-757-1800
- Mental Health Association of Minnesota 612-331-6840

6.0 Grievance paperwork will be scanned and attached to the client's record in an attachment folder accessible only to the Compliance Officer.

6.1 The Compliance Officer will create a note in the EMR documenting that a Grievance was filed and who it was filed against. This note is private and only available to the Compliance Officer.

6.2 If the grievance is regarding a staff member, the paperwork will also be sent confidentially to the Human Resource department, who will attach the paperwork to the staff record with access limited to only the HR Department.

Attachments: Grievance Form

Reference: MN State Laws

Revision Date: September 24, 2014; September 22, 2016
Changes: 9/22/16 changed language related to staff titles from manager/director to supervisor
Approved By: Shelly Zuzek, Compliance Officer

VAIL PLACE GRIEVANCE FORM

Date of Grievance: _____

Name of person filing Grievance: _____

Address of person filing Grievance: _____
Phone number: _____

Write out (clearly) the Grievance in the space below (or attach additional pages):

Signature of person filing Grievance: _____

ADMINISTRATIVE SECTION (Completed by supervisor):

Date Received: _____ Date of Follow-up Action: _____

Response to Grievance (completed by supervisor):

Compliance Officer Response (optional):

Compliance Officer Signature: _____
Date: _____

Clubhouse International
Creating Community: Changing the World of Mental Health

International Standards for Clubhouse Programs ™

The International Standards for Clubhouse Programs, consensually agreed upon by the worldwide Clubhouse community, define the Clubhouse Model of rehabilitation. The principles expressed in these Standards are at the heart of the Clubhouse community's success in helping people with mental illness to achieve social, financial, educational and vocational goals. The Standards also serve as a "bill of rights" for members and a code of ethics for staff, board and administrators. The Standards insist that a Clubhouse is a place that offers respect and opportunity to its members.

The Standards provide the basis for assessing Clubhouse quality, through the Clubhouse International Accreditation process.

Every two years the worldwide Clubhouse community reviews these Standards, and amends them as deemed necessary. The process is coordinated by the Clubhouse International Standards Review Committee, made up of members and staff of Accredited Clubhouses from around the world.

MEMBERSHIP

1. Membership is voluntary and without time limits.

2. The Clubhouse has control over its acceptance of new members. Membership is open to anyone with a history of mental illness, unless that person poses a significant and current threat to the general safety of the Clubhouse community.

3. Members choose the way they utilize the Clubhouse, and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members.

4. All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.

5. Members at their choice are involved in the writing of all records reflecting their participation in the Clubhouse. All such records are to be signed by both member and staff.

6. Members have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a significant and current threat to the Clubhouse community.

7. The Clubhouse provides an effective reach out system to members who are not attending, becoming isolated in the community or hospitalized.

RELATIONSHIPS

8. All Clubhouse meetings are open to both members and staff. There are no formal member only meetings or formal staff only meetings where program decisions and member issues are discussed.

9. Clubhouse staff are sufficient to engage the membership, yet few enough to make carrying out their responsibilities impossible without member involvement.

10. Clubhouse staff have generalist roles. All staff share employment, housing, evening and weekend, holiday and unit responsibilities. Clubhouse staff do not divide their time between Clubhouse and other major work responsibilities that conflict with the unique nature of member/staff relationships.

11. Responsibility for the operation of the Clubhouse lies with the members and staff and ultimately with the Clubhouse director. Central to this responsibility is the engagement of members and staff in all aspects of Clubhouse operation.

SPACE

12. The Clubhouse has its own identity, including its own name, mailing address and telephone number.

13. The Clubhouse is located in its own physical space. It is separate from any mental health center or institutional settings, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.

14. All Clubhouse space is member and staff accessible. There are no staff only or member only spaces.

WORK-ORDERED DAY

15. The work-ordered day engages members and staff together, side-by-side, in the running of the Clubhouse. The Clubhouse focuses on strengths, talents and abilities; therefore, the work-ordered day must not include medication clinics, day treatment or therapy programs within the Clubhouse.

16. The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems.

17. The Clubhouse is open at least five days a week. The work-ordered day parallels typical working hours.

18. The Clubhouse is organized into one or more work units, each of which has sufficient staff, members and meaningful work to sustain a full and engaging work-ordered day. Unit meetings are held to foster relationships as well as to organize and plan the work of the day.

19. All work in the Clubhouse is designed to help members regain self worth, purpose and confidence; it is not intended to be job specific training.

20. Members have the opportunity to participate in all the work of the Clubhouse, including administration, research, enrollment and orientation, reach out, hiring, training and evaluation of staff, public relations, advocacy and evaluation of Clubhouse effectiveness.

EMPLOYMENT

21. The Clubhouse enables its members to return to paid work through Transitional Employment, Supported Employment and Independent Employment; therefore, the Clubhouse does not provide employment to members through in-house businesses, segregated Clubhouse enterprises or sheltered workshops.

Transitional Employment

22. The Clubhouse offers its own Transitional Employment program, which provides as a right of membership opportunities for members to work on job placements in the labor market. As a defining characteristic of a Clubhouse Transitional Employment program, the Clubhouse guarantees coverage on all placements during member absences. In addition the Transitional Employment program meets the following basic criteria.

a. The desire to work is the single most important factor determining placement opportunity.

b. Placement opportunities will continue to be available regardless of the level of success in previous placements.

c. Members work at the employer's place of business.

d. Members are paid the prevailing wage rate, but at least minimum wage, directly by the employer.

e. Transitional Employment placements are drawn from a wide variety of job opportunities.

f. Transitional Employment placements are part-time and time-limited, generally 15 to 20 hours per week and from six to nine months in duration.

g. Selection and training of members on Transitional Employment is the responsibility of the Clubhouse, not the employer.

h. Clubhouse members and staff prepare reports on TE placements for all appropriate agencies dealing with members' benefits.

i. Transitional Employment placements are managed by Clubhouse staff and members and not by TE specialists.

j. There are no TE placements within the Clubhouse. Transitional Employment placements at an auspice agency must be off site from the Clubhouse and meet all of the above criteria.

Supported and Independent Employment

23. The Clubhouse offers its own Supported and Independent Employment Programs to assist members to secure, sustain, and better their employment. As a defining characteristic of Clubhouse Supported Employment, the Clubhouse maintains a relationship with the working member and the employer. Members and staff in partnership determine the type, frequency and location of desired supports.

24. Members who are working independently continue to have available all Clubhouse supports and opportunities as well as participation in evening and weekend programs.

EDUCATION

25. The Clubhouse assists members to reach their vocational and educational goals by helping them take advantage of educational opportunities in the community. When the Clubhouse also provides an in-house education program, it significantly utilizes the teaching and tutoring skills of members.

FUNCTIONS OF THE HOUSE

26. The Clubhouse is located in an area where access to local transportation can be assured, both in terms of getting to and from the program and accessing TE opportunities. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.

27. Community support services are provided by members and staff of the Clubhouse. Community support activities are centered in the work unit structure of the Clubhouse. They include helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in accessing quality medical, psychological, pharmacological and substance abuse services in the community.

28. The Clubhouse provides assistance, activities and opportunities designed to help members develop and maintain healthy lifestyles.

29. The Clubhouse is committed to securing a range of choices of safe, decent and affordable housing including independent living opportunities for all members. The Clubhouse has access to opportunities that meet these criteria, or if unavailable, the Clubhouse develops its own housing program. Clubhouse housing programs meet the following basic criteria.

    a. Members and staff manage the program together.
    b. Members who live there do so by choice.
    c. Members choose the location of their housing and their roommates.
    d. Policies and procedures are developed in a manner consistent with the rest of the Clubhouse culture.
    e. The level of support increases or decreases in response to the changing needs of the member.
    f. Members and staff actively reach out to help members keep their housing, especially during periods of hospitalization.

30. On a regular basis the Clubhouse conducts an objective evaluation of its effectiveness, including Clubhouse International Accreditation.

31. The Clubhouse director, members, staff and other appropriate persons participate in a comprehensive two or three week training program in the Clubhouse Model at a certified training base.

32. The Clubhouse has recreational and social programs during evenings and on weekends. Holidays are celebrated on the actual day they are observed.

FUNDING, GOVERNANCE AND ADMINISTRATION

33. The Clubhouse has an independent board of directors, or if it is affiliated with a sponsoring agency, has a separate advisory board comprised of individuals uniquely positioned to provide financial, legal, legislative, employment development, consumer and community support and advocacy for the Clubhouse.

34. The Clubhouse develops and maintains its own budget, approved by the board or supported by an advisory board, which provides input and recommendations prior to the beginning of the fiscal year and routinely monitors it during the year.

35. Staff salaries are competitive with comparable positions in the mental health field.

36. The Clubhouse has the support of appropriate mental health authorities and all necessary licenses and accreditations. The Clubhouse collaborates with people and organizations that can increase its effectiveness in the broader community.

37. The Clubhouse holds open forums and has procedures which enable members and staff to actively participate in decision making, generally by consensus, regarding governance, policy making, and the future direction and development of the Clubhouse.

Clubhouse International

747 Third Avenue – 2nd Floor
New York, New York 10017
USA
Telephone: 212 582 0343
Web: www.clubhouse-intl.org

October 1989 ©
Revised as of December 2018

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	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:** **23 9th Avenue S, Hopkins MN 55343**
Phone:	**FAX:**

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:

- 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.

VailPlace

transforming the lives of people with mental illness through community

Vail Place has given me courage and a place where I am accepted unconditionally. I don't think I'd be where I am today without Vail Place. – Ralph

The staff at Vail Place helped me see potentials in myself I didn't know existed. People saw me as a person and not as a "mental illness." – Christine

23 - 9th Avenue South
Hopkins, MN 55343
952.938.9622
952.938.7934 fax

www.vailplace.org

MEMORANDUM

To: All Vail Place program participants
From: Vail Place
Date: 1/9/19

Vail Place has joined a growing movement among organizations across the State of Minnesota to focus on the whole health of program participants and staff by adopting tobacco-free policies.

This decision is because tobacco use is the leading cause of disease, disability and death in the United States. Addressing tobacco use can greatly improve the length and quality of life and is in line with Vail Place's mission to foster hope, health and recovery for people living with mental illness.

In keeping with this policy, **Vail Place Administrative Offices, Hopkins and Uptown Clubhouse locations will be tobacco-free as of April 1st, 2019**. As of this date, all staff, program participants and visitors are expected to be tobacco and smoke free during open (work) hours on our grounds.

Additionally, the policy recognizes that second-hand smoke is a hazard to people's health. Therefore, Vail Place staff are not permitted to smoke at an individual's home or in their presence. **It is requested that individuals not smoke in Vail Place staff's presence, during and 30 minutes prior to appointments.**

Finally, if you are interested in resources to stop smoking or using tobacco products, please ask Vail Place staff for more information.

Thank you for your support of Vail Place and our mission!

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request access to the protected health information about me that has been created or is maintained by **Vail Place**.

INDIVIDUAL WHO IS THE SUBJECT OF THE PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: ____/____/____ (mm/dd/yy)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

PLEASE NOTE THE FOLLOWING:

1. Vail Place will respond to your request promptly; no later than 30 days from the request.
2. We may deny access to protected health information in certain situations and conditions. If you are denied access to any portion of the protected health information requested, we will notify you in writing of the reason for the denial. We will also inform you of any rights you may have to have the denial reviewed.
3. You may refuse to sign this authorization. Your refusal will **not** affect your ability to obtain treatment, but you will not be able to obtain copies of your records without signing this form.
4. There is a charge for requesting copies of your records. A summary of charges is outlined in the Records Request Fees section of this form.
5. Vail Place will not charge for records requests in some situations, as outlined in our "Individual's Right to a copy of their PHI" policy. Please see the Records Request Fees section of this form for more information.
6. You may request that we mail your information to you, if you agree to shipping and handling costs as identified in the Records Request Fees section of this form.
7. You may request a summary of the protected health information, if you agree to any cost associated with producing the summary.

TIME PERIOD OF REQUEST

I am requesting access to the protected health information created or received by **Vail Place** between:
____/____/____ and ____/____/____ (mm/dd/yy).

INFORMATION BEING REQUESTED

I am requesting access to the following protected health information created or maintained by Vail Place:

☐ Treatment or Goal Plans
☐ Clinical assessments or records
☐ Diagnostic Assessments or other records documenting eligibility for Vail Place services
☐ Authorization to Release Information forms
☐ Information recorded in the Client Profile
☐ Progress notes or records documenting services provided by Vail Place employees
☐ Progress notes or records received from other providers
☐ Other (describe the information as specifically as possible):

_____

_____

_____

_____

RECORDS REQUEST FEES

In some situations, Vail Place will not charge for records requests. Please contact the Supervisor handling your request if you believe it meets any of the following conditions:

- for the purpose of reviewing the individual's current medical care, defined as: the most recent Goal Plan, Functional Assessment, LOCUS and/or Crisis Plan created by Vail Place; current Authorization to Release Information forms; and last six months of Progress Notes; or
- for the purposes of appealing a denial of social security disability income or social security disability benefits under the Social Security Act; or
- for the purposes of further appeals, an individual may receive no more than two updates of their information without charge, but only for information previously not provided.

☐	CHARGE:	COST:	SUPERVISOR COMMENTS:
☐	Records Preparation (required)	$15.00	
☐	Copies of records – per page (required)	$1.00 X _____	
☐	Shipping and handling (optional)	$5.00	
☐	Summary of Protected Health Information (optional*)	$20.00	
☐	Other charges – determined at discretion of Vail Place's HIPAA Privacy or Security Officer		
	ESTIMATE OF COSTS:		

*If you only request a Summary of Protected Health Information, you will not be charged records preparation and copying fees.

LOCATION TO SEND THE INFORMATION

I am requesting that the protected health information be delivered to me as follows:

☐ I will pick up the copies of my protected health information;
☐ Please fax copies of my protected health information to the following number: _____
☐ Please provide an electronic copy of my protected health information (CD format)
☐ Please mail the copies of my protected health information to the address provided above
☐ Please mail the copies of my protected health information to the following address:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

INDIVIDUAL'S (OR LEGAL REPRESENTATIVE'S) NAME: _____

INDIVIDUAL'S (OR LEGAL REPRESENTATIVE'S) SIGNATURE: _____

DATE: _____

CAPACITY OR AUTHORITY OF LEGAL REPRESENTATIVE* (IF APPLICABLE): _____
*May be requested to provide verification of representative status.

Form 100 5/05/2014