Welcome to Vail's Results Focused Model (RFM) Program:

Vail Place has provided services to people experiencing mental health concerns for 38 years and has helped many individuals on their journey to healthier and happier lives.

Vail has a contract with HealthPartners, your insurance carrier, and they have recommended you for this program. We are excited to work together to help you make changes in your life.

If you are experiencing mental health or medical conditions that you are having trouble managing, we will provide you with support to help things improve.

Here are a few examples of what we can offer you:

- Providing you with a Navigator who will stay involved with you while you are in our program.
- Helping you work towards your goals.
- Helping you learn about housing options if you are homeless or not living in a safe place.
- Helping you manage medical conditions such as Asthma, Diabetes, or Heart Disease by:
  - Connecting you to a primary care physician or a specialist;
  - Talking with Vail's nurse about your health;
  - Helping you make appointment to see your doctor and arranging medical transportation;
  - Helping coordinate your care by talking with your doctors; and
  - Supporting you during your appointments.
- Helping you find the best mental health providers or programs for you if your symptoms are causing you difficulties by:
  - Coordinating with your providers; and
  - Providing support if you are experiencing symptoms or are in a crisis.

Connection to Vail's Clubhouse Community Support Program:

We will introduce you to our Clubhouse Community Support Program where you be with others and work together to run our program. Here are a few opportunities at the Clubhouse:

- Supporting your job search;
- Joining your fellow members for a $2 lunch and dinner several times a week;
- Participating in health and wellness activities such as tobacco support groups, meditation group, and walking club; and
- Participating in softball, picnics, musical activities, camping and so on!

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 & Security Official, Jen Boulton at (952) 945-4231 or jboulton@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 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.

Our Uses and Disclosures

Our uses and disclosures for TPO ... cont'd

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	August 1, 2018 (replaces January 15, 2016 version)
Name and contact of Privacy Official	Jen Boulton, Director of Operations 952-945-4231 jboulton@vailplace.org. VAIL PLACE 23 - 9th Avenue South Hopkins, MN 55343 www.vailplace.org

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.

Vail's Results Focused Model Program
Consent to Services Addendum

The Results Focused Model Program (RFM) is offered through a partnership with HealthPartners Insurance. You have been referred by HealthPartners to receive this service that is provided through Vail Place. This is a voluntary service and listed below are a few ways we can help you:

- Have a Navigator to work with you 1:1 to set goals and get connected to services or programs.
- Have access to a Registered Nurse to help manage your health conditions.
- Access support from a housing specialist if needed.
- Get support with finding a job.
- Get connected to the Vail Clubhouse Program for support, connection to others, nutritious meals, socialization, etc.

There are many other benefits to the Results Focused Model and you will not be charged for this service through your insurance.

You must have Medical Assistance with HealthPartners to receive this service. If you change insurance, you will not be eligible for the RFM Program. We will help refer you to other programs or services if you change your insurance.

I have read and understand the information above and agree to receive services through the RFM.

Please provide this copy to the individual and capture signature in Credible Record or on the paper Signature Page.

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: _____

Vail's Results Focused Model Program: Summary of Rights and Responsibilities

You can expect the following from the Results Focused Team members:

1. Courteous, respectful treatment and communication by team members.
2. If a team member will not be able to keep a scheduled appointment for any reason, you will be notified as soon as possible.
3. Because drive times can be unpredictable, you can expect that staff will arrive within 15 minutes on either side of the agreed upon appointment time. Occasionally, inclement weather or other circumstances beyond our control may cause staff to be more than 15 minutes late for an appointment. In these instances, staff will attempt to reach you by phone to notify you of the impending late arrival.
4. If you leave a message for a team member, you can expect a call back within 1 business day, sooner if possible.
5. Our team will work to connect you with other resources and support services as needed.
6. Our team will collaborate with others involved with you to assure the best care for you.
7. You can request a change to the goals/strategies outlined in your Goal Plan at any time.

The team will expect the following of you during your time with our program:

1. Courteous, respectful treatment and communication with our team members.
2. If you will not be able to keep a scheduled appointment for any reason, please call the team member and notify us at least one hour before the scheduled start of the appointment.
3. You agree to meet regularly with the team members, at a minimum meet once/month in person. If you agree to this, we will send you text message reminders.
4. You will notify the team in a timely manner of any changes to your contact phone number or address.
5. You will notify the team if your Medical Assistance coverage with HealthPartners changes. **PLEASE REMEMBER:** YOU CAN NOT RECEIVE THIS SERVICE UNLESS YOU HAVE HEALTHPARTNERS INSURANCE.
6. You will notify Vail Care immediately if you need help with completion of routine benefit-related paperwork to prevent a lapse in coverage.
7. You will identify one or more goal areas which the team can help support you in. You will work together with the team to make progress on these goals.

Vail Place is teaming up with HealthPartners to offer a new program, Results Focused Model, to HealthPartners members. Vail Place is a community-based organization with 39 years of experience providing high-quality service to people living with mental illnesses.

The Results Focused Model (RFM) program offers support from a navigator and a nurse who can help connect you to resources, healthcare, and other providers, as well as to community support to address challenges you may be facing and to help you live your best life. This program is available at no cost to you.

The care coordination team at HealthPartners works closely with the RFM team to ensure you receive excellent care and support. We hope that you choose to participate in this exciting and beneficial new program.

We look forward to the opportunity to work with you. If you have questions, contact your HealthPartners team at (952) 883-7774 or RFM staff at Vail Place, Sarah Barrett at 952-529-1010 or Julie Plante at 952-807-6337.

Thank You!

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.

VAIL PLACE AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION FOR REFERRAL PURPOSES

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) REASONS FOR RELEASING OR OBTAINING INFORMATION: (This form is only to be used to make referrals and secure services, housing, etc.)

Describe the nature of the referral:

3) I AUTHORIZE VAIL PLACE TO RELEASE INFORMATION TO OR OBTAIN INFORMATION FROM THE FOLLOWING TYPES OF ORGANIZATIONS:

☐ Waivered Housing Options
☐ Assisted Living Facilities
☐ Intensive Residential Treatment Services Programs (IRTS)
☐ Nursing Homes
☐ Housing programs (list type of program):_____
☐ Nancy Page Crisis Residence or other Crisis Program (please identify): _____
☐ Other:

_____

OPTIONAL:

☐ I APPROVE ONLY THE ORGANIZATIONS LISTED: _____
☐ I DO NOT APPROVE THE FOLLOWING ORGANIZATION(S): _____

4) This consent is valid for communication with Vail Place employees as needed to complete the referral process. Please direct communications to:

Primary Vail Place Contact:	**Phone:**
☐ **23 9th Avenue S, Hopkins MN 55343**	☐ **FAX:**

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

☐ Program Intake Assessment
☐ Discharge summary from hospital or other program
☐ Clinical Diagnostic Assessment
☐ Psychiatric Assessment/Evaluation
☐ Treatment Plan or Community Support Plan
☐ Case Notes
☐ Progress Reports/Treatment Records
☐ Basic Medical Information
☐ Other:
☐ Income and economic benefits information
☐ Medical insurance information
☐ Housing History
☐ Educational and vocational history
☐ Program and service involvement
☐ Civil Court information (MI or MI/CD)
☐ Legal information, including any current legal processes
☐ Medication Records

_____

☐ **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)*

6) I UNDERSTAND AND AGREE:

- **This consent is only valid until the REFERRAL IS COMPLETED, unless I indicate an earlier date or event below.**
- 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.

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: 09/01/16

VAIL PLACE AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION FOR REFERRAL PURPOSES

FORM INSTRUCTIONS:

By signing this form, you are giving permission for Vail Place to release or obtain your health information with others, for the purpose of making referrals on your behalf. **We encourage you to read all instructions and information before completing and signing the form.**
Please note the following:

- This form is only to be used to provide referrals. This will allow Vail Place staff to efficiently share your information with a variety of providers to access services for you more quickly.
- 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.**
- 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 case management 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) REASONS FOR RELEASING OR OBTAINING INFORMATION: Describe what the purpose of this referral is. Be as specific as possible.

3) I AUTHORIZE VAIL PLACE TO:

- In this section, identify what types of organizations you want case management to share your health information with.
- The primary use of the Referral Release form is to allow Vail Place to share information with others.
- **Please be as specific as possible.** If you want to limit the disclosure, you can specify the places you want your information **shared with** or you can name specific organizations you **do not want** your information shared with.

4) THIS CONSENT IS VALID FOR COMMUNICATION WITH EMPLOYEES AS NECESSARY TO COMPLETE THE REFERRAL PROCESS.

5) THE INFORMATION SHARED MAY INCLUDE:

- Indicate what health information you want shared. **Select ONLY the information you are authorizing to be released or shared.**
- 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.
- Please be aware that for the purposes of this referral consent, **we may re-disclose information** in your record that was obtained from other providers/agencies. **If you do not want to have information we have obtained from others re-disclosed, please request that your case manager provide you with the main Authorization to Release information form in to use instead.**

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.**

6) I UNDERSTAND:

- The consent is valid until the referral is completed unless I indicate an earlier date or event in this section.
- By signing this consent form, I am giving permission for written, verbal or electronic communication between Vail Place and the employees at the types organizations 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.

7) CLIENT SIGNATURE AND/OR LEGALLY AUTHORIZED REPRESENTATIVE:

- Please sign and date the form using today's date.
- 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

CRISIS NUMBERS

First Call for Help—211

COPE (Community Outreach for Psychiatric Emergencies)--612-596-1223
Children's Mental Health Crisis—612-348-2233
Metro Warmline (Tuesday-Saturday, 4-10pm)—651-288-0400
National Suicide Prevention Lifeline -- 1-800-273-8255
1-800-SUICIDE (1-800-784-2433) – www.hopeline.com
1-800-273-TALK (8255) – www.suicidepreventionlifeline.org
Crisis Text Line: text MN to 741741—www.crisistextline.org
Department of Veterans' Affairs (VA) – www.mentalhealth.va.gov
--Veterans can call 1-800-273-TALK (8255) and press "1" to reach the VA hotline

Hennepin County Medical Center – Acute Psychiatric Services (APS)
--Assessment & Referral – 612-873-3161
--Suicide Hotline – 612-873-2222

Nancy Page Crisis Residence (call for availability)—612-870-3787
--Address: 245 Clifton Avenue South, Minneapolis, MN 55403

Walk-In Counseling (2421 Chicago Avenue South) -- 612-870-0565

AA Greater Minneapolis Intergroup -- 952-922-0880
AIHCDC Detox at 1800 Chicago Ave—612-879-3646
Mission Detox—763-559-1402
Cochran Recovery Services Detox in Hastings—651-437-4209
Fairview Detox—612-672-6600

Crisis Nursery—763-591-0100

Case Manager: _____ Phone: _____

Additional Numbers That Are Helpful to Me: