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 reach out to your staff member or contact the Privacy & Security Officials at (952) 945-4269 or Compliance@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.
- We may say "no" to your request, but we'll tell you why in writing within 60 days. *[HIPAA regulation 45 CFR Part 164.526]*

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	May 1, 2023 (replaces August 1, 2018 version)
Contact Us	Privacy & Security Officials 952-945-4269 compliance@vailplace.org. VAIL PLACE 23 - 9th Avenue South Hopkins, MN 55343 www.vailplace.org

Vail Place Consent to Receive Services

Revised 05/1/2023

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 reviewed regularly 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 the 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 call 988, your county crisis line, 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.

Telehealth Services: Confidentiality still applies for video conferencing services, and Vail Place will not record the session. The Vail Place provider will be in a private space and make every effort to avoid or minimize interruptions. This also applies to interpreters. By consenting to Telehealth Services, you are consenting to receive email or text communication regarding appointments, using the contact information you provide to us. Vail Place has identified video conferencing tools which are secure, HIPAA-compliant forms of communication. If you have a legal guardian, we need the permission of your legal guardian for you to participate in video conference sessions. Telehealth services may be discontinued if you decline to use video conferencing services, or if you or your Team identifies safety risks or other barriers to receiving telehealth services.

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 or may have your appointment rescheduled. Please refrain from using prior to your scheduled appointment. We kindly ask you to respect our tobacco free grounds.

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

- If you are experiencing a psychiatric crisis, staff may contact your local crisis line or call 911. Employees will work with crisis 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.

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

Access to records: You have a right to request a copy of your records. The request form is on our website, or you can ask your program staff for a copy of the form.

Encounter Alert System: If you are enrolled in a Medical Assistance paid health plan, Vail Place may receive notifications through the Encounter Alert System (EAS) regarding your hospitalizations and access to emergency departments. Vail Place uses this information to coordinate your services and provide support for your medical and mental health needs. You may opt out of these notifications by informing program staff.

Tennessen Warning Notice: 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 services at Vail Place.

Payment for Services: Vail Place is reimbursed for providing some services. This includes programs such as Case Management, Vail Care (Behavioral Health Home), Housing Stabilization Services, Vail Connect & Assertive Outreach. By signing acknowledgment of this form, you are giving permission for Vail Place to request reimbursement from Medical Assistance providers, other contracted 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.*

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.

Your rights regarding this document: Vail Place staff review this consent with individuals served at the time of intake. If you have questions about any of the items in this form, you can ask the staff working with you to explain. We ask you to sign a form to confirm it has been reviewed and that you understand this information. As the person receiving services (or the guardian of a person receiving services), you can choose not to provide your signature. However, you may not be able to access services if you do not provide your signature.

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: _____

Work Together Agreements

Empowered Relationships

Vail Place strives to work with you in a person-centered way, where you are treated with respect and in charge of the decisions in your own life. The staff you work with at Vail Place will encourage you to share your hopes for the future and provide you support to accomplish those goals. We understand the basis of positive working relationships depends on openness, honesty, and trust. We encourage you to discuss frequently with staff providing feedback about the services you receive. We want you to get the best support possible, and that requires us to know what is most helpful for you.

Vail Place embraces the strengths and values of all individuals; this applies to people accessing services and our employees. Our mission is to help people avoid crisis, achieve stability, and pursue active, fulfilling lives. We do this through a work- and relationship-oriented approach that empowers each person to take control of their own recovery.

Expectations of one another

Positive working relationships come with clear boundaries and expectations of one another. Vail Place believes that diversity and different identities among people should be celebrated and embraced.

Vail Place employees will:

- Treat you with respect and honor your values
- Follow through with tasks as agreed upon
- Explore resources you are looking for and be honest with you about limitations in resources that are available
- Attend meetings as scheduled or communicate with you ahead of time if unable to attend

Individuals receiving services will:

- Treat staff with respect
- Attend meetings as scheduled or communicate ahead of time if unable to attend

Unacceptable behavior

Vail Place will not tolerate language or actions that are disparaging of any group or individual. We strive to build spaces that are welcoming and supportive for people from all walks of life. Examples of unacceptable behavior may include but are not limited to:

- Language or actions that are disparaging of other people's race, culture, abilities, religion, sex, gender identity, sexual orientation or otherwise derogatory comments towards other groups or individuals
- Ethnic slurs, racial comments, gender-specific comments, offensive jokes, or anything that may be construed as harassment or showing disrespect for others
- Hostile, confrontational, or threatening behavior
- Abusive behavior
- Unwanted physical contact or sexual advances

If you experience any form of the behaviors listed above, please let us know.

- ***Individuals receiving services*** may contact a supervisor directly, or complete a grievance form, available on our website (www.vailplace.org) or by request from an employee. Vail Place's phone number is **952-938-9622**.
- ***Employees*** may contact their supervisor or contact Human Resources for assistance.

Vail Place reserves the right to suspend or discontinue services to those who violate these behavioral expectations in our work together. Individuals will be provided information regarding other service providers who may be able to address their needs.

Vail Place Case Management
Termination of Services Appeal Process

10/15/11

Case Management Services will end **10** days after you have been notified by your case manager.

- If you do not agree with the decision to discontinue your services you may make an appeal by completing the attached appeal form within **7** business days of receiving this notice. **You can continue to receive case management services during your appeal.** The appeal form should be sent to the following address:

  Jolene Peterson
  23 9th Ave South
  Hopkins, MN 55343

- The appeal will be reviewed by the Clinical Services Team and the decision will be communicated to you within **4** business days of receipt of the appeal. This will be considered the final decision of Vail Place.

- You have the right to make an appeal regarding this decision directly to the state agency. Please note that you must begin the appeal process with the State of Minnesota within **30** days after receiving the this notice and the Hennepin County Notice of Action form or within **90** days if you can show a justified reason for your delay. Your written appeal should be sent to the following address:

  Minnesota Department of Human Services
  444 Lafayette Road
  St. Paul, MN 55155-3813

VAIL PLACE
MENTAL HEALTH CASE MANAGEMENT
APPEAL FORM

Name: _____ Date: _____
(month/date/year)

Address: _____

_____

_____ Phone Number: (____)_____

Why do you feel you are eligible to continue receiving Case Management services?

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Signature: _____

Date Received: _____

Response to Appeal:

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Clinical Services Manager/Director Signature

MEDICA BEHAVIORAL HEALTH MEMBER RIGHTS

1. If you do not agree with the decision made by Medica Behavioral Health you may file an appeal. If you decide to appeal it will NOT affect your eligibility for medical benefits. There is no cost to you for filing a health plan appeal or State fair hearing.
2. If we are stopping or reducing a service, you can ask to keep getting the service when you file a health plan appeal or a State fair hearing **within ten days after we send you the notice, or before the service is stopped or reduced, whichever is later.** The treating provider must agree the service should continue. The service can continue until the appeal or State fair hearing is resolved. If you lose the appeal or State fair hearing, you may be billed for the service.
3. **If you have seen a medical provider who is part of Medica Health Plans (Medica) and want another opinion, you can get a second opinion. You must see another Medica medical provider.**
4. If you have seen a mental health provider who is part of Medica Behavioral Health and have been told that no structured mental health treatment is needed, you may get a second opinion. If you have seen a chemical dependency assessor who is part of Medica Behavioral Health and you disagree with the assessment, you may get a second opinion. The second opinion **must be provided by a licensed mental health provider or chemical dependency assessor, who does not need to be a Medica Behavioral Health provider but MUST be prior approved by Medica Behavioral Health.** Medica and Medica Behavioral Health must consider the second opinion but does not have to accept a second opinion for medical or mental health services.
5. You can have a relative, friend, advocate, provider, or lawyer help with your appeal or State fair hearing. A provider may appeal on your behalf with your written consent. Your attending health care provider may appeal a service authorization decision *without* your consent. You may present your evidence and facts about the case in person, by telephone, or in writing.
6. You may ask for a decision to be made quickly for urgently needed services.
7. If you ask to see your medical records, or want a copy, your provider or your health plan must provide them to you at no cost. You may need to put your request in writing.

HOW TO REQUEST AN APPEAL OR STATE FAIR HEARING

- We suggest you contact Medica Behavioral Health first to talk about the decision but you are not required to do so. Our phone number is 952-769-1396 or 1-800-848-8327 ext. 31396. TTY 1-800-543-7162 or 711; or through the Minnesota Relay at 1-877-627-3848 (speech to speech relay service).
- You can choose to appeal to the health plan or request a State fair hearing, OR you may do both at the same time. You do not have to finish one process before using another
- Tell why you disagree with the decision. If you need a decision quickly, state that in your appeal or request for State fair hearing. If you need help, contact Customer Service at the health plan or the State ombudsman.

You must follow the appeal and State fair hearing time lines.

APPEAL TO MEDICA BEHAVIORAL HEALTH Or APPEAL TO Medica

Write to: **Medica Behavioral Health**,
MN CAC – Attn: Appeals;
P.O. Box 1459, MR:MN045-S210
Minneapolis, MN 55440-1459

Or call: **Medica Behavioral Health**
Customer Service at:
952-769-1396 or 1-800-848-8327 ext. 31396.
TTY 1-800-543-7162 or 711;
or through the Minnesota Relay at 1-877-627-3848 (speech to speech relay service).

Write to: **Medica Health Plans**
State Public Programs
P.O. Box 9310, CP340
Minneapolis, MN 55440-9310

Or call: **Medica Customer Service** at:
952-992-2322 or 1-800-373-8335.
TTY 952-992-2357 or 1-800-234-8819.

You must appeal within 90 days after the date of this notice.

- If your appeal is about an urgently needed service, we will give you an answer within 72 hours. If we do not agree that the service is urgently needed, we will tell you within 24 hours. If you disagree, you may file a grievance with us or request a State fair hearing.
- Within 10 days we will tell you that we received your appeal.
- We will give you a decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.
- You may see your case file, including medical records and other documents considered by us during the appeal process. You may request your case file anytime before or during the appeal.

REQUEST A STATE FAIR HEARING

Write to: Appeals Office/Department of Human Services Or fax: 651-431-7523
PO Box 64941
St. Paul MN 55164-0941

- A Human Services Judge will hold a meeting. You can choose to attend in person or by phone.
- You must request a State fair hearing in writing within 30 days after the date of this notice. You have up to 90 days if you have a good reason for being late.
- The process can take between 30 and 90 days.
- If your hearing is about a medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

OMBUDSMAN

A State ombudsman may be able to help with your problem. They can also help you appeal to the health plan or request a State fair hearing.

Write to: Minnesota Department of Human Services
Ombudsman for Managed Health Care Programs
PO Box 64249
St. Paul, MN 55164-0249

Or Call: 651- 431-2660 or toll free 1-800-657-3729
TTY: 711 or 1-800-627-3529

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.

Request For Access to Protected Health Information

I hereby request access to the Protected Health Information (PHI) about me that has been created or is maintained by **Vail Place**.

My Information:

Full Legal Name:	Date of Birth:	
Address:		
City:	State:	Zip Code:
Phone Number:	Email Address:	

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.

Time Period of Request

I am requesting access to the PHI created or received by **Vail Place** between:

____/____/_____ and ____/____/_____ (mm/dd/yyyy).

If not specified we will provide records for one year from date of request.

Information Being Requested

I am requesting access to the following PHI 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
- ☐ All records
- ☐ Other (describe the information as specifically as possible):

_____

_____

Request For Access to Protected Health Information

Location to Send the Information

I am requesting that the PHI be delivered to me as follows:

- ☐ I will pick up printed copies of my PHI
- ☐ Please fax copies of my PHI to the following number: _____
- ☐ Please securely email copies of my PHI to: _____
- ☐ Please mail the copies of my PHI to the address provided above
- ☐ Please mail the copies of my PHI 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):

- ☐ Guardian
- ☐ Other legal representative: _____

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: