Crow Wing County HIPAA Notice

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

As part of providing services to you, we will collect information about your health care. We need this information to provide you with quality services and to comply with certain legal requirements. This notice applies to all of the records of your care generated at Crow Wing County. The law requires us to:

- make sure that information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to information about you; and
- follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Information About You. Listed below are a number of reasons or ways in which information about you might be disclosed. In each category we will explain what we mean and give an example. NOT EVERY USE OR DISCLOSURE IN A CATEGORY WILL BE LISTED. The ways we might disclose information include:

For Treatment. We may disclose information about you to any personnel at Crow Wing County or outside of Crow Wing County who are involved in your care. For example, your nurse may need to share information about your medications with your psychiatrist or physician.

For Payment. We may use and disclose information about you so that services may be billed and payment may be collected from you, an insurance company, or a government health program. We may also tell your health plan about a service you may receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use information about you to run our program and to make sure you receive quality services, or to decide if we should change or modify our services.

As Required by Law. We will disclose information about you when required by federal, state, or local law. For example, we may reveal information about you to the proper authorities to report suspected abuse or neglect.

To Avoid a Serious Threat to Health or Safety. We may use or disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans. If you are a member of the armed forces, we may release information about you as required by military command authorities.

Workers' Compensation. We may release information about you for workers' compensation or similar programs.

Health Oversight Activities. We may disclose information to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning your services, we may disclose information about you in response to a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. In certain situations, we may release information about you to law enforcement officials. For example, we might release information about you to identify or locate a missing person; about a death that may be the result of criminal conduct; or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description of location of the person believed to have committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release information to a coroner or medical examiner to identify a deceased person or determinate a cause of death. We may release information to funeral directors as necessary to help them carry out their duties.

National Security and Intelligence, Protective Services for the President and Others. We may release information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Correctional Programs. If you are an inmate or in the custody of a law enforcement officer, we may release information about you to the correctional institution or law enforcement official, for example, to provide you with health care, to protect your health and safety or the health and safety of others.

Your Rights Regarding Information About You (you have the following rights:)

To Inspect and Copy Your Crow Wing County Medical Record(s). Usually, this includes medical and billing records, but may exclude psychotherapy notes. To inspect and copy information in your record, you must submit your request in writing to your worker or State Director or HIPAA Privacy Officer. We may charge a fee for the costs of copying, mailing or other costs related to your request. In very limited circumstances, we may deny your request. If we deny your request, you may ask that the denial be reviewed. Another licensed health care professional of Crow Wing County's choice will review your request for review.

To Amend Your Records. If the information we have about you is incorrect or incomplete, you may make a written request to the HIPAA Privacy Officer to amend the information. You must include a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information kept in our file;
- is not part of the information you would be permitted to inspect and copy or
- we believe the information is accurate and complete.

If you disagree with the denial, you may submit a statement of disagreement. If you request an amendment to your record, we will include your request in the record, whether the amendment is accepted or not.

To Receive an Accounting of Disclosures. We will keep a log of disclosures made on or after April 14, 2003, other than disclosures for treatment, billing or health care operations. You have the right to request the list of disclosures. You must submit a written request to the HIPAA Privacy Officer. The request may not cover more than a six-year period.

To Request Restrictions. You may request a restriction on the disclosure of information about you for treatment, payment or health care operations. Your request must be in writing and made to the HIPAA Privacy Officer. Your request must tell us 1) what information you want to limit; 2) whether you want to limit our use, our disclosure or both; and 3) to whom you want the limit to apply. For example, you could ask that we not use or disclose information to a certain person about services you've received. We do not have to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To Request Alternative Ways to Communicate. You may request that we communicate with you about your services in a certain way or at a certain location. For example you can ask that we contact you only at work, or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and it must be and sent to the HIPAA Privacy Officer. We will accommodate all reasonable requests.

To Receive a Paper Copy or Electronic Copy of this Notice. You have the right to receive a paper copy or an electronic copy of this notice. You may request either a paper or an electronic notice from the HIPAA Privacy Officer.

Additional Rights Under State Law. State privacy laws may provide additional privacy protections. Any such protections will be listed in our Tennessen Notice.

Changes to this Notice. We may change this notice in the future. We can make the revised or changed notice effect for information we already have about you as well as any information we have in the future.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer or with the Secretary of Health and Human Services. All complaints must be in writing.

We will not retaliate against you for filing a complaint.

Privacy Officer
Crow Wing County
County Administrator's Office
326 Laurel St.
Brainerd, MN 56401
Phone: (218)824-1055

Office of Civil Rights
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D.C. 20201
Phone: (866)627-7748

Crow Wing County Privacy Rights
(THE TENNESSEN NOTICE)

YOU HAVE THE RIGHT TO PRIVACY

The Minnesota Government Data Practices Act aids in protecting your right to privacy. You have the right to know that most of the information we collect about you is private. That *means you and the government agencies that need* the *information can see it; others cannot.* We can take statistics and other anonymous data from information we collect. This is public and open to anyone, but it will not identify you in any way. In a few cases, information we collect is confidential. Confidential Data is not open to anyone (not even you), except the *government agencies that need it.* Data *in this category* deals *with* adoption, *investigations,* some medical data, and the names of reporters of abuse and neglect.

Purpose of Information

The information we ask you to provide will help determine whether you are eligible for Social *Services.* It will enable *us to collect* federal *or state funds. We can* determine *which services* are appropriate and make referrals. We can then develop treatment plans, and evaluate and audit programs.

You are not legally required to provide information and may refuse to do so.
If you choose not to give information, you will probably not be able to receive the services for which you are applying.

Right to Access to Your Records

Access By You—you can see all records about yourself. You can see your file by going to the Social Services office and asking. It may take a few days, but 10 working days is the longest *you* will *have to wait. You may ask for copies. Each page copied* will *cost 25 cents. You may* also give other people permission to see your records.
Access By Others—We may give information about you to other agencies, if they need it for investigations or to help you or help us help you. This does not mean we always share information about you with these people. It only says that the law says we may share some information sometimes. We may share information with the following agencies:

- Minnesota Department of Human Services
- Anyone under contract with the Minnesota Department of Human Services or U.S. Department of Health and Human Services Other County Social Service Agencies Mental Health Centers
- State Hospitals or Nursing Homes
- Ombudsman for Mental Health and Mental Retardation
- Insurance Company to check benefits
- Hospital if you, a friend, or relative has an emergency and someone needs to be contacted County Welfare Board
- Others who may pay for your care
- County Attorney, Attorney General, or other Law Enforcement Officials, and the Court system if your case is referred for investigation or prosecution
- State and federal auditors
- Your guardian
- Local and state health departments
- Employees or volunteers of this agency who need the information to do their jobs Child or adult protection teams

Crow Wing County Appeal Rights

YOU HAVE THE RIGHT TO APPEAL

- **Appeal rights.** You have the right to appeal if the county denies, reduces, suspends or terminates social services or if you or your authorized representative do not agree with the services identified in your service plan. To start an appeal, send a very short letter saying you want to appeal to:

Write:	Call:	
Minnesota Department of Human Services	Metro:	(651) 431-3600 (Voice)
Appeals Office	Outstate:	(800) 657-3510
PO Box 64941	TTY:	(800) 627-3529
St. Paul, MN 55164-0941	Fax:	(651) 431-7523

The Appeals Office will hold a hearing and allow you and/or your authorized representative and the county to explain their positions. Shortly after the hearing the Appeals Office will issue a written decision, outlining the facts in your case and determining if the county has acted correctly.

- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age, or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies:

Minnesota Department of Human Services
Office for Equal Opportunity
PO BOX 64997
St. Paul, MN 55614-0997
(651) 431-3040 (Voice)
(866) 786-3945 (TTY)

Minnesota Department of Human Rights
190 East 5th St., Suite 700
St. Paul, MN 55101
(800) 657-3704 (Voice)
(651) 296-1283 (TTY)

U.S. Department of Health and Human Services
Office of Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 866-2359 (Voice)
(312) 353-5693 (TTY)

ACKNOWLEDGEMENT

I received a copy of Crow Wing County's HIPAA/Privacy Notice. I have had an opportunity to review it and to ask questions.

I understand that by submitting a written request, that I may receive a copy of my file; request an amendment to my file; request alternative communication methods; request limited distribution of information in my file; or obtain an accounting of disclosures.

Consumer's Name _____

Consumer's Signature _____ Date _____

Services	Phone Numbers
Administrative	(218) 824-1140
Child Support	(218) 824-1260
Community Corrections	(218) 824-1135
Health Services	(218) 824-1080
Income Maintenance	(218) 824-1250
Social Services	(218) 824-1140
Toll free	(888) 772-8211

COMMUNITY SERVICES
204 LAUREL ST.
P.O. BOX 686
BRAINERD, MN 56401
WWW.CROWWING.US
FAX (218) 824-1305
EMAIL CWCSS@CROWWING.US

MISSION: WORKING TOGETHER TO STRENGTHEN OUR COMMUNITY

Community Services Referral for AMH/SUD

CWC-1062
08/19

Date: _____

Client Information

Name: _____ Date of Birth: _____

SSN: _____

Home Address: _____

Other Address: _____

Phone: _____ Email: _____

What is the current need/request from Crow Wing County Community Services?

- ☐ Mental Health Case Management (TCM)
- ☐ Substance Use Disorder – Treatment/Care Coordination
- ☐ Consolidated Funding for CD Treatment needed - **CCTDF** – Please fill out last section also.
- ☐ Homeless, Assistance with Housing and/or Housing Search
- ☐ Assistance with other Community Referrals
- ☐ Other: _____

Please briefly describe specific needs:

PMI/MA#: _____ County of Financial Responsibility: _____ PMAP: _____

Medicare Number: _____ Medicare Part D provider: _____

Do you have private health insurance? ☐ No ☐ Yes (list) _____

Are you a veteran? ☐ No ☐ Yes (explain) _____

Do you have a…

☐ Social Worker	Name/County: _____	Phone: _____
☐ Child Protection Social Worker	Name/County: _____	Phone: _____
☐ Probation Officer	Name/County: _____	Phone: _____

Mental Health Diagnoses

Other Community Mental Health Supports (i.e Psychiatrist, ARMHS, etc.)

Alcohol/Drug

Diagnoses:

Drug of choice:_____ Date of last use: _____

Date of last assessment and which agency completed it: _____

Medical

Medical Diagnoses/Health Problems:

Have you Been Diagnosed with Any infectious Diseases:

Medication List:

Who is prescribing them? _____

Pharmacy used? _____

General Practitioner Name: _____ Agency & Phone #: _____

Transportation

Method: _____

Financial

Income (list type(s) & amount(s))_____

Rep Payee? _____

Guardian/Conservator Name: _____ Agency & Phone #: _____

Individual's Support/Safety/Crisis Plan(s)

Referent information

Agency: _____

Individual Contact: _____ Role: _____

Phone: _____ Fax: _____ Email: _____

Does client know of this referral?_____

Please attach any applicable information to referral. (i.e. med list, ROI, applicable assessment, etc.)

FOR CCDTF ONLY

Marital Status**:** ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Who do you live with? (i.e. parents, spouse, biological children).

***Please do not include unmarried partners or their children.**

_____

Race: _____

Income (Please provide the two most recent proofs of income at the time of assessment, if applicable)

Do you and/or your spouse receive income? ☐ No ☐ Yes	How often?	How much?
1. Employment (hourly, salary, or by the day)	_____	_____
2. Tips	_____	_____
3. Commission	_____	_____
4. General Assistance (GA)	_____	_____
5. SSI, Social Security, or Disability	_____	_____
6. Child Support (received)	_____	_____
7. Other income	_____	_____
8. Total from above		_____
9. Child Support (paid)		_____
Total income (income received minus child support paid)		_____

Applicants Signature _____

COMPREHENSIVE ASSESSMENT SUMMARY

Recommendations **DATE:**

CLIENT NAME:

DOB:

Referral:

Dimension 1 - acute intoxication/withdrawal potential:
Consider the client's ability to cope with withdrawal symptoms and current state of intoxication.

Severity Rating
Narrative supporting risk description:

Dimension 2 - biomedical conditions and complications:
Consider the degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort; determine the impact of continued chemical use on the unborn child if the client is pregnant.

Severity Rating
Narrative supporting risk description:

Dimension 3 - emotional, behavioral, and cognitive conditions and complications:
Determine the degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas and the likelihood of risk of harm to self or others.

Severity Rating
GAINS: SS Score:
Narrative supporting risk description:

Dimension 4 - readiness for change
Consider the amount of support and encouragement necessary to keep the client involved in treatment.

Severity Rating
Narrative supporting risk description:

Dimension 5 - relapse, continued use, and continued problem potential:
Consider the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

Severity Rating
Narrative supporting risk description:

Dimension 6 - recovery environment:
Consider the degree to which key areas of the client's life are supportive of our antagonistic to treatment participation and recovery.

Severity Rating
Narrative supporting risk description:

Does the client meet DSM criteria for substance use disorder:

DSM-V Criteria for Substance Abuse
Instructions
Determine whether the client currently meets the criteria for a Substance Use Disorder using the diagnostic criteria in the DSM-V, pp. 481-589. Current means during the most recent 12 months outside a facility that controls access to substances.

Category of substance	Severity	ICD-10 Code/DSM V Code
☐ Alcohol Use Disorder	☐ Mild	☐ (F10.10) (305.00)
	☐ Moderate	☐ (F10.20) (303.90)
	☐ Severe	☐ (F10.20) (303.90)
☐ Cannabis Use Disorder	☐ Mild	☐ (F12.10) (305.20)

	☐ Moderate ☐ Severe	☐ (F12.20) (304.30) ☐ (F12.20) (304.30)
☐ Hallucinogen Use Disorder	☐ Mild ☐ Moderate ☐ Severe	☐ (F16.10) (305.30) ☐ (F16.20) (304.50) ☐ (F16.20) (304.50)
☐ Inhalant Use Disorder	☐ Mild ☐ Moderate ☐ Severe	☐ (F18.10) (305.90) ☐ (F18.20) (304.60) ☐ (F18.20) (304.60)
☐ Opioid Use Disorder	☐ Mild ☐ Moderate ☐ Severe	☐ (F11.10) (305.50) ☐ (F11.20) (304.00) ☐ (F11.20) (304.00)
☐ Sedative, Hypnotic, or Anxiolytic Use Disorder	☐ Mild ☐ Moderate ☐ Severe	☐ (F13.10) (305.40) ☐ (F13.20) (304.10) ☐ (F13.20) (304.10)
☐ Stimulant Related Disorders	☐ Mild	☐ (F15.10) (305.70) Amphetamine type substance ☐ (F14.10) (305.60) Cocaine ☐ (F15.10) (305.70) Other or unspecified stimulant
	☐ Moderate	☐ (F15.20) (304.40) Amphetamine type substance ☐ (F14.20) (304.20) Cocaine ☐ (F15.20) (304.40) Other or unspecified stimulant
	☐ Severe	☐ (F15.20) (304.40) Amphetamine type substance ☐ (F14.20) (304.20) Cocaine ☐ (F15.20) (304.40) Other or unspecified stimulant
☐ Tobacco use Disorder	☐ Mild ☐ Moderate ☐ Severe	☐ (Z72.0) (305.1) ☐ (F17.200) (305.1) ☐ (F17.200) (305.1)
☐ Other (or unknown) Substance Use Disorder	☐ Mild ☐ Moderate ☐ Severe	☐ (F19.10) (305.90) ☐ (F19.20) (304.90) ☐ (F19.20) (304.90)

Substance Use Disorder Diagnostic Criteria Documentation in the Assessment

A. A problematic pattern of use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

Check all that apply

☐ 1. Substance is often taken in larger amounts or over a longer period than was intended.

☐ 2. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

☐ 3. A great deal of time is spent in activities necessary to obtain substances, use substances, or recover from its effects.

☐ 4. Craving, or a strong desire or urge to use substances.

☐ 5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

☐ 6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substance use.

☐ 7. Important social, occupational, or recreational activities are given up or reduced because of substance use.

☐ 8. Recurrent substance use in situations is which it is physically hazardous.

☐ 9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance use.

10. Tolerance, as defined by either of the following:

☐ a. A need for markedly increased amounts of substance to achieve intoxication or desired effect.

☐ b. A markedly diminished effect with continued use of the same amount of a substance.

11. Withdrawal, as manifested by either of the following:

11. Withdrawal, as manifested by either of the following:

- ☐ a. The characteristic withdrawal syndrome for a particular substance
- ☐ b. Alternative substance is taken to relieve or avoid withdrawal symptoms.
- ☐ Specify if: In early remission: After full criteria for substance use disorder were previously met, none of the criteria for substance use disorder have been met for at least 3 months but for less than 12 months (with the exception that, "Craving, or a strong desire or urge to use," may be met).
- ☐ In sustained remission: After full criteria for substance use disorder were previously met, none of the criteria for substance use disorder have been mat at any time during a period of 12 months or longer (with the exception that Criterion, "Craving, or a strong desire or urge to use," may be met).
- ☐ Specify if: In a controlled environment: This additional specifier is used if the individual is in an environment where access to substances are restricted.

Current severity

- ☐ Mild: Presence of 2-3 symptoms.
- ☐ Moderate: Presence of 4-5 symptoms.
- ☐ Severe: Presence of 6 or more symptoms.

Counselor Signature: _____

Supervisor Signature: _____

CROW WING COUNTY MINNESOTA

Authorization for Disclosure of Information

CWC-1040
01-20

***Note*: All applicable items on this form should be completed to ensure prompt release of information.**

Client Information	**Client Name:**		**Date of Birth:**
	Previous Name(s):		**Phone #:**
	Address:	**Email Address:** (optional)	
	City:	**State:**	**Zip Code:**
Reason for Disclosure	☐ Coordination of Care ☐ Client Request/Personal ☐ Legal/Court ☐ Insurance Company ☐ Financial/Billing ☐ Family Request ☐ Other (please specify):		
How do you want the information released	☒ Exchange with (paper and/or verbal) ☐ Fax (for patient care only) ☐ Email (email required below) ☐ Pickup (photo ID required @ pickup) ☐ Mail (address required below) ☐ Verbal Only (NO actual records given)		
Release/Receive Information From Crow Wing County Community Services (CWC CS)	☐ Comm. Services ☐ Substance Abuse ☐ Child Protection ☐ Attorney's Office ☐ Community Corrections ☐ Jail ☐ Child Support		
	Business Name: Crow Wing County Community Services		**Phone #:**
	Contact Name:		**Fax #:**
	Address: 204 Laurel St.	**Email:**	
	City: Brainerd	**State:** MN	**Zip Code:** 56401
Recipient **To do the following:** ☐ Release info to ☐ Receive info from	**Business Name:**		**Phone #:**
	Contact Name:		**Fax #:**
	Address:	**Email:**	
	City:	**State:**	**Zip Code:**
Information to be Released (Disclosed) If dates are not specified, only the most recent visit will be released.	**Please Specify Dates of Service**	**From Date:**	**To Date:**
	☐ Progress Notes ☐ Diagnostic Assessment (DA) ☐ Psychological Evaluation ☐ School Records		
	☐ Verbal Only (NO Records) ☐ Medication Notes ☐ Psychiatric Evaluation ☐ Legal/Court/PO		
	☐ Treatment Plans ☐ Billing Records ☐ Summary of Services ☐ Social Services Info		
	☐ Other (please specify):		

Special Consents If dates are not specified, only the most recent visit will be released. **Prohibition on Re-Disclosure** (42 CFR, Part 2)	**This section for Chemical Dependency Records only.** **The law requires a Special Consent for Chemical Dependency Program Information.**		
	Please Specify Dates of Service	**From Date:**	**To Date:**
	☐ CD Assessment Summary ☐ CD Weekly Summary Notes ☐ CD Discharge Summary ☐ Rule 25 ☐ Verbal Only (NO records) ☐ Other (please specify):		
	Each disclosure made with the client's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.		

Re-Disclosure	**CWC CS cannot prevent the re-disclosure of records released as a result of this request, and after the information is released from CWC CS, the records may not be subject to the Federal Privacy Rule Laws.** A photo copy of this authorization will be treated in the same manner as the original.	
Expiration (not to exceed 1 year)	**This consent will expire one year from the date the form is signed** unless I indicate a different expiration date or event.	
	Date:	**Specific Event:** (can shorten or lengthen the expiration period)
Revocation	**I have the right to revoke this authorization at any time by giving written notice to the CWC Community Services Department.** I understand that the revocation will not apply: 1) to information that has already been released in response to this authorization, or 2) to my insurance company as the law provides my insurer with the right to contest a claim under my policy.	
Authorization	**Client, or Parent, or Guardian Signature:** (typing a name into this field is equivalent to an actual signature)	**Date:**
	Reason Client is unable to sign: ☐ Minor ☐ Legal (documentation req'd) ☐ Client is not own Guardian (documentation req'd) ☐ Other (please specify):	

Please return to Crow Wing County Community Services | 204 Laurel St., Brainerd, MN 56401
Telephone 218-824-1140 | Fax 218-824-1305 | Email cwcss@crowwing.us