Marion County
OREGON
Health & Human Services

Individual Orientation Information

Welcome to Marion County Children's Behavioral Health (CBH). We offer mental health services for youth ages 0-17. As a health department, our mission is to create a safe and welcoming environment where all people can access high-quality health and human services and are supported to achieve their highest level of health.

SAME DAY ACCESS

We are improving access to mental health services. The way our Same Day Access Model works is that once you have completed a Registration Form, you can call any day Monday to Friday between 8am-11am for an intake assessment. Assessments will take place at 1:00pm and take about 2 hours to complete.

ABOUT YOUR FIRST APPOINTMENT

Your first appointment is called an Intake. You will meet with a therapist, and we will learn about the concerns that brought you here. We will ask questions to understand your situation, and your goals. We will talk about what types of services and supports may help you. Together we will develop a plan tailored to your individual needs. The length and frequency of treatment will vary depending on the individual. Your therapist will discuss options with you.

THERAPEUTIC SERVICES THAT WE MAY RECOMMEND

Our therapists integrate a trauma informed lens while providing treatment.

- Psychotherapy- Individual and Family
- Group Therapy
- Skills Training- Individual and Group
- Psychiatric Assessment and Medication Management
- Case Management
- Peer Support Services

ABOUT CANCELLATIONS/NO-SHOWS

Treatment outcomes are affected by attendance; therefore, it is important that you attend your scheduled appointments.
For Intake Appointments:
If your registration is complete and you need to either cancel or access another intake appointment, please contact our Centralized Scheduling office at 503-576-4676. Our Same Day Access model invites you to call any day from Monday-Friday between 8am-11am to request an intake assessment that same day.
For Ongoing Therapy Appointments:
If you need to cancel your appointment, please notify CBH 24 hours prior to the appointment time by calling the following number. For CBH Salem, call 503-588-5352. For CBH Woodburn, call 503-981-5851. In the event of no-shows, we may not be able to provide services and your case may be closed. For 3 consecutive no-shows, you will receive a 10-day closing letter. We encourage you to discuss any questions or concerns you have about treatment with your therapist. If you would like to discuss the matter with someone other than your therapist, you may request to speak with a Supervisor.

ABOUT OUR LOBBIES/PARKING LOTS

We make every effort to provide a safe and welcoming atmosphere for you and your family. To do this, all youth under the age of 14 must be accompanied and supervised by their guardian or a responsible adult who has been identified by the guardian, when not in session with a therapist. We will not be responsible for your child's safety if left unsupervised on our premises (lobby or parking lot). Please talk with your therapist if you have any questions.

ABOUT CRISIS SERVICES

Crisis services are available 24 hours a day, 7 days a week. For Youth Family Crisis Services, call 503-576-4673 or go to 1118 Oak St. SE Salem, OR 97301. You can also call 988 to speak with a Lifeline provider. Lifeline providers are available in English and Spanish, and interpreting agencies are used for other languages.

Marion County Children's Behavioral Health Registration Form

Please fill out the following information for the person who will be receiving mental health services. You can complete this form online, print and mail it, or deliver in person to CBH Salem at 3867 Wolverine St Bldg. F NE Salem, OR 97305 or CBH Woodburn at 976 N Pacific Hwy Woodburn OR 97071. Please contact our Centralized Scheduling office at 503-576-4676 if you need assistance completing these forms.

Client Information

Last Name:	**First name:**	**MI:**
Legal Last Name at Birth:	**Date of Birth:**	**Social Security #**

Legal Sex/Gender: ◯ Male ◯ Female ◯ Other

Guardian/Parent Name:

Marital Status: ◯ Never Married ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Legal Status: ◯ None ◯ Probation ◯ Juvenile Psychiatric Security Review Board ◯ Guardianship (Court) ◯ Guardianship (Child Welfare) ◯ Aid & Assist ◯ Involuntary Custody

If ODHS Child Welfare Custody, check box ◯	**Resource Parent Name:**
Emergency Contact Name:	**Phone:**

Ethnicity: ◯ Puerto Rican ◯ Mexican ◯ Cuban ◯ Other Specific Hispanic ◯ Hispanic Origin Not Specified ◯ Not of Hispanic Origin

Race: ◯ Alaska Native ◯ American Indian ◯ Black or African American ◯ White ◯ Asian ◯ Native Hawaiian or Pacific Islander ◯ Other Single Race ◯ Two or More Specified Races

Tribal Affiliation: ◯ Unassigned ◯ Burns Paiute Tribe ◯ Confederated Tribe of Coos, Lower Umpqua & Siuslaw ◯ Coquille Indian Tribe ◯ Confederated Tribes of Grande Ronde ◯ Confederated Tribes of Siletz ◯ Confederated Tribes of Umatilla ◯ Confederated Tribes of Warm Springs ◯ Cow Creek Band of Umpqua Indians ◯ Klamath Tribes ◯ Not Applicable ◯ Other

Residential Address:	**City:**	**State:**	**Zip Code:**	**County:**

Mailing Address (If different than residential)

Living Arrangement: ◯ Transient/Homeless ◯ Foster Home ◯ Residential Facility ◯ Jail ◯ Other Private Residence ◯ Private Residence (At Home) ◯ Private Residence (With Relative) ◯ Private Residence (With Non-Relative) ◯ Residential Facility (BRS)

Oregon Health Plan (OHP) ID #

Primary Health Insurance: ◯ Private Health Insurance/Manage Care Organization ◯ Medicare ◯ Medicaid/OHP ◯ Other ◯ None ◯ Other Health Plan Name

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Marion County Children's Behavioral Health Registration Form

Primary Phone: | **Type:** ◯ Home ◯ Mobile ◯ Work ◯ Legal Guardian

Preference: ◯ Voice Message ◯ Detailed Message ◯ Call Back Only ◯ No Message

Text Primary: ◯ Yes ◯ No

Secondary Phone: | **Type:** ◯ Home ◯ Mobile ◯ Work ◯ Legal Guardian

Preference: ◯ Voice Message ◯ Detailed Message ◯ Call Back Only ◯ No Message

Text Secondary: ◯ Yes ◯ No | **How would you like to receive appointment reminders?** ◯ Home ◯ Mobile ◯ Work

Contact Email:

Primary Language:

Interpreter Needed: ◯ Foreign Language ◯ Hearing Impaired ◯ None

Primary Care Provider Name:

Clinic Name/Location:

Highest Grade Completed: | **If currently a student, school name:**

Source of Income/Support: ◯ Wages/Salary ◯ Public Assistance ◯ Retirement/Pension/SSI ◯ Disability/SSDI ◯ Other ◯ None

Estimated Gross Household Monthly Income: | ◯ No Income ◯ Refuse to Answer

Expected/Actual Source of Payment: ◯ Self-Pay ◯ Medicare ◯ Medicaid/OHP ◯ AMH County Financial Assistance Agreement ◯ Other Government Payments ◯ Worker's Compensation ◯ Private Health Insurance ◯ No Charge ◯ Other

Total Number in Household: | **Number of Child Dependents:**

Referred From: ◯ Child Welfare ◯ Vocational Rehabilitation ◯ Developmental Disabilities ◯ School ◯ Community Based MH and/or SA Provider ◯ State Psychiatric Facility (i.e., OSH) ◯ Coordinated Care Organization (CCO) ◯ Private Health Professional ◯ Justice Court ◯ Jail – City or County ◯ Police or Sheriff – Local, State ◯ Probation – County/State/Federal – Includes Juveniles ◯ Juvenile Justice System/Oregon Youth Authority ◯ Self ◯ Family/Friend ◯ Advocacy Group ◯ Attorney ◯ Crises/Helpline ◯ Media/Internet ◯ Other ◯ Crisis Bed

Being Served by I/DD (Intellectual and Developmental Disabilities)? ◯ Yes ◯ No

Tobacco Use: ◯ Yes ◯ No | **Substance use During last 90 Days:** ◯ Yes ◯ No | **Pregnant:** ◯ Yes ◯ No ◯ N/A

Do you have any allergies: ◯ Yes ◯ No | **If yes, please list:**

Have you received counseling in the past? ◯ Yes ◯ No

Clinic Name:

If yes, what is the counselor's name?

This registration form is valid for 30 days from the date of receipt. After 30 days and you have not had an intake and started treatment, you will need to re-register.

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Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN		#	
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): PCP	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): Medical history, prescriptions, behavioral assessments/notes	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Substance Use Disorder:** _____	
RELEASE TO	
Release to (entity name): MCHHS - Children's Behavioral Health	
Contact person:	Phone number: 503-588-5352
Address, City, State, and ZIP: 3867 Wolverine St NE, Building F Salem, OR 97305	
Email address:	Fax number: 503-576-4591
Purpose of the requested use or disclosure: Coordination of Care	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

**This authorization is valid for one year from the date of signing unless otherwise specified.*

YOUR ACKNOWLEDGMENT
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from Marion County Health & Human Services. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time, and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local Marion County program. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure, as noted immediately above, may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**
Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

To provide or pay for health services: If Marion County is acting as a **provider** of your health care services, or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be: assessments, tests, or evaluations*.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS, OHA or Marion County Health service, where MCHHS is not acting as a health care provider

This is a voluntary form. Marion County cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs upon signing this authorization, except as described above. However, you should be given accurate information about how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

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Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN		#	
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): School Name:	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): Academic, Behavioral and Testing Records	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Substance Use Disorder:** _____	

RELEASE TO	
Release to (entity name): MCHHS - Children's Behavioral Health	
Contact person:	Phone number: 503-588-5352
Address, City, State, and ZIP: 3867 Wolverine St NE, Building F Salem, OR 97305	
Email address:	Fax number: 503-576-4591
Purpose of the requested use or disclosure: Coordination of Care	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

**This authorization is valid for one year from the date of signing unless otherwise specified.*

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Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

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Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN		#	
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Mental Health Provider:	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): Screenings, Progress/Chart Notes, Assessments, Treatment Plans relating to mental health, Labs & Discharge Summary.	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Substance Use Disorder:** _____	
RELEASE TO	
Release to (entity name): MCHHS - Children's Behavioral Health	
Contact person:	Phone number: 503-588-5352
Address, City, State, and ZIP: 3867 Wolverine St NE, Building F Salem, OR 97305	
Email address:	Fax number: 503-576-4591
Purpose of the requested use or disclosure: Coordination of Care	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

**This authorization is valid for one year from the date of signing unless otherwise specified.*

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Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

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FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

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Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN		#	
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Department of Human Services	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): Mental Health Assessment, Treatment plan, Discharges, Notes and updates.	

Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type****.*)

HIV/AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Substance Use Disorder: _____

RELEASE TO	
Release to (entity name): MCHHS - Children's Behavioral Health	
Contact person:	Phone number: 503-588-5352
Address, City, State, and ZIP: 3867 Wolverine St NE, Building F Salem, OR 97305	
Email address:	Fax number: 503-576-4591
Purpose of the requested use or disclosure: Coordination of Care	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

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Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

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FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

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Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN		#	
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Resource Parents:	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): Mental Health Assessment, Treatment plan, Discharges, Notes and updates.	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Substance Use Disorder:** _____	

RELEASE TO	
Release to (entity name): MCHHS - Children's Behavioral Health	
Contact person:	Phone number: 503-588-5352
Address, City, State, and ZIP: 3867 Wolverine St NE, Building F Salem, OR 97305	
Email address:	Fax number: 503-576-4591
Purpose of the requested use or disclosure: Coordination of Care	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

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Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

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- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS, OHA or Marion County Health service, where MCHHS is not acting as a health care provider

This is a voluntary form. Marion County cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs upon signing this authorization, except as described above. However, you should be given accurate information about how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Marion County
OREGON
Health & Human Services

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN		#	
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Marion County Juvenile Justice:	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): Screenings, Progress/Chart Notes, Assessments, Treatment Plans relating to mental health, Labs & Discharge Summary	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Substance Use Disorder:** _____	
RELEASE TO	
Release to (entity name): MCHHS - Children's Behavioral Health	
Contact person:	Phone number: 503-588-5352
Address, City, State, and ZIP: 3867 Wolverine St NE, Building F Salem, OR 97305	
Email address:	Fax number: 503-576-4591
Purpose of the requested use or disclosure: Coordination of Care	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

**This authorization is valid for one year from the date of signing unless otherwise specified.*

YOUR ACKNOWLEDGMENT
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from Marion County Health & Human Services. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time, and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local Marion County program. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure, as noted immediately above, may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**
Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

To provide or pay for health services: If Marion County is acting as a **provider** of your health care services, or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be: assessments, tests, or evaluations*.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS, OHA or Marion County Health service, where MCHHS is not acting as a health care provider

This is a voluntary form. Marion County cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs upon signing this authorization, except as described above. However, you should be given accurate information about how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Marion County
OREGON
Health & Human Services

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN		#	
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Parent-	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): Screenings, Progress/Chart Notes, Assessments, Treatment Plans relating to mental health, Labs & Discharge Summary.	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS: _____ Mental health: _____ Genetic testing: _____ Substance Use Disorder: _____**	
RELEASE TO	
Release to (entity name): MCHHS- Children's Behavioral Health	
Contact person:	Phone number: 503-588-5352
Address, City, State, and ZIP: 3867 Wolverine St NE Bldg F. Salem, OR 97305	
Email address:	Fax number: 503-576-4591
Purpose of the requested use or disclosure: Coordination of Care	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

**This authorization is valid for one year from the date of signing unless otherwise specified.*

YOUR ACKNOWLEDGMENT
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from Marion County Health & Human Services. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time, and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local Marion County program. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure, as noted immediately above, may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**
Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

To provide or pay for health services: If Marion County is acting as a **provider** of your health care services, or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be: assessments, tests, or evaluations*.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS, OHA or Marion County Health service, where MCHHS is not acting as a health care provider

This is a voluntary form. Marion County cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs upon signing this authorization, except as described above. However, you should be given accurate information about how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Marion County
OREGON
Health & Human Services

Consent For Treatment

I have read and/or had the following explained to me as part of my orientation to services with Marion County Health & Human Services (initial those that apply):

____ Rights and Responsibilities

____ Complaint and Grievance Procedure

____ Welcome Letter

If 18 years or older, initial those that apply

____ I was asked if I have completed an Advanced Directive

____ I was offered a Voter Registration Card

Declaration for Mental Health Treatment

Does the client have a Declaration for Mental Health form completed? Yes☐ No☐

If no, was the client offered the opportunity to complete a Declaration for Mental Health Treatment? Yes☐ No☐

I understand the risk and benefits as explained to me. I give Marion County Health and Human Services permission to provide me with evaluation and treatment services.

_____ _____

Signature (Individual or Guardian) Date

_____

Individual's Printed Name

☐ Refused to Sign	☐ Not Able to Sign
Circumstances for refusal/inability to sign:	

Revised 10/22

Marion County
OREGON
Health & Human Services

Marion County Health & Human Services

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

PLEASE REVIEW THIS ACKNOWLEDGEMENT CAREFULLY AND THEN SIGN AND DATE BELOW.

The Notice of Privacy Practices tells you how the Marion County Health Department may collect, use or disclose health information about you and tells you about your privacy rights. The Health Department is required to offer you a Notice of Privacy Practices by federal law.

I, _____

Client's Printed name

have been offered a copy of the Marion County Health Department's Notice of Privacy Practices and have had a chance to ask questions about how my health information will be collected, used and disclosed and how to access my privacy rights.

_____ _____

Client's Signature **Date**

_____ _____

Legal or Personal Representative of Client (if applicable) **Relationship**

This document is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA).
Contact your Service Provider, or call the general number for the Health Department at: Phone# 503-588-5357, or Fax# 503-364-6552.

Health Department Staff: *Please have this document completed and signed by the individual receiving the Notice of Privacy Practices.*

Marion County Health & Human Services

FEE AGREEMENT

I understand that the established fee for services at Marion County Health & Human Services includes office visits, client telephone contacts, and professional consultations on the client's behalf and is based on my income and the number of dependents in my family. The established fee for services is 0 percent of the full fee for service charge.

I understand and agree to make payment directly to the Marion County Health & Human Services Program for any fees or co-pays due. I understand that if I do not follow this agreement, the Marion County Health & Human Services reserves the right to deny service.

I agree to pay the following pro-rated fees for services per hour as follows:

☑ Assessment ☐ Group ☐ Individual/Family

Client's Name: _____ | _____

Signature of Parent/Legal Guardian

_____

Date

Note: Consumers with Medicaid funding will not be charged for services and will not be responsible to pay for missed appointments.

FEE REDUCED OR WAIVED DUE TO INABILITY TO PAY

☐ Fee Reduction to _____% of the full fee for service charge

☐ Fee Waiver

Comments:

_____

_____

_____

Supervisor Approved: _____ Date: _____

I understand and agree to the conditions listed above regarding the fee reduction or waiver.

Signed: _____ Date: _____

Parent/Legal Guardian

Revised 3/18

Marion County
OREGON

Electronic Communications Policy

Individual in Service: _____ **ID**: _____ **DOB**: _____

This policy explains the ways in which we will communicate with you electronically. We also ask you to specify in which ways we may contact you and share your protected health information with you. Our organization will never ask for account information, credit card numbers, or personal information via email or text message.

Email Appointment Confirmations

By enrolling in email appointment confirmations, you may receive non-appointment-related emails throughout the course of your enrollment with our program. Emails may include alerts notifying you about important program news and events. We will not spam your account with unnecessary emails, nor will we sell your information to a third party.

Text Appointment Confirmations

By enrolling in text appointment confirmations, you authorize our program to send text message appointment reminders to you on your provided cell phone number. You understand that you may reply with various commands to receive account information, such as future appointments, office location, and other alerts.

You also agree that all individuals associated with your account may receive alerts referencing the account guarantor (holder) and/or dependents. Text message charges from your cell phone provider may apply.

Email To HEALTHCARE PROVIDERS

Please note that all email communications from this program are sent using a secure, encrypted email program, and the recipient will be prompted to create a username and password to securely access your protected health information. Some recipients may choose not to utilize this secure portal, in which case, a printed copy of your records can be faxed or mailed to them.
We will use the minimum necessary amount of protected health information in any communication. The first email you will receive from us is to verify the email address you provide.

Preferred contact method: ☐ **E-mail** ☐ **Text** ☐ **Phone**

☐ I consent to receiving information (see list below) via email. I understand I can withdraw my consent at any time.

My email address is: _____

- Emergency Notifications and Information
- Wellness Checks and Information (Caring Contacts)
- Appointment Reminders
- Notifications for upcoming services due
- Notification for missed appointments

☐ I consent to receiving information via text. I understand I can withdraw my consent at any time.

My phone number is: _____

☐ I consent to receiving information via phone call. I understand I can withdraw my consent at any time.

My phone number is: _____

☐ I do not consent to receive any information via email, text, or phone. I understand that I can change my mind and provide consent later.

Consent for Leaving VOICEMAIL Messages

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific care information on my voicemail or answering machine, I need to give permission for us to do so.

I give permission for messages regarding Appointment Reminders/Changes to be left on my phone number(s) below:

☐ Cell #: _____

☐ Home #: _____

☐ Work #: _____

☐ I prefer not to receive voicemail messages

☐ Original was completed via paper form - A digital copy will be maintained in the Individual's Chart

_____ _____

Individual in Service Signature Date

_____ _____

Legal or Personal Representative of Individual Date

Marion County
OREGON
Health & Human Services

Individual Rights and Responsibilities
Paper Version

OAR 309-019-0115

Individual in Service: _____ ID : _____ DOB: _____

In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

1. Choose from services and supports that are consistent with the assessment and service plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence;
2. Be treated with dignity and respect;
3. Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan;
4. Have all services explained, including expected outcomes and possible risks;
5. Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;
6. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law.

   - Minor children may give informed consent to services in the following circumstances:

     (A) Under age 18 and lawfully married;

     (B) Age 16 or older and legally emancipated by the court; or

     (C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.

7. Inspect their service record in accordance with ORS 179.505;
8. Refuse participation in experimentation;
9. Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;
10. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
11. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
12. Have religious freedom;
13. Be free from seclusion and restraint;
14. Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
15. Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;
16. Have family and guardian involvement in service planning and delivery
17. Have an opportunity to make a declaration for mental health treatment, when legally an adult;

18. File grievances, including appealing decisions resulting from the grievance;

19. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;

20. Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and

21. Exercise all rights described in this rule without any form of reprisal or punishment.

The provider shall give to the individual and, if appropriate, the guardian a document that describes the applicable individual's rights as follows:

(a) Information given to the individual shall be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

(b) The rights and how to exercise them shall be explained to the individual, and if applicable the guardian, and;

(c) Individual rights shall be posted in writing in a common area.

By signing below, I attest, I have had the opportunity to review, discuss and ask questions about my rights and responsibilities. I have been provided a copy.

☐ Original was completed via paper form - A digital copy will be maintained in the Individual's Chart

Legal or Personal Representative Relationship to Individual (if applicable):

Individual in Service Signature:

Date :

Legal or Personal Representative of Individual:

Date :

Marion County
OREGON
Health & Human Services

Agreement to Sign

By typing your name in the box below, you agree that you have completed the forms in this packet accurately and agree to provide hand-written signatures where applicable prior to receiving services.

Clients Printed Name

Individual or Guardians Printed Name

Date

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

Marion County
OREGON

As an individual served by Marion County Health Department, we want to assure that your rights and responsibilities will be respected. The following is a summary of your rights and responsibilities. Please feel free to ask any questions you may have concerning this information.

YOUR BASIC RIGHTS

1. You can access and receive services regardless of race, color, religion, sex, sexual orientation, age marital status, national origin and mental or physical disability.
2. You will receive courteous and timely service in an environment that offers reasonable safety, protection from harm, and reasonable privacy.
3. You have the right to be free from seclusion, restraint, abuse and neglect.
4. You may report any incident of abuse or neglect without being subject to retaliation.
5. You will be treated with dignity and respect.
6. You will not involuntarily participate in experimentation.

YOUR ACCESS AND INFORMATION RIGHTS

7. You can access and receive services in a manner and language consistent with your culture, including access to an interpreter if needed.
8. You will be asked to give informed consent in writing prior to the start of services.
9. You will receive information about the policies and procedures, service agreements and fees applicable to the services provided.
10. You will receive information about other community resources and other available treatment.
11. You may receive services and treatment without custodial parent or legal guardian consent when lawfully married, 16 or older and legally emancipated by the court, or age 14 or older for outpatient services only.
12. You have the right to receive emergent care 24 hours per day, 7 days per week and to be informed how and where to receive the care.

YOUR TREATMENT RIGHTS

13. You will receive quality care and services.
14. You may request information concerning the credentials and training of staff.
15. You can participate in the development of a written services plan, receive services consistent with that plan and participate in periodic review.
16. You may receive a copy of the written ISSP.
17. Your family and others of your choice may participate in this planning and review.
18. You have the right to ask about risks and benefits of treatment and about alternate treatment methods.
19. You will receive medication specific to your diagnosed clinical needs.
20. You will be informed about the side effects of any medications.
21. You can choose from available services and supports those that are the least restrictive, least intrusive, and that provide for the greatest degree of independence.
22. You can access the materials in their Individual Service Record, clinical and/or medical record which were originated by the Health Department.
23. Upon written request, you will receive copies of your clinical or medical records which were originated by the Health Department.
24. Consistent with state and federal laws, information about you and your treatment will be kept confidential.
25. You must give written permission before information concerning your treatment or services can be shared.

26. Your confidential information can be released without consent only when:
    a. A court orders release of information under certain limited circumstances
    b. There is a clear danger to the you or others
    c. There is reasonable cause to believe that neglect or abuse of a child, elder, person with developmental disabilities or nursing home patient has been or is occurring
    d. Under limited circumstances if the individual is a minor (dependent on the type of treatment being delivered.)
    e. To obtain reimbursement from your insurance.
    f. To coordinate your care with the Mid-Valley Behavioral Care Network/Oregon Health Plan (if you have that coverage).
27. You can choose to refuse treatment including any specific procedure or medication.
28. You have the right to execute a Declaration of Mental Health Treatment and to receive help with completing the Declaration.
29. You have the right to receive information about medical Advanced Directives.
30. You will receive prior notice of service conclusion or transfer, if services will be reduced or terminated.

YOUR OTHER RIGHTS

31. OHP/MVBCN members have additional rights and responsibilities. These additional rights and responsibilities will be distributed to OHP/MVBCN members at intake and be made available in the reception areas. These can also be found on the MVBCN website, www.mvbcn.org.
32. You can file a written or oral grievance or complaint relating to treatment or providers and receive assistance in filing the complaint.
33. You will not be punished or retaliated against if you file a complaint.
34. You will not be punished for exercising your rights.

YOUR RESPONSIBILITIES

35. You will treat others with courtesy and respect.
36. You will provide information that is needed in order to provide care.
37. You will participate, in the degree possible, in developing mutually-agreed upon treatment goals.
38. You will follow the treatment plans you have agreed to.
39. You will inform care givers/practitioners of any dissatisfaction with services or treatment.
40. You will arrive on time for scheduled appointment or call in advance if an appointment must be cancelled or rescheduled.
41. You will inform care givers/practitioners of changes in address, telephone numbers, and other personal information relating to their treatment.
42. You will bring insurance information and cards to appoints and inform care givers/practitioners of any changes in coverage.
43. You will take medications as prescribed or consult the prescriber before making any medication changes.
44. You will seek help for any addiction or mental health issues that may interfere with treatment.
45. You will protect the confidentiality and safety of other individuals.
46. You will pay for any services detailed in a fee agreement.

Marion County Health Department

Notice of Privacy Practices

Effective Date: June 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS IS YOUR RIGHT TO NOTICE.

This Notice is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA). Contact your Service Provider, or call the general number for the Health Department at: Phone 503-588-5357, or Fax 503-364-6552.

In this Notice, the words "we," "us," "our," and "Department" mean the Marion County Health Department.

The Purpose of this Notice

The Department provides many types of services, such as medical care and mental health services. Department staff must collect information about you to provide these services. The Department knows that information we collect about you and your health is private. We are required to protect this information by federal and state law. We call your individual health information "protected health information" (PHI).

This Notice of Privacy Practices will tell you how the Department may use or share information about you. Not every situation may be described. If you have any questions about any statements in this notice, please feel free to ask your Service Provider. The Health Department is required by law to make a copy of our notice of privacy practices available to you at your request. By law, we must follow the terms of the notice currently in effect.

How We May Use and Share Your Information

- **For Treatment.** The Department may use or share information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.
- **For Payment.** The Department may use or share information to get payment or to pay for the health care services you receive. For example, we may provide your health information to bill your heath plan for your medical visit here.
- **For Health Care Operations.** The Department may use or share information in order to manage its programs and activities. For example, we may use information to review the quality of services you receive.
- **In Organized Health Care Arrangements**. We may use and share health information with organizations such as the Marion County Integrated Delivery System, HIV Alliance, and the Behavioral Care Network. We participate in joint health care activities such as ensuring continuing care for you.
- **In the State Certified Coordinated Care Organization.** We may use and share health information with organizations involved in the Willamette Valley Community Health (WVCH). You can find a full list of involved participants posted in all department waiting rooms.
- **For Appointment Reminders and Other Notifications To You.** The Department may call you or send you reminders for medical care or counseling visits with us. We will call you at the phone number you give us unless you tell us to call you at a different phone number. You can also tell us not to call you at all.
- **For Public Health Activities.** The Department is the public health agency that keeps and updates vital records, such as births, deaths, and some communicable diseases.
- **For Health Oversight Activities.** We may use or disclose your information during inspections or in investigations of our service.
- **For Law Enforcement or Courts.** The Department will use and share information when required or permitted by federal or state law or by a court order.
- **For Abuse Reports and Investigations.** We are required by law to receive and report abuse and neglect to proper state authorities. This may result in a PHI disclosure.
- **For Government Programs.** The Department may use and share information for public benefits under other government programs. For example, we may share your information to check eligibility for a nutrition program such as WIC.
- **For Coroners, Medical Examiners and Funeral Directors.** We may disclose information for the identification of a deceased person, and other activities permitted by law.
- **To Avoid Harm and Special Government Activities.** The Department may share PHI with law enforcement or the US government in order to avoid a serious threat to the health or safety of any person, the public in general or for protection of the President.
- **For Research.** The Department uses PHI for public health studies and some reports. These studies and reports do not identify specific people.
- **For Fundraising.** The department will not use any of your information for fundraising purposes.
- **For Facility Directories.** The Department does not maintain a facility directory.
- **For Workers' Compensation.** We may disclose your health information to comply with laws for workers' compensation or similar programs.
- **Sharing Your Information with Family, Friends and Others.** We may share health information with your family or other persons you have identified as involved in your medical or mental health care. You have the right to object to the sharing of this information.

Other Uses and Disclosures that Require Your Written Authorization

Marketing. We must obtain your authorization prior to using your health information to send you any marketing materials. We can though provide you with marketing materials face-to-face or give you a gift of nominal value without your authorization. In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without your authorization.

Other Laws Protect Your Health Information

Many Department programs have other federal and state laws to follow for the use and disclosure of your information. These will require your authorization. For example, you must give your written authorization for us to share your mental health and alcohol or drug treatment records. Types of health information that have special privacy protections include, but are not limited to: treatment of a mental illness and session therapy notes, alcohol and drug abuse treatment services, HIV/AIDS testing and services, and genetic testing.

Your Health Information Privacy Rights

As a client of the Department, you are afforded the following rights:

- **Right to See and Receive Copies of Your Records.** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.
- **Right to Request Correction or Amendment to Your Records.** You may ask to change or add missing information to your records, if you think there is a mistake. You must make the request in writing and provide a reason for your request. We may deny your request. If we deny your request, we will send you a letter that tells you why your request is denied and how you can ask for a review of the denial.
- **Right to Request an Accounting of all Disclosures.** You have the right to ask the Department for a list of non-routine disclosures and routine disclosures made electronically within three years prior to the date of request. You must make the request in writing. You can request this type of list once per year.
- **Right to Request Limits on Uses or Disclosures of Your Information.** You have the right to ask that the Department limit how your information is used or shared. You must make the request in writing and tell us what information you want to limit and/or to whom you want the limits to apply. We are not required to agree to the limitation. You can request that the limitation be terminated in writing or verbally.
- **Right to an Access Report.** You have the right to ask the Department for the access report that documents the particular persons who electronically accessed and viewed your protected health information. You must make the request in writing.
- **Right to Restrict Uses and Disclosures of PHI to a Health Plan when You Pay In Full Out of Pocket.**
- **Right to Revoke an Authorization.** If you are asked to sign an authorization to use or share information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared. Exception: Alcohol & Drug clients have the right to verbally revoke authorizations.
- **Right to Choose How We Communicate With You.** You have the right to ask that we share information with you in a certain way or at a certain place. For example, you may ask us to send information to your work address instead of your home address. Or, you may ask us to call you at a different phone number. Generally, you must make this request in writing. You do not have to explain why.
- **Right to File a Complaint.** You have the right to file a complaint if you do not agree with how the Department has used or shared your health information or if you disagree with our privacy practices in general.
- **Right to Receive or Decline a Paper Copy of This Notice.** You have the right to ask for a paper copy of this notice at any time.
- **Right to be Notified of a Breach.** You have the right to be notified if we (or a business associate) discover a breach of your unsecured health information.

For More Information and How to Contact Us

You may contact your Service Provider or the Health Department Privacy Officer at any time if you have a question about this notice or need more information on how to use your rights. Please use the address and phone number below.

Marion County Health Department **Privacy Officer** 3180 Center Street NE Salem, OR 97301 Phone number: 503-588-5357 http://www.co.marion.or.us/HLT/hipaa.htm	**Office for Civil Rights – Region X** **U.S. Department of Health and Human Services** 2201 Sixth Avenue – M/S: RX-11 Seattle, WA 98121-1831 Phone: 800-368-1019 • TTY: 800-537-7697 • FAX: 206-615-2297 Email: OCRComplaint@hhs.gov

How to File a Complaint or Report a Suspected Problem

You may contact us or the US Department of Health and Human Services (DHHS) as listed above if you want to file a complaint or to report a problem with how the Department has used or shared information about you. The services we provide will not be affected by any complaints you make. The Department cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

Duration of This Notice

We may change the terms of this notice at any time. Any changes will apply to information we already have, as well as any information we may receive in the future. A copy of the new notice will be posted at each Health Department Service Provider site and provided as required by law. You may ask for a copy of the current notice anytime you visit a Health Department site, or you may get a copy on-line at: **http://www.co.marion.or.us/HLT/hipaa.htm**

Effective Date: June 1, 2013

Date Complaint Received:

Marion County
OREGON
Health & Human Services

Instructions for Filing a Complaint

If you have a concern or problem with the services or treatment you are receiving from Marion County Health and Human Services (MCHHS), we encourage you to attempt to discuss the issue with the staff person from the program from which you are receiving services.

If you remain dissatisfied, you may file a complaint with us either verbally or in writing. Your complaint will be kept confidential, and you will not be treated disrespectfully for filing a complaint.

How to File a Complaint

1. The Complaint form is available at any Marion County Health and Human Services facility, on our website at www.co.marion.or.us/HLT/Pages/complaints.aspx, or if you would like us to mail you a Complaint form, you can call us at 503-588-5357. If you need help completing the Complaint form, you may ask any MCHHS staff member to assist you or you can have someone else file the Complaint for you. If you have someone else (other than a MCHHS employee) file the complaint for you, you will need to sign the bottom of the Complaint form in order for us to communicate with the person filing the complaint on your behalf.

2. To submit a Complaint, you can either take the Complaint form into the office where you are receiving services, or you can mail it to:

Marion County Health and Human Services
Attention: Complaint's Coordinator
3180 Center Street NE, Suite 2100
Salem, Oregon 97301

What To Expect After You Have Filed a Complaint:

- Your complaint will be kept confidential. This is required by federal and state laws and rules.
- We will review the details and facts of the complaint and speak to those involved.
- We will contact you if we need more information from you.
- We will try to respond to your complaint within 5 working days, however if we need more than 5 days, we will notify you in writing letting you know why we need more time and how much time is needed.
- If additional time is needed, we will send you a letter with our decision of how your complaint will be handled, no later than 30 calendar days from the date that we received your complaint.

If you are not satisfied with our written decision, you may contact the Health and Human Services Administrator, Ryan Matthews, in writing, at 3180 Center Street NE, Suite 2100, Salem, Oregon 97301.

Marion County
OREGON
Health & Human Services

Marion County Health and Human Services
Complaint Form

Your Name:	Your Phone Number:	Today's Date:
Your Address:	**City:**	**State:**	**Zip:**
Name of person receiving services (If different):	**SSN (optional) or Medicaid ID Number for person receiving services:**	

Date of event:	Location of event:
Names of those involved:	

Describe what happened:

Do you believe that the nature of this complaint is such that it requires attention within 48 hours to prevent serious risk of mental or physical health or threat to safety? ☐ **Yes** ☐ **No**

Do you have suggestions about how we could resolve this issue?

I allow Marion County Health and Human Services to investigate and share information for the purpose of investigating and resolving this complaint. If someone else is filing this on my behalf, I also give my permission for Marion County Health and Human Services to exchange information with the individual named above.

Client's Signature/Date

Complainant's Signature (if not the client)/Date