

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 determine 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 Tennessee 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 of records about yourself. You can see your file by requesting this in writing. The county will act on the request immediately or within ten (10) days of the date of the request, excluding Saturday, Sunday and legal holidays. You may view the records without any charge. You may request copies of the records; the county may require a fee for making and certifying the copies. 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 Developmental Disabilities
- 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:

Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941

Call:

Metro: (651) 431-3600 (Voice)
Outstate: (800) 657-3510
TTY: (800) 627-3529
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 the HIPAA and Privacy Rights/Tennessen notices. I have had an opportunity to review them 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 _____
(First) (M.I.) (Last)

Consumer's Signature _____ Date _____

Services

Administrative
Child Support
Community Corrections
Health Services
Income Maintenance
Social Services
Toll free

Phone Numbers

(218) 824-1140
(218) 824-1260
(218) 824-1135
(218) 824-1080
(218) 824-1250
(218) 824-1140
(888) 772-8211

**COMMUNITY SERVICES**

204 LAUREL ST.
P.O. Box 686
BRainerd, MN 56401
WWW.CROWWING.GOV
FAX (218) 824-1141
EMAIL CWCSS@CROWWING.GOV

OUR MISSION: SERVE WELL. DELIVER VALUE. DRIVE RESULTS.

CWC-1062
02/24

Community Services Referral for AMH/SUD

Date: _____

Client Information:

Name: _____ Date of Birth: _____ SSN: _____

Home Address: _____ City: _____ Zip: _____

Other Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Referent information:

☐ Self- Referral (CWC Walk-ins) Assisted by: _____

☐ Agency Referral: _____ Individual Contact: _____

Role: _____ Phone: _____ Fax: _____ Email: _____

Does Client know of this Referral? ☐ Yes ☐ No Does the client WANT services? ☐ Yes ☐ No

What is the current need/request from Crow Wing County Community Services?☐ **Mental Health Case Management -**

Adult Mental Health Case Management consists of assisting the person in obtaining supports and services to medical/Mental, social, educational, and other services necessary to meet the person's mental health needs and goals. There are eligibility requirements for this service.

☐ **Substance Use Disorder Care Coordination -**

Substance Use Disorder Care Coordination consists of assisting a person with obtaining services, assessments, referrals, and access to programs and supports for their substance use. There are eligibility requirements for this service.

☐ **Other -**

Please briefly describe specific needs and supports looking for:

Health Insurance:

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

Medicare Number: _____ Medicare part D provider: _____

Do you have Private Health insurance? ☐ No ☐ Yes (List) _____**Does individual have a:**

Social Worker: ☐ No ☐ Yes - If yes, County: _____ Phone: _____Child Protection Social Worker: ☐ No ☐ Yes - If yes, County: _____ Phone: _____Probation Officer: ☐ No ☐ Yes - If yes, County: _____ Phone: _____**Mental Health - Primary Diagnosis:**

☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Borderline Personality Disorder☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Other: _____☐ Other Diagnoses: _____**Other Community Mental Health Supports In Place (i.e Psychiatrist, ARMHS, etc.):**

☐ ARMHS/ICTS: _____ ☐ Counselling: _____☐ Psych Med. Management: _____ ☐ ACT Team: _____☐ IHS/PCA: _____ ☐ AFC/CRS: _____☐ Other: _____**Alcohol/Drug:**

Diagnoses: _____

Drug of Choice: _____ Date of last Use: _____

Date of last Assessment: _____ What Agency completed it: _____

Medical:

Medical Diagnoses/Health Problems: _____

Medication List: _____

Who is prescribing Physician? _____ Pharmacy used? _____

Primary Physician Name: _____ Clinic Name and Phone Number: _____

Transportation Method(s):

☐ Own Vehicle ☐ Walk ☐ Bus ☐ Friends/Family ☐ Other: _____

Financial:

Income = (List type(s) & amount(s)): _____

Rep Payee? ☐ No ☐ Yes - If yes, who? _____ Phone Number: _____

Guardian/Conservator? ☐ No ☐ Yes - If yes, who? _____

 If yes, Agency: _____ Phone Number: _____

Please attach any applicable Information to referral. (i.e. – Med list, ROI, Applicable Assessment, etc.)

Services

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(218) 824-1135
(218) 824-1080
(218) 824-1250
(218) 824-1140
(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

CWC-1083

12/21

SUD Comprehensive Assessment Summary (245G)

Recommendations**Date:** _____**Client Name:** _____ **DOB:** _____**Address:** _____**Phone:** _____**Probation agent and/or Child Protection Worker (if any):** _____**Assessment completed by:** _____ **Assessor Phone No:** _____**Referral:** _____**Dimension I: 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 II: Biomedical Complications and Conditions

Consider the degree to which any conditions or complications are likely to interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort: determine the impact of continued use on unborn child if client is pregnant.

Severity Rating: _____

Narrative supporting risk description:

Dimension III: Emotional, Behavioral, 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: _____

Narrative supporting risk description:

Dimension IV: 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 V: 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 VI: Recovery Environment

Consider the degree to which key areas of client's life are supportive of or antagonistic to treatment participation and recovery.

Severity Rating: _____

Narrative supporting risk description:

Primary Substance Use Disorder Diagnosis:

Secondary Substance Use Disorder Diagnoses:

Substance Use Disorder Diagnostic Criteria Documentation in the Assessment

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 in 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:
 - ☐ 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 met 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, 11 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

Assessor Signature _____

Date _____



Authorization for Disclosure of Information

CWC-1040

06-24

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	<input type="checkbox"/> Coordination of Care <input type="checkbox"/> Client Request/Personal <input type="checkbox"/> Legal/Court <input type="checkbox"/> Insurance Company <input type="checkbox"/> Financial/Billing <input type="checkbox"/> Family Request <input type="checkbox"/> Other (please specify):			
How do you want the information released	<input checked="" type="checkbox"/> Exchange with (paper and/or verbal) <input type="checkbox"/> Fax (for patient care only) <input type="checkbox"/> Email (email required below) <input type="checkbox"/> Pickup (photo ID required @ pickup) <input type="checkbox"/> Mail (address required below) <input type="checkbox"/> Verbal Only (NO actual records given)			
Release/Receive Information From Crow Wing County Community Services (CWC CS)	<input type="checkbox"/> Comm. Services <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Child Protection <input type="checkbox"/> Attorney's Office <input type="checkbox"/> Community Corrections <input type="checkbox"/> Jail <input type="checkbox"/> Child Support			
	Business Name:		Phone #:	
	Contact Name:		Fax #:	
	Address:		Email:	
	City:	State:	Zip Code:	
Recipient To do the following: <input type="checkbox"/> Release info to <input type="checkbox"/> 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:
	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Diagnostic Assessment (DA) <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> School Records			
	<input type="checkbox"/> Verbal Only (NO Records) <input type="checkbox"/> Medication Notes <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Legal/Court/PO			
	<input type="checkbox"/> Treatment Plans <input type="checkbox"/> Billing Records <input type="checkbox"/> Summary of Services <input type="checkbox"/> Social Services Info			
	<input type="checkbox"/> 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:
	<input type="checkbox"/> CD Assessment Summary <input type="checkbox"/> CD Weekly Summary Notes <input type="checkbox"/> CD Discharge Summary <input type="checkbox"/> Rule 25 <input type="checkbox"/> Verbal Only (NO records) <input type="checkbox"/> 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	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: <input type="checkbox"/> Minor <input type="checkbox"/> Legal (documentation req'd) <input type="checkbox"/> Client is not own Guardian (documentation req'd) <input type="checkbox"/> 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 cwcsc@crowwing.gov