***Intake Screening & Assessment***

(to be started at referral)

**Requested Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Services Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is SLC contracted for these services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about Silver Lining? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where Services are transferring from: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the gender preference? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Citizenship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Veteran Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identified Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Language spoken in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the recipients and/or family’s cultural or personal preferences (examples: celebrating Holidays, birthdays, removing shoes when entering my home, etc.)?

Client SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MCO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Resides With: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Bell Info/Track/School DIstrict: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

Did we receive (Psych Eval, SIS Assessment, RSNA/HRA, Typical Week Schedule, Behavior Support Plan, Updated ISP, Updated Budget, Updated Authorization?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Problems

I/DD Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MH Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Communication Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dietary Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Equipment Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Care Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social and Family Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Request for Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral:  Accepted  Declined: (reason) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

***Please Notify Joseph Vanderpool (Owner SLCM) of this new referral if accepted.***

***Email: Joseph-Vanderpool@outlook.com***

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION**

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (445 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name: | Medicaid ID Number: | Medical Record ID: | Date of Birth: |

I, the above named person, authorize ***Silver Lining Care Management // 185 Fox Ridge Dr. Hendersonville, NC. 28739***

*Agency/person* ***releasing i****nformation & Address (if needed)*

To use or disclose to: **\_Health and community entities for service provision as required that pertain to member health and well being. Any of these entities can be removed at anytime and a new consent form will be signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DSS – Department of Social Services in the county for which the member receiving services lives.\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MCO – Medicaid Office for the county in which the member receiving services lives.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Providers – Doctor, Dentist, Eye Examiner (Only if needed or medically necessary or an emergency)**

**Community Partners for service provision – Community entities that help with services referred to.\_\_\_\_\_\_\_\_\_\_\_\_**

**Other provider agencies as needed – If another agency is involved in ISP meetings or team meetings for quality of care to the member or additional service needs are being met in tandem with that provider.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Natural Supports – Family and Friends who are unpaid and normally around the client for support and structure.**

*Agency or person to* ***whom use or disclosure*** *will be made & Address (if needed)*

**The Purpose Of This Release Is To:**

Gather information and support to meet the individual’s wants/wishes/needs and provide Continuity of Care through identification, coordination, and linkage of all medical, financial, social, educational, biological/natural, and Non-Medicaid resources and supports.

Furthermore, the information and/or supports may be used or disclosed to advocate and educate the member (and family) during: (1) the person-centered planning process, (2) the individualized service planning process, and/or (3) the individual and family directed service models of self-direction.

**The Following Information Is Being Released:**

Any information listed in the member’s record, file, or chart, such as (biographical information, IEP/school records, medical records, assessments/evaluations, medication lists (MARs), medication and nutritional orders/prescriptions, data logs/sheets, Supports-Intensity-Scale (SIS), Person-Centered Plan (PCP), Individualized Service Plan (ISP), financial records/information, insurance records/information, genealogical records/information, funding applications/scholarships, etc.)

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immune deficiency virus (HIV). All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. (NC GS 130A-143)

|  |  |  |
| --- | --- | --- |
|  | **REDISCLOSURE** |  |

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

|  |  |  |
| --- | --- | --- |
|  | **REVOCATION AND EXPIRATION** |  |

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. [If I want to revoke this authorization, I must do so in writing.] The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Silver Lining Care Management’s Notice of Privacy Practices, a copy of which has been provided to me.

**If not revoked earlier, this authorization is valid from the signature date through the expiration date listed below.**

|  |  |  |
| --- | --- | --- |
|  | **NOTICE OF VOLUNTARINESS** |  |

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Silver Lining Care Management. cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign.

|  |  |  |
| --- | --- | --- |
|  | **SIGNATURES** |  |

Signature of Consumer (If needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last day of MCO ISP)

Signature of LRP/Guardian (If needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of LRP/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_

(Last day of MCO ISP)

Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

* Conference presentations
* Educational presentations or courses
* Informational and marketing presentations
* On-line educational courses or informational presentations
* Educational videos

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

The procedure for how I may revoke this release, as well as the exceptions to my right to revoke, are explained in Silver Lining Care Management’s Notice of Privacy Practices, a copy of which has been provided to me.

**If not revoked earlier, this authorization is valid from the signature date through the expiration date listed below.**

**I Accept Photos and Videos to be taken and consent to the permissions listed above.**

**I Decline Photos and Videos to be taken and do NOT consent to the permissions listed above.**

***Signatures Page:***

Print Individual’s Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*If this release is obtained from a presenter under the age of 18, then the signature of that presenter’s parent or legal guardian is also required.***

Print LRP/Guardian Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LRP/Represenative Signature (if needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent Expires on the date listed or when revoked by the individual or the guardian

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Memorandum of Understanding**

**PARTICIPATION IN DEVELOPMENT OF A TREATMENT PLAN AND/OR GOALS**

As an individual, parent, and/or legal guardian of an individual, I met with a Silver Lining Care Management’s agency staff to review and discuss the use of assessments, development of short-term objectives, and identifying the expected outcomes that will be listed in my or my loved one's treatment plan and/or clinical chart.  I agree that I have been Informed that I will be able to provide input in the draft of short-term objectives for treatment.  The short-term objectives and direction of expected outcomes must meet my expectations and I must agree with the direction of services prior to any implementation of services for me or my loved one.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**ACCESS to ASSESSMENTS, OBJECTIVES, and/or MEDICAL RECORD DOCUMENTS**

As an individual, parent, and/or legal guardian of an individual, I understand that I may receive a copy of all assessments, short-term objectives, and/or treatment plans developed on my or the individual’s behalf at the time these documents/forms are signed. If I desire copies of any other services documents in the Medical Record, I understand that a formal request in writing must be submitted to the Quality Management Director for review and approval by the organization’s Administrative Team. I further understand that copies of documentation in the Medical Record that originated from an outside organization/provider must be requested from that outside organization/provider.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**GRIEVANCE POLICY**

**(*Page #29 of Individual and Family Handbook*)**

I have received and understand Silver Lining Care Management grievance policy. The policy states Silver Lining Care Management will provide an effective internal channel for individuals to be heard and respond to regarding any services or actions they deem inadequate or unsatisfactory. I also understand that Silver Lining Care Management can assist me with filing a grievance with the Managed Care Organization (MCO) that monitors all Medicaid-approved services I receive.

To file a grievance with Partners BHM, please contact: (***888) 235-4673***

To file a grievance with Vaya Health, please contact: ***(800) 849-6127***

To file a grievance with Alliance Health, please contact: ***(800) 510-9132***

To file a grievance with Trillium Health Resources, please contact: ***(866) 998-2597***

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_**ACKNOWLEDGEMENT FOR RECEIPT AND REVIEW OF CLIENTS RIGHTS**

**(*Page #28 of Individual and Family Handbook*)**

I, ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***, have read or had explained to me information concerning client rights as presented in Silver Lining Care Management’s Policy and Procedure Manual and outlined in the Individual & Family Handbook.

I further acknowledge that I have been presented a copy of the Individual & Family Handbook, which contains information about the rules each client is expected to follow and possible penalties for their violation.

A. Information regarding the disclosure of confidential information (*HIPAA*).

B. An overview of client rights and the use of restrictive interventions,

C. Grievance procedure including steps and appropriate contacts,

D. Right to contact Disability Rights of NC (*formerly,* *The Governor's Advocacy Council for Persons with Disabilities - GACPD*).

E. Permitted restrictive interventions, protective devices will not be used.

I (we) have been provided with a copy of the Silver Lining Care Management. “Member Rights”, and I (we) understand the rights to which individuals in Silver Lining Care Management. are entitled. Any questions concerning an individual’s right should be addressed by Silver Lining Care Management’s Administrative Team.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**DISCLOSURE OF CONFIDENTIALITY/PRIVACY NOTICE ACKNOWLEDGEMENT**

**(*Page #27 of Individual and Family Handbook*)**

Confidentiality (North Carolina General Status 122-C-52): Confidentiality applies to all facets of the individual’s life. Silver Lining Care Management will adhere to the individual’s right that no confidential information acquired be disclosed by the agency without securing at the very least verbal consent (*preferably written consent/disclosure*). I acknowledge that Silver Lining Care Management has reviewed the consent/disclosure of confidentiality with me.

I acknowledge that I have been provided a copy of the Notice of Privacy Practices for Silver Lining Care Management that addresses the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*).

I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related concern/grievance.

I may review a copy of the Notice of Privacy Practices in the main office of Silver Lining Care Management

I may obtain a copy of this Notice of Privacy Practices from Silver Lining Care Management at any time by contacting staff with Silver Lining Care Management

I understand that the terms of this Notice of Privacy Practices may be changed in the future, and these changes will be posted in the main office of Silver Lining Care Management

If this occurs, I may also request a copy of the new Notice of Privacy Practices by contacting the ***Quality Management Director.***

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**PROGRAM AGREEMENT**

I, ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***, give my consent and authorization to participate in treatment services as outlined in his/her Person-Centered Plan (PCP) and/or Individualized Service Plan (ISP). Furthermore, I give consent and authorization for the individual to travel in the community (*if applicable*) to work towards his/her short-term goals with his/her direct care staff. I agree to cooperate with and participate in scheduled service planning meetings, and to be involved with services identified in the Individualized Service Plan (ISP). I agree to provide transportation to any appointments related to the person’s needs. I further agree to ensure that he/she is available at all agreed upon scheduled times.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**STATEMENT of PROVIDER CHOICE**

I have received information regarding services which I am eligible to receive. I have been informed of providers from whom I am eligible to receive such services. Based on this information, I have made an informed decision to choose the following services and providers:

I,  ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***, am selecting **Silver Lining Care Management**, as my provider of choice for the following Services:

**Name of Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

It has been explained that I may continue to receive services through my current provider, or I may select another provider to deliver these same services.

**Please note:** *It is the policy of Silver Lining Care Management to uphold the integrity with the issue of choice for individuals.*

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**CLIENT ORIENTATION FORM**

As a Client of Silver Lining Care Management, upon admission, I have been instructed in or given written materials regarding:

* Rights and responsibilities of the person served.
* Grievance and appeal procedures.
* Ways in which input is given regarding:
* Quality of care
* Achievement of outcomes
* Satisfaction of persons served
* An explanation of the organization's:
* Services and activities
* Expectations
* Hours of operation
* Access to after-hour services
* Code of ethics
* Confidentiality policy
* Requirements for follow-up for the mandated person served, regardless of his or her discharge outcome.
* An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization.
* The program’s policies regarding:
* The use of seclusion or restraint
* Smoking
* Legal or illegal drugs brought into the program
* Weapons brought into the program.
* Abuse and Neglect
* Identification of the person responsible for service coordination.
* A copy of the program rules for the individual/family served that identifies the following:
* Any restrictions the program may place on the individual being served
* Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the individual being served
* Means by which the individual being served may regain rights or privileges that have been restricted
* Education regarding advance directives, if appropriate.
* Identification of the purpose and process of the assessment.
* A description of how the individual plan will be developed and the individual being served participates in it.
* Information regarding transition criteria and procedures.
* When applicable, an explanation of the organization’s services and activities include
* Expectations for consistent court appearances
* Identification of therapeutic interventions, including:

(a) Sanctions

(b) Interventions

(c) Incentives

(d) Administrative discharge criteria

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**ADMISSION AGREEMENT**

Date of Update: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I (we) give consent for the above-named individual to be placed in Silver Lining Care Management program and in doing so agree to abide by the terms as outlined in this agreement.

I (we) acknowledge that this service is voluntary and at any time I (we) can revoke and remove the individual from this service.

I (we) agree to allow Silver Lining Care Management. staff to implement regular and accepted methods of therapeutic intervention as indicated by the individuals mutually agreed upon treatment goals/plan.

My (our) stated religious preference for this individual is**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.** I (we) understand Silver Lining Care Management. will respect this religious preference, and that this individual will be permitted to attend services of this preference whenever feasible.

I (we) consent to information exchange between Silver Lining Care Management and the agencies for which we have signed release, but only to the extend necessary for the planning and implementation of individualized services for this individual. I (we) understand that this information will include historical, psychological, medical, social, vocational, educational, and behavioral data. The Confidentiality/Exchange/Release of Information policy has been explained to me (us) and I (we) understand that my (our) consent is voluntary and may be revoked by me (us) at any time. I (we) understand that Silver Lining Care Management. has policies protecting the confidentiality of this individual.

We understand under the following conditions that confidential information may be disclosed without consent:

Silver Lining Care Management may disclose the fact of admission or discharge of an individual to the individual’s next of kin whenever the responsible professional determines that the disclosure is in the best interest of the individual, and

An individual may have access to confidential information in his individual record, except for information that would be detrimental to the individual’s physical or mental well-being, as determined by director

For filing a petition for involuntary commitment when deemed in the best interest of the individual

Whenever there is a reason to believe the individual may be eligible for financial benefits through a governmental agency but only to the degree necessary to establish benefits

To certain individual advocates

To attorneys and in certain court proceedings

For reporting suspected abuse and/or neglect

Under orders of a court of competent jurisdiction

When requesting by the Department of Correction for an inmate

A responsible professional may disclose confidential information when, in his opinion these is imminent danger to the health or safety of the individual or another individual or there is a likelihood of the commission of a felony or violent misdemeanor and

A responsible professional may exchange confidential information with a physician or health care provider who is providing emergency services to an individual to the extent necessary to meet the emergency need, and

For certain statistical reporting and research.

I (we) grant permission for this individual to participate in community outings as outlined in his/her treatment plan.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**EMERGENCY TREATMENT ACKOWLEDGEMENT**

I (we) authorize Silver Lining Care Management to provide first aid. Furthermore, I (we) authorize Silver Lining Care Management. to obtain emergency medical or psychiatric care for this individual, if needed; until such time I (we) can be reached to authorize further care. Preferences in treatment providers can be found in documentation gathered by the treatment/ISP/PCP team. Any treatment, which is urgently required and there is no documented preference, will be determined for this individual at that time.

I (we) understand that I (we) will be notified of any serious illness, any change in medical treatment or any medications administration to the individual because of obtained medical care.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**PHOTOGRAPH, AUDIO AND VIDEO AGREEMENT ACKNOWLEDGEMENT**

**(*Page #30 of Individual and Family Handbook*)**

I (we) acknowledge and understanding that photographing and audio taping or videotaping of individual for any purpose or audience requires additional written consent from the legal responsible person. ***SILVER LINING CARE MANAGEMENT Photo and Video Release Form*** is required to be secured for any material that will be displayed in or on Silver Lining Care Management’ paper or electronic media (*newsletter or website*). Silver Lining Care Management guarantees that confidentiality will be used with all printed and/or photographed material from individuals and/or families when no signed “Release” exists.

SILVER LINING CARE MANAGEMENT may request this individual to be photographed and audio taped or videotaped, for treatment, training/supervision & advertising purposes and only for use by Silver Lining Care Management staff. I (we) understand that photographing and audio taping or videotaping of this individual for any purpose or audience other than those defined above shall require my (our) additional written consent. Finally, I (we) understand that confidentiality will be guaranteed in the use of all media material.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**REVIEW OF INDIVIDUAL GRIEVANCE PROCEDURE**

I (We) have been provided with a copy of the Silver Lining Care Management “Individual Grievance Procedure”, and I understand that the individual and I may use the procedure to file a grievance if we are dissatisfied with the program services or feel that the individual’s rights have been violated.

Exceptions and additions to consents:

I (we) understand that the responsibility for conducting family work with the individual’s parents will be specified in the service plan. These responsibilities will include specifications for the responsible agency, the responsible professional, and frequency of interventions, location, and documentation.

All fees and plan for payment are the responsibility of the placing agency and NOT the individual or individual’s legal custodian unless otherwise specified by separate contract.

The projected length of stay, discharge date and after-care plan will be developed during the Service Plan meetings. Service plan meetings and conferences will be held at least quarterly or as needed.

The individual’s service plan will specifically document any special conditions or client rights restrictions.

I (we) agree that this document may be amended on an as-needed basis, and that any such amendment will require the signature of the individual, individual’s parent and/or guardian.

I (we) understand that on this date a copy of the Admission Agreement, the Individual Rights, and the Individual Grievance Procedure will be made available to the individual.

We understand that consents will be reviewed and signed annually.

**My INITIALS below indicates that I have read and understand this release.**

\_\_\_\_\_\_\_\_\_\_

**FINAL CONSENT AND ACKNOWLEDGEMENT**

I acknowledge that I have received, read/ reviewed (*with Silver Lining Care Management staff representative*) and understand the following forms:

* Participation with Treatment Plan/ Short-Term Goal Development
* Request/Receipt of Medical Record Documents
* Grievance Policy
* Acknowledgment Form for Receipt and Review of Client Rights
* Disclosure of Confidentiality/Privacy Notice Acknowledgment Form
* Program Agreement
* Statement of Provider Choice
* Client Orientation Form
* Admission Agreement
* Authorization for Use and Disclosure of Protected Information

**The entire Memorandum of Understanding (*MOU*) If not revoked earlier, is valid from the signature date through the expiration date listed below.**

This document will be reviewed annually. At any time, you have the right to retract any or all the consents stated in this document. If you desire to withdraw consent, please contact the Silver Lining Care Management Representative listed in this document to reverse consents.

Individual Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LRP/Representative Signature (If needed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SLCM Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Release/Disclose Information**

**To**

**Health Information Exchange/NC Health Connex**

**Benefits**:

* A secure and electronic network that gives authorized health care providers the ability to access and share health-related information across a statewide information highway. It exists to improve health care quality, enhance patient safety, improve health outcomes, and reduce overall health care costs by enabling health information to be available secure.
* North Carolina’s new, modernized health information exchange, NC Health Connex, will bring added value to the health care conversations that are happening at all levels in the health care industry. It will break down information silos between health care providers, achieve greater health care outcomes for patients and create efficiencies in state-funded health care programs such as Medicaid. Many other states have been operating health information exchanges for years and are seeing success in improving patient care
* NC Health Connex is a tool to link disparate systems and existing HIE networks together to deliver a holistic view of the patient record
* Greatly decrease room for error
  + OTC is a comprehensive documentation and communication solution for support providers. Agencies are able to control access to data of individuals in a meaningful way to those involved in planning and delivering services to clients, and on top of that, the reports and audit trails assist in managerial processes. Access control mechanisms also encourage sharing the right data with the right caregivers so that everyone is well equipped to make the best decisions.
* You have the right to opt out
* You have the right to rescind a previous decision to opt out

**Consequences of opting out:**

Health Information Exchange (HIE) systems have been in development nationwide since a federal law was passed in 2009 to promote the use of electronic movement and use of health information among health care providers. *The law requires* that health care *providers* who receive State funds (e.g. Medicaid, State Health Plan) to connect to NC Health Connex by certain dates in 2018 and 2019 in order to *continue to receive payments for services provided*.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (445 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immune deficiency virus (HIV). All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. (NC GS 130A-143)

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

REVOCATION AND EXPIRATION, I understand that, with certain exceptions, I have the right to revoke this authorization at any time. [If I want to revoke this authorization, I must do so in writing.] The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Silver Lining Care Management’s Notice of Privacy Practices, a copy of which has been provided to me.

**If not revoked earlier, this authorization is valid from the signature date through the expiration date listed below.**

I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Silver Lining Care Management cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits on my refusal to sign.

Signature of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last day of MCO ISP)

LRP/Representative Signature (If needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last day of MCO ISP)

Please explain representative’s authority to act on behalf of individual:

|  |
| --- |
|  |

**Silver Lining Care Management**

“When Quality Matters”

**NOTICE OF PRIVACY**

**PRACTICES**

*This Notice is effective on January 1, 2022*

**THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION**

**ABOUT YOU MAY BE USED AND**

**DISCLOSED AND**

**HOW YOU CAN GET ACCESS TO THIS**

**INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**WE ARE REQUIRED BY LAW**

**TO PROTECT HEALTH CARE**

**INFORMATION**

**ABOUT YOU.**

**WE ARE REQUIRED BY LAW TO PROTECT YOUR HEALTHCARE INFORMATION.**

We are required by law to protect the privacy of health care information about you and health care information that identifies you. This may be information about health care services that we provide to you or payment for health care provided to you. It may also be information about your past, present, or future health care condition.

We are required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to health care information. Silver Lining Care Management and other health care providers are legally bound to follow the terms of this Notice.

Silver Lining Care Management has executed a Business Associate Agreement with the Area Program/LME which for the purpose of treatment and operations we may be required to disclose protected health information, except when prohibited pursuant to State and Federal laws. We may disclose to these Business Associate entities information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a Business Associate Agreement in place. In connection with our Business Associates, they have an independent responsibility to comply with all HIPAA Privacy regulations as it relates to disclosure of protected health information.

In other words, we are only allowed to use and disclose health care information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all health care information that we maintain. If we make changes to this Notice, we will:

* Post the new Notice in our main office or other prominent location
* Have copies of the new Notice available upon request (you may also contact our Clinical Director and/or designee at 980-284-1639 to obtain a copy of the current Notice)

The rest of this Notice will:

* Discuss how we may use and disclose health care information about you
* Explain your rights with respect to health care information
* Describe how and where you may file a privacy-related complaint

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you may contact our Clinical Director and/or designee at 980-284-1639.

**WE MAY USE AND DISCLOSE HEALTH CARE INFORMATION**

**ABOUT YOU IN SEVERAL CIRCUMSTANCES**

We use and disclose health care information about consumers everyday. This section of our Notice explains in some detail how we may use and disclose health care information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose health care information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, you may contact our Clinical Director and/or designee at 980-284-1639.

**1. Treatment**

Silver Lining Care Management may use and disclose health care information about you to provided health care treatment to you except as prohibited by State and Federal law. In other words, we may use and disclose health care information about you to provide,

coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

***We will use your health information for treatment.***

**Example:** Information obtained about you by a clinical staff member of your health care team will be recorded in you record and used to determine the course of treatment that should work best for you. Members of your healthcare team will also record goals that you establish and the interventions used to help you reach your goals. Your assigned psychiatrist will also record information about medications they have prescribed for you as well as your response to these medications.

We may use and/or disclose health care information about you in order to inform you of or recommend new treatment or different methods for treating a health care condition that you have or to inform you of other health related benefits and services that may be of interest to you.

**Example:** Jane is a consumer at our group-home and she has been diagnosed with oppositional defiant disorder. The group home has developed an educational program to help consumers manage their lifestyle. The group home sends Jane’s legal responsible person a flyer with information about the program.

We may also use and/or disclose health care information about you to send you and/or legal responsible person reminders about your appointment.

**2. Payment**

Silver Lining Care Management except as prohibited by State and Federal law, may use and disclose health care information about you to obtain payment for health care services that you received. This means that, within the agency, we may use health care information about you to arrange for payment (such as preparing billing and managing accounts). We also may disclose health care information

about you to others (such as insurers, collection agencies, and/or consumer reporting agencies) except as prohibited by State and Federal regulations. In some instances, we may disclose health care information about you to an insurance plan before you receive certain health care services because, for example, we may

want to know whether the insurance plan will pay for a particular service.

***We will use your health information for payment.***

**Example:** A bill will be sent to you and/or a third-party payer. Information on or accompanying the bill may include information that identifies you as well as your diagnosis, your treating clinician and the type of services you have received.

**3. Health care operations**

Silver Lining Care Management except as prohibited by State and Federal law, may use and disclose health care information about you in performing a variety of business activities that we call “health care operations”. These “health care operations” activities allow us to, for example, improve the quality of care we provide and reduce health care costs. For example, we may use or disclose health care information about you in performing the following activities:

* Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you;
* Providing training programs for students, trainees, health care providers or non-health care professionals to help them practice or improve their skills;
* Cooperating with outside organizations that evaluate, certify, or license health care providers, staff, or facilities in a particular field or specialty;
* Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other consumers
* Improving health care and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
* Cooperating with outside organizations that assess the quality of the care provided, including government agencies and private organizations;
* Planning for our organization’s future operations;
* Resolving complaints, grievances, and appeals within our organization and/or contract agencies;
* Reviewing our activities and using or disclosing health care information in the event that control or our organization significantly changes;
* Working with others (such as lawyers, accountants, or other providers) who assist us to comply with this Notice and other applicable laws.

***We will use your health information for health care operations.***

**Example:** Members of the treatment team(s) and Quality improvement staff may use information in your health record to assess the care and outcomes in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the services we provide. We will use your health information to enter data for billing and documentation purposes. We may also contact you via telephone or letter to provide appointment reminders.

**4. Persons Involved in Your Care**

Silver Lining Care Management except as prohibited by State and Federal law, may disclose health care information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care except as mandated by State and Federal regulations. If the consumer is a minor, we may disclose health care information about the minor to a parent, guardian or other person responsible for the

minor except in limited circumstances. For more information on the privacy of a minor’s information, contact our Clinical Director and/or designee at 980-284-1639.

We may also use or disclose health care information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose health care information about you to persons involved in you care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the consumer is a minor. If the consumer is a minor, we may or may not be able to agree with your request.

**Example:** Jane’s husband regularly comes to the mental health center with Jane for her appointments and he helps her with her

medication. When the nurse is discussing a new medication with Jane, Jane invites her husband to come into the private room. The nurse discusses the medication with Jane and Jane’s husband.

**5. Required by law.**

We will use and disclose health care information about you whenever we are required by law to do so. There are many State and Federal laws that require us to use and disclose health care information. For example, State law requires us to report suspected communicable disease to the health department and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those State laws with other applicable laws.

**6. National priority uses and disclosures**

When permitted by law, we may use or disclose health care information about you without your permission for various activities that are recognized as “national priorities.” In other words, the government has determined that under certain circumstances

(described below), it is so important to disclose health care information that it is acceptable to disclose health care information without the individual’s permission. We will only disclose health care information about you in the following circumstances when we are permitted to do so by law. For more information on these types of disclosures, contact our Clinical Director and/or designee at 980-284-1639.

* **Threat to health or safety:** We may use or disclose health care information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
* **Public health activities:** We may use or disclose health care information about you for public health activities. Public health activities require the use of health care information for various activities, including but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of disease.
* **Abuse, neglect, or domestic violence:** We may disclose health care information about you to a governmental authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect, or domestic violence.
* **Health oversight activities:** We may disclose health care information about you to a health oversight agency-which is basically an agency responsible for overseeing the health care system or certain governmental programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
* **Court proceedings:** We may disclose health care information about you to a court or an officer of the court (such as an
* attorney) with an appropriate order from a judge. For example, we would disclose health care information about you to a court if a judge orders us to do so.
* **Law Enforcement:** We may disclose health care information about you to law enforcement officials for specific law enforcement purposes. For example, we may disclose limited health care information about you to the police officer if the officer needs the information to help find or identify a missing person.
* **Coroners and others:** We may disclose health care information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye, and tissue transplants.
* **Worker’s compensation:** We may disclose health care information about you in order to comply with workers’ compensation law.
* **Certain government functions:** We may use or disclose health care information about you for certain government functions, including but not limited to military and veteran’s activities and national security and intelligence activities. We may also use or disclose health care information about you to a correctional institution in some circumstances.

**7. Authorization**

Other than the uses and disclosures described above (#1-6), we will not use or disclose health care information about you without the “authorization” by you or your legally responsible person. In some instances, we may wish to use or disclose health care information about you and we may contact you to ask you to sign an authorization form. You may contact us to ask us to disclose health care information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose health care information about you, you may later revoke (or cancel) your authorization in writing (except information which has already been released, or in very limited circumstances, related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Executive Director or assigned staff member. If you revoke your authorization, we will follow your instructions, except to the extent that we have already relied upon your authorization and taken some action.

**YOU HAVE RIGHTS WITH RESPECT**

**TO HEALTH CARE INFORMATION ABOUT YOU**

This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Clinical Director and/or designee at 980-284-1639.

**1. Right to a copy of this Notice**

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area or other prominent locations. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Clinical Director and/or designee at 980-284-1639.

**2. Right of access to inspect and copy**

You have the right to inspect (which means see or review) and to receive a copy of health care information about you that we maintain in certain groups of records. If you would like to inspect or receive a copy of health care information about you, you must provide us with a request in writing. Our agency must act on this request no later than 30 days after receipt of this request.

We may deny your request in certain circumstances. If we deny your

request, we will explain our reason for doing so in writing. We will

also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the information, we may charge you a fee to cover the costs of the copy. We may be able to provide you with a summary or explanation of the information. Contact our Executive Director and/or designee for more information on these services and any possible additional fees.

**3. Right to have health care information amended**

You have the right to have us amend (which means correct or add) health care information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and make reasonable efforts to notify others who have copies of the inaccurate or incomplete information. Our agency must act on this request no later than 60 days after receipt of the request.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

**4. Right to any accounting disclosures we have made**

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years (beginning your start date). If you would like to receive an accounting, you may send us a letter requesting an accounting. Our agency must act on this request no later than 60 days after receipt of the request.

The accounting will not include several types of disclosures, including disclosures for treatment, payment, or health care operations. It will also not include disclosures made prior to Your start date.

If you request an accounting more than once every twelve (12 months), we may charge you a fee to cover the costs of preparing the accounting.

**5. Right to request restrictions on uses and disclosures**

You have the right to request that we will limit the use and disclosures of health care information about you for treatment, payment, and health operations.

We are **not** required to agree to your request.

If we do agree to your request, we must follow your restrictions (except if the information is necessary for an emergency situation or unless it is a situation with mandates by State and Federal law). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

**6. Right to request an alternative method of contact**

You have the right to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternation method of contact, you must provide us with a request in writing.

**(13)**

**YOU MAY FILE A COMPLAINT**

**ABOUT OUR PRIVACY PRACTICES**

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us of with the Federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint, you may bring your complaint to your clinician, his/her supervisor, the Executive Director or you may mail it to the following address:

ATTN: Joseph Vanderpool, BS.P./BS.S., QP

Owner / Silver Lining Care Management

185 Fox Ridge Dr.

Hendersonville, NC. 28739

Phone: 828-393-5925

[Joseph-Vanderpool@outlook.com](mailto:Joseph-Vanderpool@outlook.com)

To file a complaint with the Federal government, you may send you complaint to the following address:

Office of Civil Right

US Department of Health & Human Services

200 Independence Avenue, SW

Room 509 F, HHH Building

Washington, DC 20201

**SAMPLE**

***Privacy Notice Acknowledgement Form***

* I acknowledge that I have been provided a copy of the Notice of Privacy Practices for Silver Lining Care Management
* I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related complaint.
* I may review a copy of the Notice in the main office of Silver Lining Care Management
* I may review a copy of the Notice in the main office of Silver Lining Care Management
* I understand that the terms of this Notice may be changed in the future, and theses changes will be posted in the main office of Silver Lining Care Management I may also request a copy of the new Notice by contacting the Clinical Director and/or designee at 980-284-1639.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legally Date Signed

Responsible Person, If Required

Effective: on your start date Privacy Notice Acknowledgement Form

**Provider Choice Acknowledgement**

This document of acknowledgement confirms my decision to choose Silver Lining Care Management as my Provider of Choice.

**Requested Services:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Options Statement:**

Prior to accepting services through Silver Lining Care Management, I was provided a list of currently contracted Providers in the Medicaid County for which I am seeking services via my Care Coordinator that offer the same services.

Alliance \_\_\_\_\_ Partners \_\_\_\_\_ Vaya \_\_\_\_\_ Trillium \_\_\_\_\_

Furthermore, I was not offered any incentive, reward, or bribe, etc. for choosing Silver Lining Care Management as my Provider of Choice. I have made this decision after reviewing my situation along with options for services, and have determined that Silver Lining Care Management best supports my needs and wants for services opposed to all other providers at this time.

**Request of Respect to choice:**

I would ask that my right to choose my provider of choice with an agency that I trust be respected as it meets all the service needs of myself or my family at this time.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/LRP Signature Date