



## Sierra County Health and Human Services

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### Social Services

P.O. Box 1019  
Loyalton, CA 96118  
202 Front Street  
(530) 993-6720  
Fax (530) 993-6767

Lori McGee, INT Director

### Public Health

P.O. Box 7  
Loyalton, CA 96118  
202 Front Street  
(530) 993-6700  
Fax (530) 993-6790

Rhonda Grandi, INT Director

### Behavioral Health

P.O. Box 265  
Loyalton, CA 96118  
704 Mill Street  
(530) 993-6746  
Fax (530) 993-6759

Sheryll Prinz-McMillan, Director

### HHS Satellite Office

P.O. Box 38  
Downieville, CA 95936  
22 Maiden Lane  
(530) 289-3711  
Fax (530) 289-3716

Thank you for making your first appointment with Sierra County Behavioral Health.

In order for us to provide services, please fill out the entire intake packet prior to your first appointment. At this time, please provide a **valid picture ID**, Sierra County **Medi-Cal card** and **proof of residence** such as a utility bill showing your physical address and your name. If the packet is not filled out in full or you have forgotten to bring it with you, we will need to reschedule your appointment. This may cause a delay in you receiving services.

Should you need assistance in filling out the paperwork, call our office at 530-993-6746 during normal business hours and we will be glad to assist you. You may request alternative formats. Our office is opened: M-F 8am-5pm; closed 12pm-1pm for lunch and on major holidays. For after-hours you can also call our toll free access line **1-888-840-8418**.

If you feel you are in crisis, please call our office during normal business hours. For after hours and weekends, call our 24-hour crisis line **1-833-723-2968 or 988** to speak with an on-call crisis worker.

Thank you for the opportunity to work with you,  
Behavioral Health Front Desk.

**Sierra County Systems of Care  
Distribution of Mental Health Plan (MHP) Informing Materials**

<b>Check all that apply</b>	<b>Informing Materials Provided also available on our website:</b> <a href="http://sierracounty.ca.gov/181/Behavioral-Health">http://sierracounty.ca.gov/181/Behavioral-Health</a>
ALL <input type="checkbox"/>	<b>Notice of Privacy Practices (HIPAA 03)</b> The Notice of Privacy Practices tells you how Sierra County may use or disclose information about your physical and/or mental health. The county is required by federal law to give you this notice. <i>Included in the intake packet.</i>
ALL <input type="checkbox"/>	<b>Systems of Care (SOC) Client &amp; Family Information Brochure</b> The Client & Family Information Brochure is a brief, easy to read summary of all the services available in the Systems of Care with quick contact numbers. <i>Included in the intake packet.</i>
ALL <input type="checkbox"/>	<b>Systems of Care (SOC) Grievance Form and Procedure (CARE-020)</b> The SOC Grievance Form is a tool to help you file a complaint about your services if you need to at some point. The procedure tells you how to file the complaint. <i>Included in the intake packet.</i>
ALL <input type="checkbox"/>	<b>Informed Consent (CARE-440)</b> <i>Included in the intake packet.</i> The Informed Consent Form outlines the expectations regarding the treatment you will receive. It also explains that the risks, benefits, and alternatives to treatment have been explained to you.
ALL <input type="checkbox"/>	<b>Formal Request for Change of Provider Form/Request for Second Opinion (CARE-084)</b> The Formal Request to Change a Provider/Request for Second Opinion Form is a tool to help you to change the person who is providing your service or to receive a consultation from a second provider. <i>Download a copy at: <a href="https://sierracounty.ca.gov/335/Client-Services">https://sierracounty.ca.gov/335/Client-Services</a></i>
Medi-Cal <input type="checkbox"/>	<b>Sierra County MHP “Guide to Medi-Cal Mental Health Services”</b> The MHP “Guide to Medi-Cal Mental Health Services” contains information on how a person is eligible for mental health services through Medi-Cal. It also explains how to access those services, what services are available, what your rights and responsibilities are, and how to file a grievance or file for a state fair hearing. The guide contains important phone numbers regarding our Mental Health Plan (MHP). <i>Download a copy at: <a href="http://sierracounty.ca.gov/181/Behavioral-Health">http://sierracounty.ca.gov/181/Behavioral-Health</a></i>
Medi-Cal <input type="checkbox"/>	<b>MHP Provider List – Sierra County</b> The MHP Provider List is a list of providers who are contracted by the MHP to provide mental health services through Medi-Cal for our Sierra County residents. Non-emergency services must be pre-authorized. <i>Download a copy at: <a href="https://sierracounty.ca.gov/335/Client-Services">https://sierracounty.ca.gov/335/Client-Services</a></i>
ALL Over Age 18 <input type="checkbox"/>	<b>Voter Registration Card and Voter Preference Form (CARE-126)</b> The National Voter Registration Act requires handing you these forms at entry to services and every year thereafter. You may receive help filling out these forms. You may ask for new forms every time you change address. <i>Located at Behavioral Health office</i>
ALL Over Age 18 <input type="checkbox"/>	<b>Advance Health Care Directive Brochure</b> <i>Included in the intake packet.</i> The Advance Health Care Directive Brochure explains your right to make decisions about your medical treatment. It includes how to appoint a person who can make health care decisions for you when you are unable (Health Care Agent). It tells you how to change your directive at any time.
	<b>Do you already have an Advance Health Care Directive or a Durable Power of Attorney for Health Care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>If yes, will you provide a copy for our medical record?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Distributed face-to-face by: _____ (MHP Staff)
<input type="checkbox"/> Distributed via US mail by: _____ (MHP Staff)
Date given to client or posted: _____

**Name of Client:** \_\_\_\_\_

**Client #:** \_\_\_\_\_

Client # \_\_\_\_\_

## Sierra County Behavioral Health Department Demographic Form

**Referral Source:** \_\_\_\_\_ **Referral Phone** \_\_\_\_\_

**Legal Name:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

**Birth Name** (If different from above) Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

**Alias (es):** Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**DOB:** \_\_\_\_\_  Actual  Estimated **Gender:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Reason SSN Not Provided** \_\_\_\_\_

**Driver's License/State Id:**  Yes  No **State** \_\_\_\_\_ **No.** \_\_\_\_\_

**Born in U.S.**  Yes  No **If No, what Country:** \_\_\_\_\_

**State:** \_\_\_\_\_

**County - if born in California:** \_\_\_\_\_

**Mother's First Name:** \_\_\_\_\_

**Ethnicity:**  Not Hispanic  Hispanic  Other Hispanic \_\_\_\_\_

**Race:**  Caucasian  African American  Native American  Other \_\_\_\_\_

**Primary Language:**  English  Spanish  Other \_\_\_\_\_

**Language Preferred** (Individual): \_\_\_\_\_ (Caretaker): \_\_\_\_\_

**Interpreter Needed?**  Yes  No

**Communication Method:**  Verbal  Translator  Sign Language  Other \_\_\_\_\_

**Veteran:**  Yes  No **Branch:** \_\_\_\_\_

**Employment Status:**  Full-time Job  Part-time Job  Actively looking for work  Homemaker

Student  Volunteer Worker  Retired  Other \_\_\_\_\_

**Living Arrangement:**  House or Apartment  Foster Home  Adult Residential Facility

Homeless  SNF/ICF/IMD for psych  Other \_\_\_\_\_

August 15, 2024 - MK

**Education:** (highest grade completed)\_\_\_\_\_

**Special Education:**  Yes  No

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

**Number of Children under the age of 18 the Client cares for/responsible for 50% or more of the time**\_\_\_\_\_

**Number of Dependents age 18 or older the Client cares for/responsible for 50% or more of the time**\_\_\_\_\_

**Conservator/Court Status:**  Not Applicable  Unknown/Not Reported  
 Temp. Conservatorship  PC2974, Penal Code Sec. 2974  Dependent of Court W&I 300  
 LPS Conservatorship  Representative Payee without Conservatorship  Murphy Conservatorship  
 Ward of the Court, W&I 601  Probate Conservatorship  Ward of the Court, W&I 602

**Disability:**  None  Developmentally Disabled  Mental Health  Hearing  Mobility  
 Speech  Vision  Other Disability\_\_\_\_\_

**Smoking Status:**  Every Day  Some Days  Heavy  Light  Former  Never

**Physical Address:**\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_ - \_\_\_\_\_

**Mailing Address:**\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_ - \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

May we leave message at:

**Home?**  Yes  No

**Work?**  Yes  No

**Cell?**  Yes  No

**Text?**  Yes  No

May we contact you by **mail**?  Yes  No

May we contact you by **email**?  Yes (email)\_\_\_\_\_  No

May we leave a message via **emergency contact**?  Yes  No

Preferred Method of Contact:\_\_\_\_\_

**Emergency Notification Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Employment Place: \_\_\_\_\_

**Legal Information:** Self or:

Responsible person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical Information:**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

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

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

**Notice of Privacy Practices Given?**  Yes  No **Form Signed Date:** \_\_\_\_\_

**Advance Directive Given?**  Yes  No

**Informing Materials Date Given:** \_\_\_\_\_

**Informed Consent Date Signed:** \_\_\_\_\_

**Release of Information needed?**  Yes  No

# Sierra County Behavioral Health Services

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

## BEHAVIORAL HEALTH INFORMED CONSENT

In the interest of assuring that you are informed of the conditions of involvement with our services, please be informed the following:

### 1. PARTICIPATION IN SERVICES

**Treatment is most effective when** there are occasional discussions about your progress and counseling experience. You will develop a treatment plan collaboratively with your counselor, and participate in periodic reviews of your treatment and progress.

If you feel your treatment isn't helping you, please inform your counselor, so that your treatment plan can be revised to most effectively meet your needs.

**Your time is reserved for you.** If you must cancel, please provide a courtesy **24** hour notice. Individual sessions generally last fifty to sixty minutes. If you do not call to cancel your appointment by **8AM** on the day of your appointment and fail to show, this could incur a missed appointment fee of up to **\$15** for each no show.

If you are more than ten minutes late for a session, this could be considered a "no show". If you arrive late, your appointment will still end at the designated time.

A returned check fee of **\$25** will be applied to your bill for all returned checks.

If you do not have insurance or your Medi-Cal should lapse for any reason, you will be required to pay the Uniform Method of Determining Ability to Pay (UMDAP) calculated by your income. You can set up monthly payments with the front office staff.

After 30 days or 3 repeated absences/failure to participate in services may result in discontinuation of services.

If you are not scheduling sessions and/or arriving for sessions for a continuous period, we will assume you are voluntarily terminating services with us, and your client file will be closed. Should your file be closed, you will be eligible to participate in another intake and assessment process, and this would be considered a new admission.

# Sierra County Behavioral Health Services

## 2. DIAGNOSIS

If you are eligible for services through Sierra County Behavioral Health, you meet criteria for a qualifying diagnosis. We are required to give a diagnosis to document that you meet criteria for services. Your clinician will discuss your diagnosis with you, and how you meet criteria for the diagnosis.

Note a diagnosis is a representation of presenting issues and is something that is experienced on a continuum. You may meet criteria for a diagnosis during one stage of your life, and not meet criteria at another. It is estimated that a majority of people will meet criteria for a mental health diagnosis at some point in their lives.

## 3. LIMITS OF CONFIDENTIALITY

- a. In accordance with State and Federal laws, Behavioral Health staff are legally obligated to make a report to the appropriate entities if they have reason to suspect the following.
  - ⇒ A **child** is in danger of abuse or neglect.
  - ⇒ An **elder** (65 years or older) is in danger of being abused or neglected. (Note, for elders, financial abuse is considered a form of abuse).
  - ⇒ Someone appears to be in **imminent danger** of harming themselves or others.
- b. Your mental health record can be subject to a **legal subpoena** in a legal proceeding.
- c. If you are paying for services through your **insurance company**, we are obligated to let your insurance company know your diagnosis and, in some cases, details of your treatment, as a condition of insurance reimbursement.

## 4. SOCIAL CONTACT WITH MENTAL HEALTH STAFF

Note it is against professional Codes of Ethics to engage in social relationships with clients or former clients. If your counselor or another mental health employee sees you in public, you are welcome to initiate a conversation. They may avoid initiating a conversation with you, in order to protect your privacy.

If you wish to discuss your case, you are encouraged to contact your counselor at the office during regular business hours. We avoid discussing confidential matters in public.

# Sierra County Behavioral Health Services

## 5. GRIEVANCES

You may file a grievance if you are dissatisfied with our service. The information described below regarding filing grievances is posted in our waiting room.

You may call any of the following entities to register a complaint:

- **Sheryll Prinz-McMillan Behavioral Director** 530-993-6746.
- **Jamie Franceschini QI/QA** 530-993-6770
- **The Patient Rights Advocate** 530-886-5419 or 1-800-488-4308 ext 5419.

You may use the provided addressed envelopes and mail your concern(s) to any of the entities listed above, C/O P.O. Box 265, Loyalton, CA 96118. Addressed envelopes are available for you in the waiting room of the mental health department.

- ❖ **The Patient Rights Advocate** can assist you with registering a formal grievance.
- ❖ Your complaint or grievance will be **confidential**.
- ❖ **You will not be discriminated against** or penalized for filing a grievance.
- ❖ You will receive **notification** that we received your grievance, provided we have your contact information.
- ❖ You will receive a **written decision** on your grievance within 60 calendar days after your grievance has been received.

## 6. CLIENT RIGHTS

Your rights as a client of Sierra County Behavioral Health include the following:

1. The right to be treated with **respect** and with due consideration for your **privacy**.
2. The **right to receive information** on available treatment options and alternatives presented in a manner understandable to you.
3. The right to **participate in decisions** regarding your health care, including the right to refuse treatment.
4. The right to **file a grievance** or appeal a decision without being subject to discrimination or penalty.
5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
6. The right to request and receive a **copy of your health information**.
7. The right to request that your health record be **amended**.

# Sierra County Behavioral Health Services

## 7. CAUSE FOR DISCHARGE

- ⇒ If it appears that the services we offer are **not beneficial for you**, a decision could be made to discontinue services.
- ⇒ Failure to treat other clients and staff with **respect** can result in discharge from program services.
- ⇒ **Failure to maintain the confidentiality** of others accessing services can result in discontinuation of services.
- ⇒ Sierra County Behavioral Health reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without good cause.

## 8. WEAPONS

Individuals are prohibited from possessing guns, knives (other than kitchen utensils), or other weapons (except for law enforcement officers acting in the line of duty) while at Sierra County Human Services.

## 9. FOLLOW-UP

**Upon discharge from the program**, someone from Sierra County Human Services may attempt to contact you to participate in a follow-up client satisfaction survey, with your permission. These surveys assist us with maximizing the effectiveness of our services. If you are willing to participate in a follow-up contact, please initial one of the following:

I am willing to participate in a follow up contact, following discharge from services \_\_\_\_\_

I am **not** willing to participate in a follow up contact, following discharge of services \_\_\_\_\_

### CLIENT CONSENT TO SERVICES

I have read and understand all conditions set forth in this Informed Consent. I consent to participate in Sierra County Behavioral Health Services.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# Sierra County Behavioral Health Services

## GUARDIAN CONSENT FOR MINOR

I have read and agree with the conditions set forth in the Informed Consent. I agree to allow my minor child \_\_\_\_\_ (name of minor) to participate in Sierra County Behavioral Health Services.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



## Sierra County Behavioral Health Services Consent for Treatment Using Teleconferencing Equipment

Your Sierra County Behavioral Health program has agreed to provide Mental Health and Substance Use services utilizing teleconferencing equipment.

**Nature of Telehealth Consultation:** Teleconferencing is a simple technology. It requires the use of a monitor and/or television and a small camera to talk to another person over secured data lines, much like a face-to-face contact and in real time. This service is confidential. This is not a satellite or broadcast service; it is a video signal sent over dedicated data lines in what is referred to as a “site-to-site connection.” This is a standard considered the most secure and confidential.

Tele-counseling will use this same technology to provide you with your MH/SUD care. You will see your counselor for regular visits, crisis evaluations, and treatment planning, just as you would if your counselor were in the office. You will sit and talk with the counselor as you would if the counselor were in the office. Your treatment should not change significantly, except to receive more trained, specialized, and accurate treatment without waiting or driving for significant periods of time. You would have the opportunity to discuss your needs and have them resolved to the best of our ability.

**Associated Risks:** Reasonable and appropriate efforts have been made to reduce the risks associated with Telehealth consultation, and all existing confidentiality protections in compliance with CFR 42, and under Federal and California laws apply to information disclosed during this Telehealth consultation. Despite these measures and protections, there remains a risk that: the transmission of information could be disrupted or distorted by technical failures in transmission; the transmission of information could be intercepted by unauthorized persons; and/or the electronic storage information generated by this Telehealth consultation in one or more databases could be accessed by unauthorized persons. In addition, Telehealth consultation may not be as complete as face-to-face care.

**Rights:** Using Telehealth consultation is voluntary and in no way diminishes your rights as a client and you continue to have the right to withhold or withdraw your consent to Telehealth consultation at any time without affecting your right to future care or treatment and without risking the loss of your health insurance coverage. You have the option of using a face-to-face visit with a counselor/clinician/doctor. You will need to ask your agency for this information if you wish to pursue this option. As a Medi-Cal beneficiary, you have the right to request transportation to and from your appointments when other available resources have been exhausted.

The laws which protect the confidentiality of Mental Health and Substance Use Disorders information apply to Telehealth consultation. No information or images from the Telehealth consultation which identify you will be disclosed to researchers or other entities without your consent.

I have read and understand the above and give my consent to participate in Telehealth services using teleconferencing equipment.

\_\_\_\_\_  
Client Name (PLEASE PRINT)

\_\_\_\_\_  
Guardian Name (PLEASE PRINT)

\_\_\_\_\_  
Signature of Client or Guardian

\_\_\_\_\_  
Date

I **do not agree** to participate in Telehealth treatment using teleconferencing equipment.

\_\_\_\_\_  
Client Name (PLEASE PRINT)

\_\_\_\_\_  
Guardian Name (PLEASE PRINT)

\_\_\_\_\_  
Signature of Client or Guardian

\_\_\_\_\_  
Date

# Sierra County Health & Human Services

## AUTHORIZATION FOR RELEASE OF INFORMATION



*A photocopy/facsimile copy may be used as an original*

### Your Information

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Last Name	First Name	Middle Initial

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Street Address	P.O. Box	City/State	Zip

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Person/Organization Providing Information:

Person/Organization Receiving Information:

Name: \_\_\_\_\_  
Position or Role: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Sierra County Behavioral Health**  
704 Mill Street | P.O. Box 265  
Loyalton CA 96118  
PH: (530) 993-6746 FAX: (530) 993-6759

### Description of Information to be Released

**(Provide a detailed description of the specific information to be released.)**

[ 45 C.F.R. § 164.503(c)(1)(i) | CA Civil Code § 56.11(d), and (g) ]

Check each type of confidential information you authorize to be released:

- |  |  |
|--|--|
| <input type="checkbox"/> HIV or AIDS Information           | <input type="checkbox"/> Alcohol/Drug Information    |
| <input type="checkbox"/> Mental Health / Behavioral Health | <input type="checkbox"/> Genetic Testing Information |
|  | <input type="checkbox"/> Other: _____                |

Specifically, \_\_\_\_\_

For the following period of time: from \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

Description of the Purpose and Limitations for the Use or Release of the Information  
**(Indicate how information will be used.)**

[ 45 C.F.R. § 164.508(c)(1)(iv) | CA Civil Code § 56.11(g) ]

\_\_\_\_\_ The information will not be used for any purpose other than its intended use. \_\_\_\_\_

Will the health plan or provider receive money for the release of this information?

[ 45 C.F.R. § 164.524(c)(4) ]  Yes  No

\* \* \* Reasonable fees may be charged to cover the costs of copying and postage. \* \* \*

This authorization for release of the above information to the above named persons or organizations will expire on: \_\_\_\_\_ (date).

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to **Sierra County Behavioral Health at 704 Mill Street | P.O. Box 704; Loyalton CA 96118**. The authorization will cease on the date my valid revocation request is received.
- The notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation.
- My treatment, payment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I have the right to receive a copy of this authorization.

Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Patient's (Personal) Relationship: \_\_\_\_\_ Date: \_\_\_\_\_  
 Representative Signature: \_\_\_\_\_

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# Sierra County Health & Human Services

## AUTHORIZATION FOR RELEASE OF INFORMATION



*A photocopy/facsimile copy may be used as an original*

### Your Information

Last Name	First Name	Middle Initial
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Street Address	P.O. Box	City/State	Zip
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Person/Organization Providing Information:

**Sierra County Behavioral Health**

704 Mill Street | P.O. Box 265

Loyalton, CA 96118

PH: (530) 993-6746 FAX: (530) 993-6759

Person/Organization Receiving Information:

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

Position or Role: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

### Description of Information to be Released

**(Provide a detailed description of the specific information to be released.)**

*[ 45 C.F.R. § 164.503(c)(1)(i) | CA Civil Code § 56.11(d), and (g) ]*

Check each type of confidential information you authorize to be released:

HIV or AIDS Information

Alcohol/Drug Information

Mental Health / Behavioral Health  
Information

Genetic Testing

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

For the following period of time: from \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

**Description of the Purpose and Limitations for the Use or Release of the Information  
(Indicate how information will be used.)**

*[ 45 C.F.R. § 164.508(c)(1)(iv) | CA Civil Code § 56.11(g) ]*

\_\_\_\_ The information will not be used for any purpose other than its intended use. \_\_\_\_

Will the health plan or provider receive money for the release of this information?

*[ 45 C.F.R. § 164.524(c)(4) ]*

Yes

No

\* \* \* Reasonable fees may be charged to cover the costs of copying and postage. \* \* \*

This authorization for release of the above information to the above named persons or organizations will expire on: \_\_\_\_\_ (date).

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to **Sierra County Behavioral Health at 704 Mill Street | P.O. Box 704; Loyalton CA 96118**. The authorization will cease on the date my valid revocation request is received.
- The notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation.
- My treatment, payment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I have the right to receive a copy of this authorization.

Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

---

Patient Signature:

Date:

---

Patient's (Personal)  
Representative Signature:

Relationship:

Date:

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

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

C.I.N. #: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

### Sierra County Behavioral Health Financial Form

Information from:  Patient  Responsible Person

New  Readmit  Update

Financial Type:  Individual  Family

Program:  Mental Health  Substance Abuse  Both

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone : \_\_\_\_\_

Employer: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

Other Source of Income: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Veteran: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Secondary Insurance Company : \_\_\_\_\_

#### Family Members In Treatment:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

<u>Income</u>	
Gross Monthly Income	
Self	\$ _____ .00
Spouse	\$ _____ .00
Other: SS, Public Assist	\$ _____ .00
Unemployment, Disability	
Sub-Total (A)	\$ _____ .00

<u>Expenses</u>	
Allowable Expenses	
Court Ordered	\$ _____ .00
Child Care	\$ _____ .00
Med. Exp. in excess of 3%	\$ _____ .00
Mandated Deductible	\$ _____ .00
Total (B)	\$ _____ .00

Household Size (including self): \_\_\_\_\_

#### FOR OFFICE USE ONLY

##### Calculation of Annual Deductible Income

A. Subtotal - Gross Mo. Income	\$ _____ .00
B. Total Allowable Expenses	\$ _____ .00
E. Total Income (A-B)	\$ _____ .00
F. MH Annual Liability	\$ _____ .00
G. Substance Abuse Sliding Scale	\$ _____ .00

UMDAP Valid \_\_\_\_\_ Through \_\_\_\_\_  
(Uniform Method of Determining Ability to Pay)

Payment Plan Agreed Amount: \$ \_\_\_\_\_

Per :  Month  Visit

#### \*\*\*Agreement to Pay Amount Due\*\*\*

I affirm that the statements made herein are true to the best of my knowledge. I understand and accept my annual deductible and agree to pay the amount due on a timely basis.

#### \*\*\*Assignment of Benefits-Release of Information\*\*\*

I hereby assign all Behavioral Health Benefits to which I am entitled including Medi-Cal, Medicare, to Sierra County Department of Health and Human Services. This assignment will remain in effect until revoked by me in writing or until such time as I am no longer receiving Sierra County Behavioral Health Services. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible to pay any deductible amount referred to above if charges are not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
*Patient or Responsible Person*

BH Representative: \_\_\_\_\_ DATE: \_\_\_\_\_

# HEALTH QUESTIONNAIRE/MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Client ID#: \_\_\_\_\_

This questionnaire is about your health. It will assist us in determining your ability to participate in our program.  
This information is confidential.

## Section 1

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

Do you have any of the following symptoms?

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| 1. A cough lasting for 3 weeks or longer? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 2. Coughing up Blood?                     | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 3. Fever or night sweats?                 | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 4. Unexplained weight loss?               | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

2. Have you ever had a stroke? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

5. Have you experienced or suffered any chest pains? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

## Section 2

6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

7. Do you take any medications for a heart condition? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

9. Have you ever had high blood pressure or hypertension? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

10. Do you have a history of cancer? If yes, please give details.

No  Yes

11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.

No  Yes

## Section 3

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.

No  Yes  Date: \_\_\_\_\_

15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder? If yes, please give details.

No  Yes  Date: \_\_\_\_\_

19. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details including any ongoing pain or disabilities.

No  Yes  Date: \_\_\_\_\_

20. Please describe and date any surgeries or hospitalizations due to illness or injury that you have had.

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

21. When was the last time you saw a physician? What was the purpose of the visit?

\_\_\_\_\_

22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).

No  Yes

23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it.

No  Yes

24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.

No  Yes

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.

No  Yes

26. When was your last dental exam? Date: \_\_\_\_\_

27. Are you in need of dental care? If yes, please give details.

No  Yes

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.

No  Yes

29. Are you pregnant? No  Yes  Due Date: \_\_\_\_\_

30. In the past seven days what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

31. In the past year what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

32. Please list current medications:

Type of Medication	Dosage

33. Do you have a Primary Care Physician? No  Yes  \_\_\_\_\_

Date of last visit and reason why \_\_\_\_\_

I declare that the above information is true and correct to the best of my knowledge:

Client Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Sierra County Health and Human Services  
**Notice of Behavioral Health Privacy Practices**

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**THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES. PLEASE REVIEW THIS INFORMATION CAREFULLY.**

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## **1. Your Rights under Federal Privacy Standards**

Your agency health record typically contains your history, current symptoms, progress notes, examination and test results, diagnoses, treatment, and planned care or treatment. Although your record is the physical property of the agency, you have the following rights:

- A. The right to request restriction on uses and disclosures of your health information for treatment, payment, and health care operations: We do not have to agree to a requested restriction on disclosures of information. If we do agree to the request, we will adhere to it unless you request otherwise or we give you advance notice.
- B. The right to ask us to communicate with you by alternate means: If the method of communication is reasonable, we will grant the alternate communication request.
- C. The right to obtain a copy of this Notice of Information Practices: You have a right to receive a copy of this Notice of Information Practices upon request.
- D. The right to inspect and copy your health information: In certain situations, such as if access could cause harm to you or somebody else, we can deny access. If we deny access to your health information, we must provide you a review of our decision to deny access.
- E. The right to request amendment/correction of your health information: We will be unable to grant the request if the record is accurate and complete, or we did not create the record. If the party that created the record amends or corrects the record, we will put the corrected information into our records.

If your request is denied, you can attach a statement of disagreement to your records and you can appeal the decision. If we grant the request, we will make the correction and distribute the correction to those who need it.

- F. The right to obtain an accounting of uses and disclosures of your information: We must provide the accounting within 60 days. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.
- G. The right to revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

## 2. Examples of How Your Information may be Disclosed

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Sierra County Behavioral Health has an ethical and legal obligation to protect the confidentiality of your information; however there are situations in which information obtained during the course of your care may be disclosed without your permission.

- A. Child or Elder Abuse: If we have reason to believe that a child below the age of 18 or elder person (age 65 or older) is subject to abuse, neglect, or exploitation we are mandated by law to notify the appropriate authorities.
- B. Duty to Protect: If we have reason to believe somebody is in imminent danger of harm from themselves or another, we are required to take appropriate action necessary to protect somebody from harm. This can include notifying law enforcement or notifying an intended target.
- C. Disclosure for Payment: With your consent, we will use your health information for payment. For example, we may send a bill to you or to a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnosis and treatment received.
- D. Business Associates: We may at some time provide some services through contracts with business associates. Business associates are required to comply with the same federal security and privacy rules as we do.
- E. Appointment Reminders: We may call you using contact information you provide to give appointment reminders or to attempt to schedule an appointment.
- F. Public Health: Where required by law, we may disclose information to authorities charged with preventing or controlling disease.
- G. Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents health information necessary for your health or the health and safety of other individuals.
- H. Legal Entities: We may disclose health information as required by law or in response to a valid subpoena or court order.
- I. Other Health Care Providers: We may share information with other health care providers as needed to coordinate your care.

Your signature below serves as acknowledgement that you have read this Notice of Information Practices and any questions you have about Sierra County Behavioral Health Information Practices have been adequately answered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

CLIENT NAME: \_\_\_\_\_

**Sierra County Systems of Care  
COMPLAINT PROCESS**

Clients who are dissatisfied with their services may file a complaint. Complaints are divided into two categories: informal complaints and formal complaints (grievances). Clients will not be subject to any penalty or discrimination for filing a complaint or grievance and may appeal decisions.

**INFORMAL COMPLAINT**

- Clients are encouraged to discuss issues regarding their services directly with their case manager or service provider.
- Clients who cannot resolve the issue through the case manager should ask to speak to the case manager's supervisor or program manager.
- Clients may call the S.O.C. Managed Care Unit or the Patient's Rights Advocate to file an informal complaint at any time.

**FORMAL COMPLAINT (GRIEVANCE)**

- Clients can call or write a letter to the Managed Care Unit or the Patient's Rights Advocate to file a formal complaint at any time. The Patient's Rights Advocacy staff is available to assist in completing the form upon request.
- Clients may authorize a person to act on their behalf during the formal complaint process or in the State Fair Hearings process.
- Clients may obtain an official complaint form at any System of Care office, Network Private Provider office, or by calling the S.O.C. Managed Care Unit.
- Clients will receive a written response to a formal complaint within 30 days. The decision can be appealed.

**MEDI-CAL STATE "FAIR HEARINGS"**

- Medi-Cal beneficiaries who disagree with the denial, reduction or termination of their Medi-Cal Mental Health services have the right to file for a State Hearing at any time.
- Instructions on filing for a State Hearing are available on the *Notice of Action* forms or by calling the S.O.C. Managed Care Unit or the Patient's Rights Advocate.

For assistance for all or any of the above procedures, contact any of the following:

Patients' Rights Advocate  
(530) 886-5419  
Or

Managed Care/Quality Improvement Coordinator  
(530) 886-5440

**24-hour telephone number for complaint/grievance procedure information: 1-888-886-5401**

**Programas de Auxilio  
del Condado de Sierra  
COMO PRESENTAR UN RECLAMO**

Aquellos clientes que estén insatisfechos con sus servicios pueden entablar un reclamo. Estos se dividen en dos categorías: reclamos extraoficiales y reclamos oficiales. No resultarán sanciones ni discriminación a los clientes por entablar un reclamo y pueden apelar la decisión.

**RECLAMO EXTRAOFICIAL**

- Se anima al cliente a considerar cuestiones en cuanto a sus servicios directamente con su administrador de caso o su proveedor.
- Aquel cliente que no puedan resolver la cuestión mediante su administrador de caso debería hablar con el supervisor de su administrador de caso o con el administrador del programa.
- El cliente también pueden llamar a la Unidad de Cuidado de Salud Administrativo o el Partidario para Derechos de Pacientes para entablar un reclamo a cualquier momento.

**RECLAMO OFICIAL**

- El cliente puede llamar o escribir una carta a la Unidad de Cuidado de Salud Administrativo o al Partidario para los Derechos de Pacientes para entablar un reclamo a cualquier momento.
- El cliente puede autorizar otra persona para ser su representante en sus reclamos formales o durante el proceso con su audiencia con el estado.
- El cliente puede obtener un formulario de reclamo oficial en cualquier oficina de Programa de Auxilio, oficina de un Proveedor Participante, o llamando la Unidad de Cuidado de Salud Administrativo de S.O.C.
- Dentro de 30 días, el cliente recibirá por escrito una respuesta a su reclamo oficial. Esta decisión puede ser apelada.

**AUDIENCIAS ESTATALES DE MEDI-CAL**

- El beneficiario de Medi-Cal que no concuerde con la negación, reducción o discontinuación de sus servicios de Salud Mental mediante Medi-Cal tiene el derecho de entablar una Audiencia Estatal a cualquier momento.
- Los formularios *Notificación de Acción* facilitan las instrucciones para entablar una Audiencia Estatal o puede pedir las llamando a la Unidad de Cuidado de Salud Administrativo de S.O.C. o al Partidario de Derechos de Pacientes.

Para asistencia con este o cualquier otra proceso, comuníquese con uno de los siguientes:

Abogar de Derechos de Pacientes  
(530) 886-5419

o

Cuidado de Salud/Administrador de Mejoria de Calidad  
(530) 886-5440

**Numero de telefono (24 horas) para information sobre el proceso de quejas.**

**Will I still be treated if I don't make an Advance Health Care Directive?**

Absolutely. You will still get medical treatment. We just want you to know, if you become too sick to make decisions, someone else will have to make them for you.

**What are the parts of the Advance Healthcare Directive form?**

They are:

**Part 1 – Power of Attorney for HealthCare**

Lets you name another individual as your healthcare agent to make medical treatment decisions for you if you become unable to make those decisions.

**Part 2 – Instructions for Healthcare**

Lets you express your wishes about your future healthcare treatment.

**Part 3 – Donation of Organs at Death (optional)**

**Part 4 – Primary Physician (optional)**

Lets you designate a primary doctor, if you wish.

**Part 5 – Signature**

Sign and date the form. You will need two witnesses to your signature.

**Where do I get the Advance Healthcare Directive form?**

You should ask your physician or physical health care office for an Advance Healthcare Directive form. A printable form is available on-line at: <http://www.calhealth.org/public/pubs/frmspstrs.html>.

**How can I get more information about making an Advance Healthcare Directive?**

Ask your primary medical doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an Advanced Healthcare Directive for you or you can complete one yourself by filling in the blanks on a form. Instructions are included on the form. Additional resource information is included on the back of this brochure.

**Important Contacts and Resources**

Patients' Rights Advocate  
(530) 886-5419

Placer/Sierra County MHP  
SOC Managed Care Unit  
(530) 886-5400

For further assistance:  
Legal Services of Northern California  
190 Reamer St.  
Auburn, CA 95603  
(530) 823-7560

Additional information on-line:  
Office of Attorney General  
[www.ag.ca.gov/consumers/general/adv\\_hc\\_dir.htm](http://www.ag.ca.gov/consumers/general/adv_hc_dir.htm)

California Medical Association  
[www.cmanet.org/publicdoc.cfm/7](http://www.cmanet.org/publicdoc.cfm/7)

**You may file a complaint regarding noncompliance with the Advance Medical Directive requirements to:**

California Department of Human  
Services Licensing and Certification  
P.O. Box 997413  
Sacramento, CA 95899-1413  
Or call  
1-800-236-9747



Sierra County  
Mental Health Plan (MHP)

**ADVANCE  
HEALTHCARE  
DIRECTIVE**



*You have the right  
to make decisions  
about your medical treatment*

### **What is an Advance Health Care Directive?**

An Advance Health Care Directive is the best way to make sure that your physical health care wishes are known and considered if for any reason you are unable to make decisions on your own.

### **Do I have to wait until I am sick to express my wishes about health care?**

No. In fact, it is better to decide before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatments you want. These documents are called “Advance” because you prepare one before healthcare decisions need to be made. They are called “Directives” because they tell who you want to speak for you and what kind of treatment should or should not be done.

### **Who can make an Advance Directive?**

Anyone over 18 years of age (or an emancipated minor) who is capable of making his/her own medical decisions can make an Advance Health Care Directive. You do not need a lawyer.

### **Who decides about my treatment?**

Your doctors will give you information and advice about treatment. You have the right to choose. You can say “Yes” to treatments you want. You can say “No” to any treatment that you don’t want - even if the treatment might keep you alive longer.

### **How do I know what I want?**

Your doctor must tell you about your medical condition and about what different treatment and pain management options are available. Your doctor must also inform you of any side effects from treatment or medications. At times, more than one treatment might help you. Your doctor can advise you about different options. You can discuss options with your family and friends. Ultimately, it is your decision.

### **Can I choose a relative or friend to make healthcare decisions for me?**

Yes. You may appoint them to be your health care “Agent” by completing Part 1: Power of Attorney for Health Care on the Advance Health Care Directive.

### **What if I become too sick to make my own decisions?**

If you have named an agent, he/she will make medical decisions on your behalf. If not, your doctor will ask your closest relative or friend to decide what is best for you. Most of the time that works, sometimes everyone cannot agree about what to do. That’s why it is helpful if you can say in advance what you want to happen if you cannot speak for yourself.

### **Who may I appoint as my health care agent?**

You may appoint any adult to be your agent. It is important that you talk to the person first to make sure that he/she understands your wishes and is willing to accept the responsibility.

### **How does my agent know what I would want?**

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make and it truly helps if your agent knows what you want. Writing down your health care wishes will be helpful for your agent. You can also write specific health care wishes in your Part 2: Instructions for Health Care of the Advance Health Care Directive.

### **When does my agent begin making my medical decisions?**

Usually a healthcare agent will make decisions only after you lose the ability to make them yourself. But if you wish, you can state in the Power of Attorney for Health Care, that you want the agent to begin making decisions immediately.

### **What if I don’t want to name someone to make my healthcare decisions (an agent)?**

You can write down your wishes for healthcare treatment without naming an agent. You can say that you want to have your life continued as long as possible, or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment. Even if you do not complete the form, you can discuss your wishes with your doctor and ask your doctor to list those wishes in your medical record. You can also discuss your wishes with family members or friends. But it will probably be easier to follow your wishes if you write them down.

### **What happens when someone else makes decisions about my treatment?**

The same rules apply to anyone who makes healthcare decisions on your behalf – a healthcare agent, a person whose name you gave to the doctor, or a person appointed by a court to make decisions for you. All are required to follow your Health Care Instructions or your general wishes about your treatment, including stopping treatment. If your treatment wishes are not known, the person who makes the decisions on your behalf must try to determine what is in your best interest. The people providing your health care must follow the decisions of the person you designated unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the health care provider must make a reasonable effort to find another healthcare provider to take over your treatment.

**What if I change my mind?** You can change or cancel your Advance Healthcare Directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.