

CHILD INTAKE & FAMILY CARE TEAM INFORMATION



Date: _____

Child's Name (First, Mid, Last): _____ Sex: M F

DOB: _____ Religious Preference (optional): _____

Ethnicity (please indicate the best fit for the child's background, or provide description):

- White (non-Hispanic)
- Hispanic (if yes, please indicate): Mexican Puerto Rican Cuban Other: _____
- Black (non-Hispanic)
- Asian (if yes, please indicate): Southeast Asian East Indian Other: _____
- Native Hawaiian/Other Pacific Islander
- Native American
- Alaskan Native
- Other race: _____

Medicaid #: _____ Social Security #: _____

Other Insurance Coverage: Yes No If yes, please provide the following:

Insurance Provider : _____

Policy Holder: _____ Policy Number: _____

Social Security Number of Policy Holder: _____

FAMILY INFORMATION

Parent(s)/Guardian(s):
Address(s) and Phone Numbers of Parent(s)/Guardian(s):

Email:			
Sibling(s):	M/F	Age	Contact? (Y/N)

Child's Hobbies/Special Interests: _____

FAMILY CARE TEAM RESOURCES

System Involvement: Please indicate all individuals involved in the clients care coordination and indicate if they need to be invited to clinical meetings and/or receive monthly reports or incident reports

Name/Title	Contact Information (phone/cell/fax/email)	Meetings/Report Distribution?
Child Welfare/Caseworker		
Supervisor		
Case Manager		
Mental Health		
Other Funding Source (primary/secondary insurance, etc.)		
Developmental Disabilities		

Name/Title	Contact Information (phone/cell/fax/email)	Meetings/Report Distribution?
Tribal Representative		
School District Rep		
Juvenile Justice		
Other (CASA, Attorney, etc.)		

Other Community Resources & Natural Supports

(NOTE: Please indicate individuals you want to attend the family care team meetings).

Individual	Role	Contact Information (phone/email)	Meetings?

CHILD'S SCHOOL STATUS UPON INITIAL INTAKE

Last School Attended: _____ Current Grade: _____

School Address or Location: _____

School District: _____ Current IEP? Y N

Child's most recent teacher(s): _____

IEP Eligibility (If known/applicable): _____

CHILD'S MENTAL HEALTH/BEHAVIORAL STATUS

Child & Family Strengths: _____

Please check the problematic behaviors which the child has exhibited:

Behavior		Comments
<input type="checkbox"/>	Violent/Aggressive	<input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Animals
<input type="checkbox"/>	Biting	
<input type="checkbox"/>	Destroys Property	<input type="checkbox"/> Own <input type="checkbox"/> Others
<input type="checkbox"/>	Difficulty with Peers	
<input type="checkbox"/>	Encopresis	<input type="checkbox"/> Daytime <input type="checkbox"/> Nighttime <input type="checkbox"/> Smears
<input type="checkbox"/>	Enuresis	<input type="checkbox"/> Daytime <input type="checkbox"/> Nighttime
<input type="checkbox"/>	Firesetting	How many occasions?
<input type="checkbox"/>	Oppositional	
<input type="checkbox"/>	Hyperactive	
<input type="checkbox"/>	Lies excessively	
<input type="checkbox"/>	Runs Away	
<input type="checkbox"/>	Self-Mutilation	How?
<input type="checkbox"/>	Sexual Offending	
<input type="checkbox"/>	Sexually Reactive	
<input type="checkbox"/>	Steals excessively	

Behavior		Comments
<input type="checkbox"/>	Controlling	
<input type="checkbox"/>	Distractible	
<input type="checkbox"/>	Attachment Problems	
<input type="checkbox"/>	Covert	
<input type="checkbox"/>	Manipulative	Unjustified accusations of abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Tantrums	How often/how long?
<input type="checkbox"/>	Nightmares	How often?
<input type="checkbox"/>	Depression	
<input type="checkbox"/>	Suicidal	<input type="checkbox"/> Ideation <input type="checkbox"/> Acts When?
Additional Comments/Clarifications (as needed):		

HISTORY OF RESTRICTIVE BEHAVIORAL INTERVENTIONS

Does the child have a history of needing restrictive behavioral interventions such as being held for violent behavior? Yes No If yes, please answer the following:

How would you describe the child's current risk to self and to others?
What are the child's triggers that often result in problematic behavior and what signs indicate the child is likely to become violent?
What types of interventions have been successfully used in the past?
What has not worked in the past?
Does this child have any medical or psychological issues that need to be considered in behavior management interventions?

! This consent allows us to enroll your child in our residential treatment program and allows him or her to participate in program activities, including outdoor or strenuous activities. It includes a summary of financial responsibilities, and a summary of our client rights, confidentiality and grievance procedures.

Name of Child: _____ Date of Birth: _____

1. AUTHORIZATION

I understand that my child has been accepted into a residential treatment or evaluation program of Jasper Mountain (hereafter known as "Agency") and I represent that I have the authority to sign this authorization and release for my child to participate, because my child is a minor and I am the child's parent or legal guardian. I hereby give my consent for the above-named child to participate in the Agency's residential programs as follows:

A. CARE I give my permission for my child to remain in the care of the assigned Agency residential program for the time period mutually agreed upon.

B. ACTIVITIES I give my permission for my child to participate in activities in connection with my child's stay in residential treatment including recreational and outdoor activities. I acknowledge that I have been provided an addendum to this release describing such activities and providing me with the purpose, benefits, potential risks, and precautions to be taken. I understand that participation by my child is voluntary in these activities and that alternative will be offered.

C. FEE-FOR-SERVICE COSTS I understand that the Agency will pursue the applicable State Medicaid Program for payment of services provided to my child. Upon request, a fee schedule is available to me, listing the costs for services. These costs may change from year to year, depending upon the current fee schedule. I understand that this schedule is always available to me, and that I will not be responsible to pay for any covered services.

Jasper Mountain provides a wide variety of medical, educational and mental health services to the public. While engaged in services provided by Jasper Mountain please be aware that no staff are to offer or agree to provide services of any kind for a fee to your child or your family on a private basis outside of their role as a Jasper Mountain service provider. If this should come up or you have any questions in this area please speak to an agency representative.

D. OUT-OF-AREA FAMILY VISITS Family visits are an essential component of a child's successful treatment. Each child will have a plan developed to maximize the benefit that can be obtained from opportunities to reintegrate into the family through visits. As the child's parent/guardian, I understand that I am responsible for the costs of the family to come to the program for visits, unless these costs are covered by the child's funding source. I also understand that visits requiring the child to travel out of the area, that are in the treatment plan and are designed for treatment purposes, will be a shared financial responsibility of the family (or the child's funding source) and Jasper Mountain. I understand that the family would be responsible for the travel costs of the child and Jasper Mountain would be

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responsible for the expenses of its staff related to a visit. If the family decides to have child visit out of the area for reasons that are not primarily treatment in nature (for example, to attend a wedding, go on a vacation, or other family preferences), the family will be responsible for all the travel costs required to facilitate the visit.

2. RELEASE OF LIABILITY

I recognize that there are risks inherent in my child's involvement in the Agency's programs, and in particular that there are risks associated with the recreational components. Although all appropriate precautions will be implemented, I recognize that my child's participation in Agency programs could lead to my child sustaining accidental physical injuries. I hereby release Jasper Mountain, its agents and employees, from any and all liability in connection with accidental injury related to my child's participation in the Agency's programs.

3. CONFIDENTIALITY POLICIES

The Agency respects the confidentiality of all clients. In the interest of treatment plan coordination, we may need to exchange information with other agencies or individuals concerning your involvement in our program. These agencies or individuals include school personnel, the Department of Human Resources, Lane County Mental Health or other mental health agencies, medical personnel, previous and potential placement resources, and other Jasper Mountain programs. Such information will be limited to that which is necessary to coordinate treatment planning. Your child's confidentiality will be maintained when/if referenced in another child's clinical record. Your child's clinical record will be safeguarded in accordance with applicable Oregon Revised Statutes, Oregon Administrative Rules and federal law. Our confidentiality policies are fully described in the agency's Notice of Privacy Practices which you will receive upon your child's intake. Jasper Mountain is a mandated reporter of abuse for vulnerable populations, including children, and is responsible to report suspicion of abuse when it comes to our attention. Such situations are an exception to our usual confidentiality policies and procedures, due to legal requirements.

4. WORKING TOGETHER TO PROMOTE YOUR CHILD'S TREATMENT

Whether a parent or supportive adult in the life of a child in treatment at Jasper Mountain, we ask you to help us produce the positive changes that will help the child. Our philosophy is that the most effective treatment starts at Jasper Mountain and continues afterward for the long-term. Most children get better in our setting away from home, but children with positively engaged family members get better even faster and maintain the improvement when they return home. We have learned over the years how families can best support a child in treatment with us. To best help your child, there are some things we will do and things we ask that you do.

We will:

A. Provide you with information, reports, and recommendations designed to help you understand our treatment process and how you can help play an important role.

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B. Offer ideas and suggestions designed to increase the amount of success you have with your child.

C. Involve you in the treatment of your child through activities such as weekly family therapy, phone calls, emails, and monthly team meetings. We can inform you of any containment holds or other significant events. You will be informed of and invited to attend school plays and special events.

D. Offer to you the use of an on-site apartment, when it is available, at no cost in which to stay for scheduled visits.

We will ask you to:

A. Let us know that you agree with the placement and are hopeful that our program can help your child.

B. Acknowledge that Jasper Mountain has a proven track record of helping children and their families and that you want our help for you and your child.

C. Agree to consider our ideas and suggestions and, as often as possible, use the suggestions so your child learns that the adults are working together.

D. Agree to provide Jasper Mountain any requested information on your child's medical, treatment, and school history.

E. Agree to participate either by telephone, webcam (Skype), or in person in weekly family therapy when this is in the treatment plan.

F. Agree not to come to the program, contact your child, or engage in therapy when you are under the influence of substances that would impair your ability to interact with your child.

G. Agree to do your best to practice new skills and new ways of looking at things that are suggested by the therapist, to keep an open mind, to be open to making changes in yourself and your family while your child is making changes.

5. CLIENT RIGHTS & RESTRICTIONS ON RIGHTS

The Agency has established client rights policies, and provides them all consumers upon intake in Jasper Mountain Client Rights Packet. In order to promote the necessary treatment environment, there are also certain expectations of children in our treatment program:

A. **COMMUNICATION** Children have the right to contact parents, guardians, or advocates such as lawyers or OAC representatives, for important communications. Other conversations are also permitted at a reasonable frequency, based on factors such as the child's ability to demonstrate safe and cooperative behavior, and the amount of such communication that is in his/her best interest. There also may be times when it is in the best interest of the child not to have contact by phone, mail or in person with individuals identified by the child's caseworker or family. Decisions about these limits are not made by the program, but by the child's family care team. Any restrictions will be explained and documented.

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- B. CLOTHING/HYGIENE** The program has standards of clothing and hygiene designed to have children look and feel positive about themselves. Clothes are to be neat, without stains and holes and without symbolizing violent or inappropriate messages.
- C. MUSIC/AUDIO-VISUALS** Music and DVD/videos are screened to eliminate themes not appropriate for traumatized children.
- D. VIOLENT PRODUCTS** Any game or item that promotes or encourages violence is not allowed in the program.
- E. ROOM & PERSONAL SEARCHES** If the program has a concern that a child may have acquired an item noted or any other illegal, unsafe or other harmful items (lighters, knives, sharp objects), the program staff is to ensure safety for everyone by searching for such an item as needed, and removing the item from the child's possession (such items will be offered to the legal guardian). If illegal items are discovered, the program will also contact law enforcement as required by law.

6. GRIEVANCE POLICY

If a consumer is displeased with the service they receive or the way they have received it, they are encouraged to bring the concern to the attention of the assigned therapist or the program director. Consumers are encouraged to speak out about any dissatisfaction with the services they receive and every attempt shall be made to resolve the issue. If the consumer is still not satisfied, the consumer may file a complaint (verbally or in writing), called a grievance action. The subject of a formal complaint or grievance is to be dissatisfaction or concern about services or lack of services that are the responsibility of the agency. Expressing a complaint will not result in any form of retaliation. The Agency's full grievance procedure is provided as part of the Jasper Mountain Client Rights Packet given to consumers upon intake, and available in the business offices of the agency. In summary, however, there are several steps available to the consumer to be followed in the order listed until the issue is satisfactorily resolved:

- Discuss the situation with the assigned therapist. If the situation is not resolved, the consumer can then ...
- Bring the matter to the attention of a program director either verbally or in writing. If there continues to be no resolution, the consumer can then...
- Submit a written grievance (complaint) to the executive director. If the consumer wants help putting the complaint in writing, assistance is available. If the situation is still not resolved, the consumer can then...
- Submit a written grievance to the Jasper Mountain Board of Directors: 37875 Jasper-Lowell Rd. Jasper, OR 97438.
- Special Note: If there is immediate concern for safety, such as a decision on a critical medication, an expedited grievance can be requested. If this is requested, the agency will decide if the matter is urgent within one day and if so, a decision will be provided within 24 hours of this decision.



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7. AUTHORIZATION & RELEASE

My signature indicates I have read and understand the above policies which will be used during the treatment of my child and my family. It further provides permission for the Agency to provide treatment as outlined in the organization's policies and procedures. I am aware that I can withdraw this consent at any time.

Name of Parent/Guardian (Print): _____

Relationship to Child: _____

Signature of Parent/Guardian: _____ Date: _____

ADDENDUM: Consent for Physically Active Recreation

Name of Child: _____ Date of Birth: _____

1. PURPOSE

Recreational activities are designed to teach children the basic socialization skills through experiential learning in a recreational setting. Activities have been carefully selected with a focus on skills such as confidence building, problem solving, decision-making, communication, conflict resolution, relationship building, moral reasoning, time management, and recreation and leisure. Activities will be suited to the age, skill and ability of my child. No activities are designed to cause physical discomfort or to intentionally cause emotional distress. I understand that if I withhold permission or if my child does not voluntarily decide to participate, alternative activities will be offered and the lack of permission will not affect whether my child can receive treatment in the program.

2. BENEFITS

Program activities are chosen for their value in reaching the purposes described above. There are many potential benefits for your child in learning skills, finding ability previously unknown, learning teamwork, learning endurance and the ability to not give up, and learning to do physically challenging tasks. It is not always clinical services that most affect children, it can often be healing that occurs when the child is learning new skills and abilities and having fun at the same time.

4. TYPES OF ACTIVITIES AND POTENTIAL RISKS

Every effort is taken to insure that activities are fundamentally safe and conducted in a manner to minimize risks. However, not all risks can be eliminated. There is always a possibility of physical injury and/or emotional discomfort. The following are examples of outdoor and strenuous activities that may be offered to your child. (Note: Not all Jasper Mountain programs offer the full array of activities listed below, but in anticipation that your child may be involved in a variety of physically active recreational activities, please respond as indicated).

Please cross out and initial any activities for which you do NOT give your permission:

Hiking: Easy and medium hikes of 1 to 7 miles with less than 1,000 ft. elevation. Participating children are in good physical condition with proper footwear and clothing and are an age and developmental level to gain from the experience.

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Swimming: Closely monitored recreational swimming for the purpose of enjoyment and skill building. Participating children are in good physical condition and are kept within their ability level with close supervision by staff who are experienced swimmers.

Jogging: Recreational jogging that includes some running and walking for periods of thirty minutes or less at a pace appropriate to the age and skill level of the child. Participating children are in good physical condition with proper footwear and have instruction and monitoring by staff experienced in jogging.

Physical Work: Physical work projects around the program that include cleaning, light digging, carrying and work around the ranch. Work is to be closely supervised by staff with an emphasis on safety, risk free skill building and exercise. Participating children are in good physical condition with proper tools, instruction and very close supervision.

Camping: Non-strenuous recreational camping in family tents at the beach and lake. Participating children are in good physical condition with close supervision by staff experienced in camping.

Horseback Riding: Corral or short trail rides with adult support appropriate for the child's age and skill level. Participating children are in good physical condition with approved animals that are known to be safe for very young children.

Athletic and Sports Activities: Basketball, baseball, soccer, the program "Olympics," trampoline, archery, obstacle course, playground or organized group games, biking/BMX track, and other sporting events. The activity is to be designed for the age and ability of each child.

5. PRECAUTIONS

The agency is committed to minimizing any risk for the children involved in activities. All direct service staff have first-aid and CPR certification. Staff are trained in the agency policies and the Activity Safety Manual, which will be provided for inspection upon request. Examples of precautions taken to reduce any risk are: very close supervision, written guidelines for each activity, procedures on emergencies, evaluating appropriate weather conditions and many other precautions.

Before any activity including the above, children are screened for their fitness for the activity. Activity leaders receive current information related to any behavior that is a threat to self or others and medical and psychiatric information. Fitness for an activity is determined by considering both the child's physical health and his/her recent behavioral patterns, with the goal of having children participate who can do so safely, with maximum benefit.

6. AUTHORIZATION

I hereby give my permission for my child to participate in activities in connection with my child's enrollment in Jasper Mountain's programs, including recreational and outdoor activities. My signature indicates I have read and understand the above information concerning activities in agency programs. I am providing my permission for Jasper Mountain to include my child in program activities unless I have indicated otherwise above. I understand this permission is



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voluntary as is my child's participation and my decision will not influence whether my child can receive other treatment with the agency.

Name of Parent/Guardian (Please Print): _____

Signature of Parent/Guardian: _____ Date: _____

PHONE CONTACT

Child's Name: _____ Therapist: _____

Date Effective: _____

ACCEPTABLE Unsupervised Phone Calls (Calls may be made or received at any time)	
Contact Name	Phone Numbers

RESTRICTED (Calls must be made/received in the presence of the child's therapist)	
Contact Name	Phone Numbers

NO CONTACT (Note: Therapist is also to document restrictions with additional form in file.)	
Name	Phone Numbers

STUDENT INFORMATION FORM

SPECIAL PROGRAMS

(Forms must be completed)

The Child Center

Jasper Mountain

Safe Center

Centerpoint

Date of Enrollment: _____

Legal Last Name: _____

Legal First Name: _____

Middle Name: _____

Gender: _____ Date of Birth: _____ Grade: _____

Home Phone Number: _____

Ethnicity:

Hispanic: Y/N (Please circle and choose one of the boxes below)

Race:

White

Black

Asian

Native Hawaiian/Pacific Islander

Native American/Alaska Native

Parent/Guardian Information:

Father/Guardian: _____ Phone: _____

Address: _____

Mother/Guardian: _____ Phone: _____

Address: _____

On IEP? Yes No

Eligibility Statement and IEP attached? Yes No

Tuition paid by:

Medicaid/Fully State Funded

Resident District

Parent/Guardian

Other (Please specify)

Residential

Day Treatment

! This consent allows us to provide treatment to your child, including the as-needed use of special treatment procedures such as physically containing a child who is being unsafe to self or others.

Name of Child: _____ Date of Birth: _____

This document is to be signed by the legal guardian and/or parent for the child listed above and is meant to provide the expressed written consent for the psychiatric and psychological residential treatment and associated special treatment procedures that are offered by Jasper Mountain, through the residential programs at Jasper Mountain Center or the SAFE Center. I acknowledge that the following information was explained to me upon the above named child's intake into a Jasper Mountain residential program:

- **Treatment Approach.** Active treatment and other interventions to be undertaken may include: recreational therapy, individual, group, and family therapy, role plays, drama, evaluation, medications, art and other projective therapy, and milieu behavioral therapy.
- **Alternatives.** Alternative treatments or interventions available, if any: if the child can be treated in a less restrictive setting such as outpatient, day treatment or treatment foster care, these alternatives should be pursued first.
- **Length of Treatment.** Projected time to complete the treatment process: length of stay in the program ranges from one to twenty-four months. Based on current anticipated needs, length of treatment for the above named child is estimated to be _____ months.
- **Progress Measures.** Indicators by which progress will be measured: improvement in the issues identified in the initial plan of care, as well as the measurable objectives in the treatment plan, will be used to measure progress.
- **Benefits.** Benefits which can reasonably be expected: reduced problem behavior(s) and improved self-esteem, social skills, emotional control, and/or increased ability to express needs and wants to others.
- **Risks.** Potential risks of treatment: this child's behaviors could get worse before getting better, discussions of topics that are emotionally difficult for you or the child, no improvement of behavioral or emotional issues for the child and his or her relationship with the family, and/or a need for further treatment in another setting.
- **Prognosis of Treatment:** Excellent: _____ Good: _____ Fair: _____ Unknown: _____



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- **Discharge.** Discharge plan, anticipated discharge date, and procedure for discharge:
The anticipated discharge placement is: _____, the approximate date is: _____. The discharge process will be developed between your therapist, yourself and your family care team, and it will include your agreement and signature.

Medications and Right to Refuse. As the child's guardian and/or parent, I have the authority and legal right to refuse treatment services for the above child, including treatment services generally accepted, such as medication. The consequences of refusing the services outlined by this agency in the child's treatment plan will be verbally and in writing explained to me at the time of refusal of services, in the event a refusal occurs. I am aware that a refusal of services for treatment will be documented in the child's clinical record.

Behavior Management. I have been provided an explanation of the behavior management policy of the agency and I authorize the Agency to use the special treatment procedures within the policies of the agency and the State regulating authority including:

- Within the limits of the policy, removing the child from the milieu and other children if he or she becomes a danger to self or others.
- Implementing therapeutic holds as outlined in the policy to contain the child when required to maintain the safety of the child and others around the child.

My signature reflects that I freely authorize Jasper Mountain to admit my child and use the general and specific treatments that have been explained to me. I acknowledge the potential risks and benefits of treatment. I also acknowledge that I have discussed and agreed with the information about the agency residential programs and the proposed treatment outlined for my child. I am aware that I can withdraw this consent at any time, but my consent is necessary for the treatment of my child.

Guardian/Parent Name (Please Print): _____

Signature: _____ Date: _____
Guardian/Parent

Agency QMHP Name (Please Print): _____

Signature: _____ Date: _____
Jasper Mountain QMHP

JASPER MOUNTAIN AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize (Source of Information): _____

to disclose a copy of the health and clinical information indicated below to Jasper Mountain, regarding:

Client's Name: _____ D.O.B. _____

consisting of: _____

and including (please INITIAL↓):

PLEASE INITIAL

___ Yes ___ No Family History ___ Yes ___ No Mental Health Services
___ Yes ___ No Employment/Unemployment ___ Yes ___ No Medical/Psychiatric Treatment
___ Yes ___ No Educational Reports ___ Yes ___ No Labs/Diagnostic Tests
___ Yes ___ No Alcohol/Drug Treatment (Minor) Other: _____

Note: Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

Please send to the indicated Agency location:	<input type="checkbox"/> Jasper Mountain Center 37875 Jasper-Lowell Road Jasper OR 97438 Fax: (541) 747-4722 Phone: (541) 747-1235
	<input type="checkbox"/> SAFE Center 89124 Marcola Road Springfield OR 97438 Fax: (541) 726-9869 Phone: (541)741-7402

Purpose of Release: The information received will be used by the Jasper Mountain programs to evaluate the child's situation and to plan for/coordinate services for the child and family, or for other purposes as specified.

Mutual exchange allowed? PLEASE INITIAL → Yes _____ No _____ Not Applicable _____

Individual Authorizing Release: _____

Above listed individual's relationship to client granting authority to sign this release:

Parent Other Guardian Other (*describe*): _____

TO THE INDIVIDUAL AUTHORIZING THIS RELEASE: The above named child's health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless the child's health care or treatment is for the purpose of 1) creating health information about the child to be disclosed to a third party; or 2) for the purposes of research. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, our agency will no longer use or disclose information about the named child for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a signed and dated written statement to Privacy Officer at Jasper Mountain, 37875 Jasper-Lowell Road Jasper OR 97438, identifying the date you signed this authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. By signing this authorization, you are directing the above listed entity to disclose health information to another organization that may or may not have or obey the same obligations to protect privacy under state and federal law. Therefore, the disclosure specified above carries with it the potential for an unauthorized redisclosure and loss of protection under state and federal law.

This Authorization is effective on _____ and is good for 90 days unless it is revoked. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and loss of protection under state and federal law. I have reviewed and understand this Authorization. By signing below, I so authorize this release:

Signature: _____ Date: _____

Jasper Mountain
NOTICE OF PRIVACY PRACTICES



! To the Clients of Jasper Mountain:

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOUR CHILD, OR YOU (TO THE EXTENT NEEDED TO TREAT YOUR CHILD), MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting our clients' confidentiality, and have developed the following policies and procedures to help address privacy issues. If you have questions about this notice, please feel free to contact Jasper Mountain's designated privacy officer, at our office at Jasper Mountain: 37875 Jasper-Lowell Road, Jasper, OR 97438. Phone: (541) 747-1235.

 **WHO WILL FOLLOW THIS NOTICE**

This notice describes the information privacy practices followed by our staff and service providers for Jasper Mountain.

 **YOUR CHILD'S HEALTH INFORMATION**

This notice applies to the information and records we have about your child's health, health status, and the care and services he/she may receive from Jasper Mountain. Your child's health information may include information created and received by this agency, may be in the form of written or electronic records or spoken words, and may include information about family history, health history, health status, symptoms, examinations, test results, diagnoses, treatments procedures, prescriptions, and similar types of health-related information.

We are required by law to give you (the child's parent/guardian) this notice. It will tell you about the ways in which we may use and disclose your child's health information and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE YOUR CHILD'S HEALTH INFORMATION.

We may use and disclose health information for the following purposes:

- **For Treatment.** We will use your child's health information to provide him/her with clinical treatment or services. In this context, we may disclose your child's health information to treatment team staff, teachers, therapists, office staff or other personnel involved in taking care of the various aspects of your child's care.

For example, your child's therapist may share information about your child's situation with the team of people who work with him/her on a daily basis, so that staff members can best understand your child's needs and how to provide the appropriate level of support and guidance in daily activities. Or your child's therapist may consult with other therapists on staff, disclosing information about your child's situation, so that together the team of therapists can help determine the most appropriate care for your child.

A friend or family member of another child in residence may come for a visit and may observe that your child is also in our program. Different personnel in our office may share your child's health information to people who do not work in our office in order to coordinate your child's care, such as phoning in prescriptions to the pharmacy, or scheduling lab work or making appointments at the doctor or dentist.

In these cases, and all others, our communication about your child's information is guided by the goal of having your child receive the best treatment and care possible.

- **For Payment.** We may use and disclose your child's health information so that the treatment and services your child receives through the agency may be billed to and payment may be collected from an insurance company or a third party. For example, we may need to give an insurance company or the mental health system information about a service your child received here so the plan will pay for the service. We may also tell your health plan about a treatment your child is going to receive to obtain prior approval, or to determine whether the plan will pay for treatment.

Under the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, you have the right to ask us not to disclose information to your health plan if you personally paid for the service received, in full.

- **For Health Care Operations.** We may use and disclose aspects of your child's health information in order to run the office and make sure that your child and our other clients receive quality care. For example, we may use your child's health information to evaluate the performance of our staff in caring for your child. We may also use health information about all or many of our clients to help us decide what additional services we should

offer, how we can become more effective, or whether certain aspects of our services are helpful.

We may also disclose aspects of your child's health information to reviewers who evaluate our services, and help us to meet all the requirements that are developed over time in providing clients the best care, and following the best practices of social service providers.

SPECIAL SITUATIONS

We may use or disclose your child's health information for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about your child when necessary to prevent a serious threat to health and safety of your child, or to another person.
- **Required By Law.** We will disclose health information about you or your child when required to do so by federal, state or local law. This could include a requirement by a military command if you are a member of the armed forces, or part of the national security or intelligence community.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the agency.
- **Public Health Risks.** We may disclose your child's health information for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose client health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose your child's health information in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Information Not Personally Identifiable.** We may use or disclose health information about your child in a way that does not personally identify you or reveal who you or your child are.

- **Marketing/Sales.** We will not use or disclose any Protected Health Information (PHI) for marketing or sell any PHI without your permission.
- **Psychotherapy Notes.** “Psychotherapy notes” (reference or working notes made by the therapist/psychiatrist that are not added to your file) will not be used or disclosed without your permission.
- **Family and Friends.** We may disclose aspects of your child’s health information to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your child’s family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your child’s personal health information to a family member if the family member comes to a counseling appointment with you. In situations where you are not capable of giving consent on behalf of your child (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to a family member or friend is in your child’s best interest. In that situation, we will disclose only health information relevant to the person’s involvement in your child’s care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your child’s health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose your child’s health information you may revoke that Authorization, **in writing**, at any time. If you revoke your Authorization, we will no longer use or disclose information about your child for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, genetics and/or substance abuse, information.

CLIENT RIGHTS REGARDING HEALTH INFORMATION

- **Right to Confidentiality.** Clients of Jasper Mountain have the right to confidentiality in accordance with the agency’s *Policies & Procedures Manual*, and further explained in the *Handbook on Confidentiality* of the Oregon Mental Health and Developmental Disability Services Division (currently, Oregon Mental Health and Addictive Services); Oregon Revised Statutes 179.505 - 179.507, 107.154 & 418.312 (as well as all other applicable sections of the ORS & OAR and federal statutes); and the Health Insurance Portability and Accountability Act of 1996. The agency is also guided in these matters

by the American Psychological Association Code of Ethics, and by legal counsel, as needed. This notice describes these policies and procedures. If you wish to obtain a copy of the policies as they are detailed in the agency's *Policies & Procedures Manual*, you may request a copy from the agency's Privacy Officer (listed at the top of this notice).

- **Right to Inspect and Copy.** You have the right to inspect and copy your child's health information, such as clinical and billing records, that we keep and use to make decisions about your child's care. You may submit a written request to the agency's Privacy Officer (listed at the top of this notice) in order to inspect and/or copy records of your child's health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy this information in certain limited circumstances. If you are denied copies of or access to your child's health information you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Special Note: Because of the age of the children treated by the agency, children are not routinely shown their file unless there is a therapeutic reason for doing so. When a child is denied access to any portion of their treatment file, this decision is carefully made by the child's therapist and the agency's clinical team, with special attention to potential harm to the child.

- **Right to Amend.** If you believe health information we have about your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information has been created by this agency. To request an amendment, submit a written request to the agency's privacy officer (listed at the top of this notice). The agency has an amendment form which you may be asked to use in addition to your written request.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- we did not create, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information that we keep;
- is information which you would not be permitted to inspect or copy;
- is accurate and complete.

If the amendment involves the correction of an error in the record, the following procedures will apply: Errors in the clinical record may only be corrected by lining out the incorrect data with a single line in ink, and then adding the correct

information, the date corrected and the initials of the person making the correction. Errors may not be corrected by removing information, or obliterating it.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of your child’s health information, for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to the agency’s Privacy Officer (listed at the top of this notice). It must state a time period, which may not be longer than six years after your child has left our programs, and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For more than one list per year, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Notice of Breach.** You have the right to receive notifications whenever a breach of your unsecured PHI occurs as required under the HIPAA Omnibus Rule.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about your child for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about your child to someone who is involved in his/her care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about an incident which occurred to your child. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to assist in an emergency situation.

To request restrictions, you may fill out a request form obtained at the agency’s business offices. The form should be submitted to the agency’s Privacy Officer, listed at the top of this notice.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you or your child about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the written request to the agency’s Privacy Officer (listed at the top of this notice). We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such

a copy, contact the agency's Privacy Officer, (listed at the top of this notice), or request a copy at any of the agency's administrative offices.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for your child's current health information as well as any such information we receive in the future. We will post a current notice in our offices with its effective date on the bottom right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint. To file a complaint with our office, contact Jasper Mountain's Privacy Officer at 37875 Jasper-Lowell Road, Jasper, OR 97438. The Privacy Officer will work with directors in the agency to help resolve the concern. If the issue is not resolved to your satisfaction, you can choose to submit a formal grievance in accordance with the agency's Grievance Procedures, as follows:

Formal Grievance Process: There are several steps available to you that can be pursued in the order listed, until the issue is satisfactorily resolved:

- Discuss the situation with the assigned therapist. If the situation is not resolved, you can then...
- Bring the matter to the attention of a program director either verbally or in writing. If there continues to be no resolution, you can then...
- Submit a written grievance (complaint) to the executive director. If the situation is still not resolved, you can then...
- Submit a written grievance to the Jasper Mountain Board of Directors: 37875 Jasper-Lowell Road, Jasper, OR 97438.

You may also file a complaint with the Secretary of the Department of Health and Human Services. Note: If you are a Trillium recipient, you have a right to the Trillium grievance procedure. *You will not be penalized for filing a complaint.*

Jasper Mountain
PRIVACY PRACTICES ACKNOWLEDGMENT & CONSENT

! This statement acknowledges that you have received our "Notice of Privacy Practices" and that you are willing to have us communicate information about your child's case as described in that Notice.

I understand that in providing treatment for my child (or the child I am authorized to represent) named below, Jasper Mountain will use and disclose my child's health information.

Child: _____ **Date of Birth:** _____

I understand that the above named child's health information may include information both created and received by the agency, may be in the form of written or electronic records or spoken words, and may include information about family & health history, health status, test results, diagnoses, treatments, prescriptions and similar types of health-related information. I understand that Jasper Mountain may use and disclose health information for treatment, payment or health care operations, including the following kinds of uses:

- make decisions about and plan for my child's care and treatment;
- refer to, consult with, coordinate among and manage along with other health care providers for my child's care and treatment;
- determine eligibility for health plan claims and other related information to insurance companies or others who may be responsible to pay for some or all of my child's health care
- and perform various office, administrative and business functions that support Jasper Mountain's efforts to provide my child with, arrange for, and be reimbursed for, quality health care.

I also understand that I have the right to receive and review a written description of how Jasper Mountain will handle health information about the above named child. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the personnel of Jasper Mountain, and rights regarding my child's health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of Jasper Mountain's Notice of Privacy Practices in effect will be posted in the waiting/reception areas of the agency. It is also available on the agency's website: www.jaspermountain.org.

I understand that I have the right to ask that some or all of my child's health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Jasper Mountain is not required by law to agree to such requests. By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Name of Parent/Guardian (Please Print)

Relationship to Child (*Granting Authority to Sign*)

Parent/Guardian Signature

Date



RELEASE FOR USE OF NON-SECURE MODES OF COMMUNICATION

This release pertains to communication using non-secure modes, regarding the below named client of Jasper Mountain:

Child: _____ **Date of Birth:** _____

It is currently recognized that internet-based communication such as Skype and telephone communications are non-secure modes of communication, in that there is the remote possibility for conversations that take place over such mediums to be overheard by an outside party. Given that this is possible, family members who are going to have conversations with their child's therapist or other agency staff regarding the treatment of their child in one of our programs need to be aware of this fact.

We ask that family members acknowledge their awareness of this issue and grant permission, if they so choose, to use Skype (web-cam) communication, or telephone line communications with this agency to discuss issues related to the child's treatment in any of our Jasper Mountain programs.

Acknowledgement

By signing below, I acknowledge awareness of the above-stated issue, and agree to the use of telephone or internet-based communications for the purpose of my child's treatment in any of the programs within the Jasper Mountain agency.

Name of Parent/Guardian (Please Print): _____

Relationship to Child: _____

Signed: _____ **Date:** _____