# CHART ORDER – FOUR-PART
# COMMUNITY PARTNERS

## Section 1 – Administration, Consents & Notices

Client Face Sheet MHMIS or IS – MH 224A - (RDE)
Contact Information - MH 525 - (OP)
Transfer of Single Fixed Point of Responsibility – MH 530 - (RDE)
Close Outpatient Episode – MH 224B - (RDE)
Open Outpatient Episode – MH 224B - (RDE)
Payor Financial Information (PFI) – MH 281 - (R)
Consent for Services – MH 500 - (OW)
Consent to Photograph/Audio Record – MH 528 - (OW)
Consent for Telemental Health Services – MH 652 - (OW)
Advance Health Care Directive – MH 635 - (OW)
Acknowledge of Receipt (Privacy Notice) – MH 601 - (OW)
Client's Request for Restriction of Use & Disclosure of Health Information – MH 614 - (OW)
Letter of Denial Regarding Client's Request for Confidential Communications – MH 616 - (OW)
Client's Request for Confidential Communications – MH 615 – (OW)
CHART ORDER

## Section 2 – Correspondence

Accounting Tracking Sheet – MH 612 (always top document)(OW)
DMH Response to Primary Care Provider – MH 649B - (OP)
Primary Care Provider Referral to DMH – MH 649A - (OP)
Subpoenas/Court Orders
Auth for Request or Use/Disclosure of PHI - MH 602 - (OW)
Final Letter to Client for Review of Denial - MH606 - (OW)
Client Request for Review of Denial to PHI - MH 605 – (OW)
Letter Response to Client Request for PHI - MH 604 – (OW)
Client Request for Access to PHI - MH 603 – (OW)
Letter Responding to Request to Amend/Correct Health Information – MH 608 - (OW)
Request to Amend/Correct PHI – MH 607 - (OW)
Letter Responding to Client's Request for Accounting of Disclosures – MH 613 - (OW)
Request for Accounting of Disclosures – MH 611 - (OW)
DMH FAX Cover for Transmitting PHI – MH 617 - (OW)
Representation of Researcher to Review PHI Held by LAC DMH to Prepare for Research – MH 619 - (OW)
Representation of Researcher to Review PHI of Decedents Held by LAC DMH to Prepare for Research – MH 620 - (OW)

## Section 3 – Assessments, COD, & Plans

Diagnosis Information – MH 501 - (RDE)
Special Program Client Care Coordination Plan (CCCP) – MH 651 - (R)
Adult Short Assessment – MH 678 - (R)
Adult Assessment Addendum – MH 532A - (OP)
5150 & related documentation (Application for 72-hour Detention For Evaluation/Treatment) – MH 302 - (R)

## Section 4 – Progress Notes

For all services except Med Support
(contents sequential, most recent on top)
Discharge Summary - MH 517 - (OP)
Progress Notes - MH 515 (the audit trail for all services) - (OP)
Case Presentation - MH 514 - (OP)

R - Required Form = Forms in PDF format or hardcopy format which must be used by all Contract Providers without alteration in content, format, or structure.

RDE - Required Data Elements = Forms in PDF format or hardcopy format in which all data elements on these forms are required in the DMH valid format; i.e., the only valid date format is mm/dd/yyyy, however, the layout and presentation of the form is up to Contractors.

OP - Optional Form = Forms in PDF format or hardcopy format in which neither data elements, format, or structure of the form we required to be used by Contract Providers. While the forms and their specific data elements are not specifically required, the concept encompassed by the form's title is. This means that Contractors must have a method of documenting the concept captured by the title of the form.

OW -Ownership Form = Forms which are required by state or federal law/code or County/Department policy/procedures but because of their potential legal implications cannot be "DMH Required" forms. These forms require the contractor to be familiar with the relevant authority and to design a form based on their agency's understanding/interpretation of the authority and its plan to implement compliance with the law/code.

6/7/11

# SECTION 1

MH 224A
Revised 10/29/09

# CLIENT FACE SHEET

**Note:** Shaded/Bolded fields must be completed on individuals prior to Triage.
The remainder of the fields must be completed prior to opening an Episode.

***See Client Face Sheet Codes Table for a listing of codes/definitions for the field.**
**** Field is NOT entered into the IS; information gathering only.**

| CLIENT DATA | | | | |
|---|---|---|---|---|
| CLIENT I.D.# | | | | |
| **Last Name:** | | | | |
| **First Name:** | **Middle Name:** | | | |
| **AKA/Maiden Last Name:** | | | | |
| **AKA First Name:** | **Middle Name:** | | | |
| **SSN:** | **Mother's Maiden Name:** | | | |
| **Gender: Male ☐ Female ☐ Other ☐ Unknown ☐** | **DOB:** | **Age:** | | |
| **English Speaking: Yes ☐ No ☐** | *Primary Lang: | *Preferred Lang: | *Ethnicity: | |
| *If Hispanic, Indicate Origin: | *If American Indian/Alaska Native, Indicate Tribe: | | | |
| *Education Level : | *Level of Care: | *Conservatorship: | | |
| *Handicap: | *Marital Status: | *APR: | Veteran: Yes ☐ No ☐ | |
| *Living Arrangement: | *Employment Status: | Date of Death: | | |
| ****Are there children in the home? Yes ☐ No ☐** | ****Dependent(s) in the home? Yes ☐ No ☐** | | | |
| ****Insurance: Medi-Cal ☐ Medicare ☐ Indigent ☐ Private/Other ☐ Unknown ☐** | | | | |

| CLIENT ADDRESS | | | |
|---|---|---|---|
| **Transient/Homeless: Yes ☐ No ☐** | ***Time Homeless:** | | |
| **Address:** | | | |
| Second Line: | | | |
| City: | *State: | Zip: | *County: |
| **Phone (Home):** | ****(Cell)** | **(Work)** | |
| Address Memo: | | | |

| EMERGENCY CONTACTS | DO NOT CONTACT EMERGENCY CONTACTS EXCEPT IN EMERGENCY SITUATIONS WHICH HAVE BEEN CLEARLY DOCUMENTED | | |
|---|---|---|---|
| Name: | | *Contact Type: | |
| Address: | City: | *State: | Zip: |
| Relationship: | Phone: | Email: | |
| Name: | | *Contact Type: | |
| Address: | City: | *State: | Zip: |
| Relationship: | Phone: | Email: | |

| Complete only if the Client's Child is enrolled in FSP | | | |
|---|---|---|---|
| Child's Name: | | Contact Type: **Child Enrolled in FSP** | |
| Address: | City: | State: | Zip: |
| DMH I.D.# | Phone: | Email: | |

| SFPR and PRIMARY CONTACT | |
|---|---|
| SFPR Name: | Provider Number: |
| Primary Contact Name: | Provider Number: |

| BIRTH INFORMATION | | |
|---|---|---|
| Indicate Client Birth Name (If different than the name listed in Client Data) | | |
| Last Name: | First Name: | Middle Name: |
| Birth County: | Birth State: | Birth Country (If born outside US): |
| Mother's First Name: | | |



**Agency:** **Provider #:**

**Los Angeles County – Department of Mental Health**

CLIENT FACE SHEET

MH 525
Revised 11/07

# CONTACT INFORMATION

| Significant Contacts | | | |
|---|---|---|---|
| Name | Relationship to Client | Telephone Number | Agency/Address |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Legal Numbers | | | |
|---|---|---|---|
| Case and/or Booking Numbers | Facility | Booking Date | Comments |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name: MIS#:

Agency: Provider #:

Los Angeles County – Department of Mental Health

CONTACT INFORMATION

MH 530
Revised 02/25/09

# TRANSFER OF SINGLE FIXED POINT OF RESPONSIBILITY (SFPR)

☐ **Intra-agency Transfer of SFPR**

**Existing SFPR Information:**
Individual/Team/Position: _____ Rendering Provider #: _____ (If Individual)

**New SFPR Information:**
Individual/Team/Position: _____ Rendering Provider #: _____ (If Individual)

☐ Update Primary Therapist to the above New SFPR

☐ **Inter-agency Transfer of SFPR**
Form completed by: ☐ Existing SFPR ☐ New SFPR ☐ Other _____

**Existing SFPR Information**
Person authorizing transfer: _____ Title/Discipline: _____ Phone #: _____
Provider Name: _____ Provider #: _____

**New SFPR Information**
Individual/Team/Position: _____ Phone #: _____
Provider Name: _____ Rendering Provider #: _____ (If Individual) Provider#: _____

**Transfer of Information**
The following forms: ☐ Will be sent ☐ Have been sent ☐ Have been received ☐ Should be sent
☐ Assessment ☐ Client Care/Coordination Plan ☐ Discharge Summary
☐ Payor Financial Info. ☐ Other: _____ Date Sent/Received: _____
Person sent to/receiving forms: _____
Fax #: _____ Phone #: _____

**Our agency has been in contact with the client and transferring SFPR and accepts SFPR responsibilities as stated in DMH Policy 202.31 "Single Fixed Point of Responsibility" and the LACDMH Organizational Provider's Manual.**

Signature of New SFPR: _____ Date: _____

**Data Entry:** (to be completed by clerical staff)
Existing SFPR deleted in the IS by: _____ Deleted on: _____
New SFPR entered in the IS by: _____ Entered on: _____



**Name:** **IS#:**
**Agency:** **Provider #:**
**Los Angeles County – Department of Mental Health**

TRANSFER OF SINGLE FIXED POINT OF RESPONSIBILITY (SFPR)

# COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328

# Close Outpatient Episode

**Outpatient** CLIENT I.D.#

Last Name:

First Name: Middle:

Discharge Date:

Referral Out Code:

Referral Out Provider:

Legal Status:

## DIAGNOSIS

| AXIS I | AXIS II | AXIS III |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Primary:

Secondary:

**AXIS IV**

- ☐ 1. Primary Support Group
- ☐ 2. Social Environment
- ☐ 3. Educational
- ☐ 4. Occupational
- ☐ 5. Housing
- ☐ 6. Economic
- ☐ 7. Access to Health Care
- ☐ 8. Interaction with Legal System
- ☐ 9. Other Psychological/Environmental
- ☐ 10. Inadequate Information

**AXIS V**

GAF/CGAS

Provider Name: _____ Provider Number: _____

# COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328

# Open Outpatient Episode

## Outpatient

CLIENT I.D.#

Last Name:

First Name: Middle:

Admit Date:

Other Factors: Physical? Yes ☐ No ☐ DD? Yes ☐ No ☐ Dual Diagnosis

Intent of Service: ☐ Assessment ☐ Improvement ☐ Maintenance

Primary Problem Area:

Referral In Code: Legal Status:

Referral In Reporting Unit:

Treatment Authorization for Minor:

Patient File #:

Primary Contact:

Service Plan Due Date:

Coord Due Date

## DIAGNOSIS

| AXIS I | AXIS II | AXIS III | AXIS IV | AXIS V |
|---|---|---|---|---|
| | | | ☐ 1. Primary Support Group | GAF/CGAS |
| | | | ☐ 2. Social Environment | |
| | | | ☐ 3. Educational | |
| | | | ☐ 4. Occupational | |
| | | | ☐ 5. Housing | |
| | | | ☐ 6. Economic | |
| | | | ☐ 7. Access to Health Care | |
| | | | ☐ 8. Interaction with Legal System | |
| Primary: | | | ☐ 9. Other Psychological/Environmental | |
| Secondary: | | | ☐ 10. Inadequate Information | |

Provider Name: _____ Provider Number: _____

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

# PAYER FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

## CLIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| 1 | CLIENT NAME | | SS # | DMH CLIENT ID # |
| 2 | MAIDEN NAME | DOB | MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP | SPOUSE NAME |

## THIRD PARTY INFORMATION

3 NO THIRD PARTY PAYER ☐

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 4 | MEDI-CAL ☐ YES ☐ NO | MEDI-CAL COUNTY CODE /AID CODE/ CIN # | | MEDI-CAL PENDING ☐ YES ☐ NO<br>REFERRED FOR ELIGIBILITY ASSESSMENT ☐ YES ☐ NO | | | DATE REFERRED | |
| 5 | SHARE OF COST ☐ YES ☐ NO | SOC AMT $ | SSI PENDING ☐ YES ☐ NO | SSI APPLICATION DATE | IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON | | | |
| 6 | CALWORKS ☐ YES ☐ NO | GROW ☐ YES ☐ NO | HEALTHY FAMILIES ☐ YES ☐ NO | HEALTHY FAMILIES CIN # | AB3632 ☐ YES ☐ NO | AB3632 CONSENT FORM SIGNED ☐ YES ☐ NO | | |
| 7 | MEDICARE ☐ YES ☐ NO | MEDICARE # | LIFETIME AUTHORIZATION SIGNED ☐ YES ☐ NO | MEDI-GAP ☐ YES ☐ NO | VET/ADM ☐ YES ☐ NO | CHAMPUS ☐ YES ☐ NO | HEALTHY WAY LA ☐ YES ☐ NO | HWLA MEMBER # |
| 8 | HMO/PPO ☐ YES ☐ NO | NAME OF CARRIER | | GROUP/POLICY/ID # | | NAME OF INSURED | | |
| 9 | CARRIER ADDRESS | | | | | ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO | | |

## PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

| | | | | | |
|---|---|---|---|---|---|
| 10 | NAME OF PAYER | RELATION TO CLIENT | DOB | MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP | PAYER CDL/CAL ID |
| 11 | ADDRESS | CITY | STATE | ZIP CODE | TEL # |
| 12 | SOURCE OF INCOME: ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐ OTHER: _____ | | | | PAYER SS # |
| 13 | EMPLOYER | POSITION | | | IF NOT EMPLOYED, DATE LAST WORKED |
| 14 | EMPLOYER'S ADDRESS (Include City, State & Zip Code) | | | | TEL # |
| 15 | SPOUSE | ADDRESS (Include City, State & Zip Code) | | | SPOUSE'S SS # |
| 16 | SPOUSE'S EMPLOYER | POSITION | | | IF NOT EMPLOYED, DATE LAST WORKED |
| 17 | SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code) | | | | TEL # |
| 18 | NEAREST RELATIVE/RELATIONSHIP | ADDRESS (Include City, State & Zip Code) | | | TEL # |

## UMDAP LIABILITY DETERMINATION

**19 LIQUID ASSETS**

| | |
|---|---|
| Savings | $_____ |
| Checking Accounts | $_____ |
| IRA, CD, Market value of stocks, bonds and mutual funds | $_____ |
| TOTAL LIQUID ASSETS | $_____ |
| Less Asset Allowance | $_____ |
| Net Asset Valuation | $_____ |
| Monthly Asset Valuation (Divide Net Asset by 12) | $_____ |

VERIFICATION OBTAINED ☐ YES ☐ NO

**20 ALLOWABLE EXPENSES**

| | |
|---|---|
| Court ordered obligations paid monthly | $_____ |
| Monthly child care payments (necessary for employment) | $_____ |
| Monthly dependent support payments | $_____ |
| Monthly medical expense payments | $_____ |
| Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) | $_____ |
| Total Allowable Expenses | $_____ |

VERIFICATION OBTAINED ☐ YES ☐ NO

**21 ADJUSTED MONTHLY INCOME**

| | |
|---|---|
| Gross Monthly Family Income | |
| Self/Payer | $_____ |
| Spouse | $_____ |
| Other | $_____ |
| TOTAL HOUSEHOLD INCOME | $_____ |
| TOTAL FROM BOX 19 | $_____ + |
| SUBTOTAL | $_____ |
| LESS TOTAL FROM BOX 20 | $_____ - |
| Adjusted Monthly Income | $_____ |

VERIFICATION OBTAINED ☐ YES ☐ NO

| | | | |
|---|---|---|---|
| 22 | Number Dependent on Adjusted Monthly Income (Client Included) | ANNUAL LIABILITY | ANNUAL CHARGE PERIOD FROM TO |
| | | | Payment Plan $_____ per month for 1 2 3 4 5 6 months. |
| 23 | PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person) | | |

## OTHER

| | | | | |
|---|---|---|---|---|
| 24 | PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD ☐ YES ☐ NO WHERE: | FROM | TO | PRESENT ANNUAL LIABILITY BALANCE |
| 25 | ANNUAL LIABILITY ADJUSTED BY | DATE | REASON ADJUSTED | |
| | ANNUAL LIABILITY ADJUSTMENT APPROVED BY | DATE | | |
| 26 | An explanation of the UMDAP liability was provided.<br>SIGNATURE OF INTERVIEWER | | PROVIDER NAME AND NUMBER | |
| 27 | I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22<br>SIGNATURE OF CLIENT OR RESPONSIBLE PERSON | | DATE | |

MH 500
Revised 02/11/11

# CONSENT FOR SERVICES *INFORMATION ONLY*

The undersigned client* or responsible adult** consents to and authorizes mental health services by:

_____

Name of Facility and/or Program

These services may include psychological testing, psychotherapy/counseling, rehabilitation services, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at a different location, services provide within the Los Angeles County mental health system will be coordinated by the staff of a single agency.

The undersigned understands:

1. He/she has a right to be informed of and participate in the selection of any of the above services provided.
2. He/she has a right to receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
3. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or staff) or withdraw this consent at any time.
4. All personnel of the agency, as a condition of their employment, annually sign an oath of confidentiality which prohibits them from sharing client information except as allowed under Federal, State, and Department confidentiality laws, policies, and procedures.
5. Any information disclosed to staff which is determined by them to be important to care, will be recorded in the clinical record to ensure treatment staff have available to them the most complete information about the client when deciding on treatment appropriate to the client's needs and for quality of care.
6. All client names are entered into a computer-based Information System that identifies the program(s) that is/are providing services to the client. This information is available without client authorization to any workforce member of the Department's directly-operated or contract service agency system.
7. Information from a client's clinical record relative to service delivery needs may be shared within this agency and within the Los Angeles County mental health system (directly-operated and contract agencies) without obtaining the authorization of the client.

_____ _____
Signature of Client* Date

_____ _____ _____
Signature of Responsible Adult** Relationship to Client Date

_____ _____
Signature of Witness/Interpreter *** Date

This Consent was interpreted in _____ for the client and/or responsible adult.
If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Consent on _____ (Date) by _____ (Initials).

**This section must be completed by Staff if signed by Minor or if there is no signature by client and/or responsible adult.**

☐ Client is willing to accept services, but unwilling to sign this Consent.

☐ I have completed or have caused to be completed the Consent of Minor form for any client between the ages of 12-18 signing above without parental/guardian consent.

_____ _____
Signature of Staff Date

* A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
** Responsible Adult = Guardian, Conservator, or Parent of minor when required.
*** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).



**Name:** _____ **IS#:** _____
**Agency:** _____ **Provider #:** _____
**Los Angeles County – Department of Mental Health**

MH 528
Revised 2/11/11

**INFORMATION ONLY**

# CONSENT TO PHOTOGRAPH / AUDIO RECORD

The undersigned client* or responsible adult** consents to:

_____ to

Name of Facility and/or Program or Unit and/or Employee Name

☐ Photograph (which, as used in this Consent, means motion picture, still photography in any form, videotapes, or any other mechanical means of recording and reproducing images)

☐ Audio record

The undersigned:

1. Agrees that photographs/audio recordings made as a result of this consent will be used for purposes of:
   - ☐ Learning and training purposes
   - ☐ Client Identification
   - ☐ Research (Approval of Department Human Subjects Committee required)
   - ☐ Publication, public relations, webpages and/or fund-raising (MH 602 Authorization required)
   - ☐ Sharing Recovery Stories (MH 677 Authorization required which must be obtained from the Clinical Records Director for the specific purpose and modality in which the stories will be shared)
2. Waives any right to compensation for use of the photographs/audio recordings;
3. Holds the Department harmless from and against any claim of injury or compensation resulting from the activities authorized by this Consent.

_____ _____
Signature of Client* Date

_____ _____ _____
Signature of Responsible Adult** Relationship to Client Date

_____ _____
Signature of Witness/Interpreter *** Date

This Consent was interpreted in _____ for the client and/or responsible adult.
If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Consent on _____ (Date) by _____ (Initials).

**This section must be completed by Staff if signed by Minor or if there is no signature by client and/or responsible adult.**

☐ Client is willing to consent to photograph/audio record, but unwilling to sign this Consent.

☐ I have completed or have caused to be completed the Consent of Minor form for any client between the ages of 12-18 signing above without parental/guardian consent.

_____ _____
Signature of Staff Date

* A minor client receiving services under his/her own signature must have the signed Minor Consent and a Consent for Service form on file in the clinical record.

** Responsible Adult = Guardian, Conservator, or Parent of minor when required.

*** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).



Name: _____ IS#: _____

Agency: _____ Provider #: _____

Los Angeles County – Department of Mental Health

CONSENT TO PHOTOGRAPH / AUDIO RECORD

MH 652
02/11/11

**INFORMATION ONLY**

# CONSENT FOR TELEMENTAL HEALTH SERVICES



I understand that:

1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The potential benefit of Telemental health services is that I will be able to talk with mental health staff today from this local setting for an evaluation of my needs. When appropriate, I will be able to participate in mental health services, start on medication today, or continue my current medications uninterrupted.
3. The potential risk of Telemental health services is that there could be a partial or complete failure of the equipment being used which could result in mental health staff's inability to complete the evaluation, mental health services, and/or prescription process.
4. There is no permanent video or voice recording kept of the Telemental health service's session.
5. All existing confidentiality protections apply.
6. All existing laws regarding client access to mental health information and copies of mental health records apply.
7. Dissemination of client identifiable images or information from the Telemental health interaction to researchers or other entities shall not occur without the consent of the client.

I, _____, consent to Telemental health services in circumstances in which mental health staff appropriate to my needs is not immediately available at my site. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above.

_____ _____
Signature of Client* Date

_____ _____ _____
Signature of Responsible Adult** Relationship to Client Date

_____ _____
Signature of Witness/Interpreter *** Date

This Consent was interpreted in _____ for the client and/or responsible adult.
If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Consent on _____ (Date) by _____ (Initials).

**This section must be completed by Staff if signed by Minor or if there is no signature by client and/or responsible adult.**

☐ Client is willing to accept Telemental health services, but unwilling to sign this Consent.

☐ I have completed or have caused to be completed the Consent of Minor form for any client between the ages of 12-18 signing above without parental/guardian consent and I affirm the client meets all eligibility criteria as noted on the Consent of Minor form to receive medication without legal representative consent.

_____ _____
Signature of Staff Date

* A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
** Responsible Adult = Guardian, Conservator, or Parent of minor when required.
*** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).



Name: _____ IS#: _____

Agency: _____ Provider #: _____

Los Angeles County – Department of Mental Health

# CONSENT FOR TELEMENTAL HEALTH SERVICES



## Telemental Health Services Information

**INFORMATION ONLY**

### What are Telemental health services and when are they used?

Telemental health services are used when mental health staff cannot be physically present with you to evaluate your mental health needs and, if appropriate, prescribe medications. Mental health staff may be present at another location and available to serve you through newly available technology. Instead of talking to someone on the phone at another location, Telemental health services use a video camera and computer to send both voice and personal images (pictures) between you and mental health staff so not only can you talk to each other, but you can also see each other. This allows mental health staff to make a better evaluation of your needs.

### How do Telemental health services work?

You will be in a private room either by yourself, with a friend, family member, or staff person. The room will have a computer with a video camera. The mental health staff will also be in a private room but at another location with the same type of equipment. When the session is ready to begin, clinic staff will start the computer and camera so that you and mental health staff can see each other and talk together. When the session is over, clinic staff will shut off the equipment.

### How is it different than a regular session with mental health staff?

Other than you and mental health staff not being in a room together, there is very little difference in the session. Mental health staff will ask and document clinical information that you share with him/her, send any prescriptions that are ordered to the pharmacy for you to pick up if medications are prescribed, document the service that is provided, and ensure that documentation is included in your clinical record for future reference.

### What happens if I choose not to consent to Telemental health services?

If you choose not to consent to Telemental health services, we will be unable to provide you with convenient and readily available services and your services will be rescheduled for a later date and/or a different site.



Name: _____ IS#: _____

Agency: _____ Provider #: _____

Los Angeles County – Department of Mental Health

MH 635
Revised 02/15/11

# ADVANCE HEALTH CARE DIRECTIVE ACKNOWLEDGEMENT FORM



**INFORMATION ONLY**

**Background**

In accordance with California Probate Code 4600 et seq. and Federal requirements under Title 42, clients 18 years of age and older shall receive information about Advance Health Care Directives and be informed of their right to make decisions about their medical treatment.

## To Be Completed by Staff

The client was given a copy of the Advance Health Care Directive Fact Sheet at the first face-to-face contact or clinic visit. ☐ Yes ☐ No

If "No" please explain why the client was not given the Fact Sheet:

Does the client have an Advance Health Care Directive currently in place? ☐ Yes ☐ No

If the client would like to execute an Advance Health Care Directive, please refer them to the resources identified on the Fact Sheet. If a client already has an Advance Health Care Directive, insert a copy into the client's Clinical Record in Section 2 (Consents and Notices).

## To Be Completed by the Client/Responsible Adult*

I have been asked about having an Advance Health Care Directive, and I have been given or offered an Advance Health Care Directive Fact Sheet.

| | | |
|---|---|---|
| _____ Signature of Client | | _____ Date |
| _____ Signature of Responsible Adult* | _____ Relationship to Client | _____ Date |
| _____ Signature of Witness/Interpreter ** | | _____ Date |

This Form was interpreted in _____ for the client and/or responsible adult.

If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Form on _____ (Date) by _____ (Initials).

* Responsible Adult = Guardian, Conservator, or Parent of minor when required.

** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).



Name: _____ IS#: _____

Agency: _____ Provider #: _____

*Los Angeles County – Department of Mental Health*

# ADVANCE HEALTH CARE DIRECTIVE

# ADVANCE HEALTH CARE DIRECTIVE FACT SHEET



**What is an Advance Health Care Directive?**
An Advance Directive is a legal document that allows an individual to state in advance their wishes should they become unable to make healthcare decisions.
In California, an Advance Directive consists of two parts:
(1) appointment of an agent for healthcare; and (2) individual health care instructions.

**What can an Advance Health Care Directive do for a person with a psychiatric disability?**
- It allows you to make treatment choices now in the event you need mental health treatment in the future. You can tell your doctor, institution, provider, treatment facility, and judge what types of treatment you do and do not want.
- You can select a friend or family member to make mental health care decisions, if you cannot make them for yourself.
- It can improve communications between you and your physician.
- It may reduce the need for long hospital stays.
- It becomes a part of your medical record.

**Who can fill out an Advance Health Care Directive?**
Any person 18 years or older who has the "capacity" to make health care decisions. "Capacity" means the person understands the nature and consequences of the proposed healthcare, including the risks and benefits.

**When does an Advance Health Care Directive go into effect?**
An Advance Health Care Directive goes into effect when the person's primary physician decides the person does not have the "capacity" to make their own healthcare decisions. This means the individual is unable to understand the nature and consequences of the proposed healthcare. ***The fact that a person has been admitted into a psychiatric facility does not mean the person lacks "capacity."***

**How long is an Advance Health Care Directive in effect?**
In California, an Advance Health Care Directive is indefinite. You can change your mind at any time, as long as you have the "capacity" to make decisions. It is a good idea to review your Advance Health Care Directive yearly to make sure your wishes are stated.

**Do I have to have an Advance Health Care Directive?**
No. It is just a way of making your wishes known in writing, while you are capable. Your choices are important.

**Where do I get legal advice about an Advance Health Care Directive?**
- Your Attorney
- Protection and Advocacy, Inc.
- Mental Health America of Los Angeles (213) 413-1130, Ext. 26

**Where can I get the Advance Health Care Directive Forms?**
- Your Attorney
- Stationary Stores
- Mental Health America of Los Angeles (213) 413-1130, Ext. 26

**Who should have a copy of the Advance Health Care Directive?**
- You (Your Advance Health Care Directive should be kept in a safe place, but easily accessible.)
- Your agent (the person designated to make health care decisions if you are unable to do so.)
- Each of your health care providers;
- Each of your mental health providers.

It is important that you keep track of who has a copy of your Advance Health Care Directive in case you make changes in the document.

Complaints concerning non-compliance with the advance health care directive requirements may be filed with the California Department of Health Services (DHS) Licensing and Certification by calling 1-800-236-9747 or by mailing to P.O. Box 997413, Sacramento, California 95899-7413.

ADVANCE HEALTH CARE DIRECTIVE
FACT SHEET

**INFORMATION ONLY**



# LACDMH NOTICE OF PRIVACY PRACTICES:
## *Acknowledgement of Receipt*

Effective Date: April 14, 2003

## ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County Department of Mental Health (LACDMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://www.dmh.co.la.ca.us or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LACDMH.

Signature: _____ Date: _____
*(client/parent/conservator/guardian)*

## INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member: _____ Date: _____

**Reasons why the acknowledgement was not obtained:**

- ☐ Client refused to sign (see progress notes for explanation)
- ☐ Other Reason or Comments:

_____

_____

_____

_____

_____

_____

_____

**INFORMATION ONLY**

*Effective Date*: April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## WHO WILL FOLLOW THIS NOTICE

This Notice describes LACDMH practices and that of:

- All employees, staff and other LACDMH personnel.
- Any member of a volunteer group we allow to help you while you are in the facility.

## OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the facility. As required and when appropriate, we will ensure that the minimum necessary information is released in the course of our duties.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations regarding the use and disclosure of medical information.

We are required by law to:

Keep your medical information, also known as "protected health information" or "PHI," private;

Give you this Notice of our legal duties and privacy practices with respect to your PHI; and

Follow the terms of the Notice that is currently in effect.

## HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We create a record of the treatment and services you receive at our facilities. We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some

medications affect your blood pressure. We may share your PHI in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

We also may disclose your PHI to people outside the facility who may be involved in your treatment, such as your case manager, or other persons for coordination and management of your health care. Your mental health information may only be released to health care professionals outside this facility without your authorization if they are responsible for your physical or mental health care.

For Payment

We may use and disclose your PHI in order to get paid for the treatment and services we have provided you. For example, we may need to give your health plan information about a medication, visit, or treatment session you received at the facility so your health plan will pay us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose your PHI to carry out activities that are necessary to run our facilities and to make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many facility clients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other facility personnel for review and learning purposes.

Appointment Reminders

We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

Treatment Alternatives and Health-Related Products and Services

We may use and disclose your PHI to recommend possible treatment options or alternatives that may be of interest to you. Additionally, we may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you (for example, Medi-Cal eligibility or Social Security benefits).

Individuals Involved in Your Care or Payment for Your Care

We may disclose your PHI to a friend or family member who is involved in your medical care or payment related to your health care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, if you are not available or are unable to agree or object, we will use our professional judgment to decide whether this disclosure is in your best interest.

Disaster Relief Purposes

We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We will give you the opportunity to agree to this disclosure or object to this disclosure, unless we decide that we need to disclose your PHI in order to respond to the emergency circumstances.

## USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU THAT DO NOT REQUIRE YOUR AUTHORIZATION

Research

We may disclose your PHI to medical researchers who request it for approved medical research projects; however, such disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers who will be required to safeguard the PHI they receive.

As Required By Law

We will disclose your PHI when required to do so by federal, state or local law.

Workers' Compensation

We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities, such as those aimed at preventing or controlling disease, preventing injury or disability, and reporting the abuse or neglect of children, elders and dependent adults.

Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government 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 PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the PHI requested.

Law Enforcement

We may disclose PHI to government law enforcement agencies in the following circumstances:

- In response to a court order, warrant, subpoena, summons or similar process issued by a court.
- If a psychotherapist believes that it is likely that you present a serious danger of violence to another person.
- To report your discharge, if you were involuntarily detained after a peace officer initiated a 72-hour hold for evaluation and requested notification.

In certain circumstances, if you have been admitted to a facility and have disappeared or been transferred.

Coroners, Medical Examiners and Funeral Directors

We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about clients of the facility to funeral directors as necessary to carry out their duties.

Specialized Government Functions

We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates

If you are an inmate or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Uses of Your Medical Information

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by the authorization, except that, we are unable to take back any disclosures we have already made when the authorization was in effect, and we are required to retain our records of the care that we provided to you.

## RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI in our records:

Right to Inspect and Copy

With certain exceptions, you have the right to inspect and copy your PHI from our records. Usually, this includes treatment and billing records.

To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to your case manager or the person in charge of your treatment. A form will be provided to you for this request. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied the right to inspect and copy your PHI in our records, you may request that the denial be reviewed. With the exception of a few circumstances that are not subject to review, another licensed health care professional within LACDMH, who was not involved in the denial, will review the decision. We will comply with the outcome of the review.

Right to Request Amendment

If you feel that your PHI in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the PHI.

To request an amendment, ask for a "Request to Amend Protected Health Information" form, and complete and submit this form to your case manager or the person in charge of your treatment. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it 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 PHI that:

Was not created by us, unless you can provide us with a reasonable basis to believe that the person or entity that created the PHI is no longer available to make the amendment;

Is not part of the PHI kept by or for the facility;

Is not part of the PHI which you would be permitted to inspect and copy; or

Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a **Statement of Disagreement** form, with a description not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want this form to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

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 PHI other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, ask for a "Request for an Accounting of Disclosures" form, and complete and submit this form to your case manager or the person in charge of your treatment. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, 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 Request Restrictions

You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request that we follow additional, special restrictions when using or disclosing your PHI to someone who is involved in your care or the payment for your health care, like a family member or friend. For example, you could ask that we not use or disclose that you are receiving services at this facility.

***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 provide you emergency treatment.

To request restrictions, ask for a "Request for Additional Restrictions on Use or Disclosure of Protected Health Information," and complete and submit this form to your case manager or the person in charge of your treatment. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, ask for a "Request to Receive Confidential Communications by Alternative Means or at Alternative Locations" form, and complete and submit this form to your case manager or to the person in charge of your treatment. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

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 this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our website: http://www.dmh.co.la.ca.us/

To obtain a paper copy of this Notice, please contact your Treatment Team.

## CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://www.dmh.co.la.ca.us/ or you may request one from your Treatment Team.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the Federal Government. All complaints must be submitted in writing. **You will not be penalized or retaliated against for filing a complaint.** To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact:

**Los Angeles County Department of Mental Health (LACDMH)**
**Patient's Rights Division**
**550 South Vermont Avenue**
**Los Angeles, CA 90020**
**(213) 738-4949**

To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office (LACCIO)**
**Chief Information Privacy Officer**
**500 West Temple Street, Suite 493**
**Los Angeles, CA 90012**
**(213) 974-2164**
**Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Region IX, Office for Civil Rights,**
**U.S. Department of Health and Human Services**
**50 United Nations Plaza-Room 322**
**San Francisco, CA 94102.**
**Voice Phone (415) 437-8310**
**FAX (415) 437-8329**
**TDD (415) 437-8311**

**INFORMATION ONLY**



# NOTIFICACIÓN DE NORMAS DE CONFIDENCIALIDAD O PRIVACIDAD DEL DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE LOS ANGELES (LACDMH):

*Comprobante de recibo*

Vigencia: 14 de abril de 2003

## COMPROBANTE DE RECIBO

Con la firma de este formulario, usted confirma haber recibido la *Notificación de Normas de Confidencialidad o Privacidad* del Departamento de Salud Mental del Condado de Los Angeles (LACDMH, por sus siglas en inglés). En nuestra *Notificación de Normas de Confidencialidad* se proporciona información sobre la manera en que podremos usar y revelar su información médica protegida. Le invitamos a que la revise cuidadosamente.

Nuestra *Notificación de Normas de Confidencialidad* está sujeta a cambios. Si hacemos cambios a nuestra Notificación, usted podrá obtener una copia de la Notificación revisada si visita nuestro sitio en la red http://www.dmh.co.la.ca.us/ o si la solicita a nuestro Equipo de Tratamiento.

Confirmo haber recibido la *Notificación de Normas de Confidencialidad* del LACDMH.

Firma: _____ Fecha: _____

*(Cliente/padre o madre/"conservator" o curador/tutor)*

## INCAPACIDAD PARA CONSEGUIR EL COMPROBANTE DE RECIBO

Llenar únicamente si no se obtiene la firma. Si no es posible conseguir el comprobante de recibo de la persona, describa los intentos de buena fe que se hayan hecho para obtener el comprobante de recibo del individuo y los motivos por los cuales no se pudo conseguir:

Firma del Miembro del Equipo de Tratamiento: _____ Fecha: _____

**Motivos por los cuales no se pudo obtener el comprobante de recibo:**

- ☐ El Cliente se negó a firmar (ver la explicación en las notas de progreso)
- ☐ Otro motivo o comentarios:

_____

_____

_____

_____

_____

_____

**INFORMATION ONLY**



# NOTIFICACIÓN DE NORMAS DE CONFIDENCIALIDAD O PRIVACIDAD DEL DEPARTAMENTO DE SALUD MENTAL DEL CONDADO DE LOS ANGELES (LACDMH):

*Comprobante de recibo*

Vigencia: 14 de abril de 2003

## COMPROBANTE DE RECIBO

Con la firma de este formulario, usted confirma haber recibido la *Notificación de Normas de Confidencialidad o Privacidad* del Departamento de Salud Mental del Condado de Los Angeles (LACDMH, por sus siglas en inglés). En nuestra *Notificación de Normas de Confidencialidad* se proporciona información sobre la manera en que podremos usar y revelar su información médica protegida. Le invitamos a que la revise cuidadosamente.
Nuestra *Notificación de Normas de Confidencialidad* está sujeta a cambios. Si hacemos cambios a nuestra Notificación, usted podrá obtener una copia de la Notificación revisada si visita nuestro sitio en la red http://www.dmh.co.la.ca.us/ o si la solicita a nuestro Equipo de Tratamiento.

Confirmo haber recibido la *Notificación de Normas de Confidencialidad* del LACDMH.

Firma: _____ Fecha: _____
*(Cliente/padre o madre/"conservator" o curador/tutor)*

## INCAPACIDAD PARA CONSEGUIR EL COMPROBANTE DE RECIBO

Llenar únicamente si no se obtiene la firma. Si no es posible conseguir el comprobante de recibo de la persona, describa los intentos de buena fe que se hayan hecho para obtener el comprobante de recibo del individuo y los motivos por los cuales no se pudo conseguir:

Firma del Miembro del Equipo de Tratamiento: _____ Fecha: _____

**Motivos por los cuales no se pudo obtener el comprobante de recibo:**

- ☐ El Cliente se negó a firmar (ver la explicación en las notas de progreso)
- ☐ Otro motivo o comentarios:

_____
_____
_____
_____
_____
_____

**INFORMATION ONLY**

*Vigencia*: **14 de abril de 2003**

**EN ESTA NOTIFICACIÓN SE DESCRIBE LA MANERA EN LA QUE SE PODRÁ USAR Y REVELAR LA INFORMACIÓN MÉDICA SOBRE USTED, Y LA FORMA EN QUE USTED PUEDE TENER ACCESO A ESTA INFORMACIÓN. REVÍSELA CUIDADOSAMENTE.**

## QUIÉN SEGUIRÁ LAS NORMAS DE ESTA NOTIFICACIÓN

En esta Notificación se describen las normas del LACDMH y las de:

- Todos los empleados y demás miembros del personal del LACDMH.
- Cualquier miembro de un grupo de voluntarios al que permitimos que le ayude mientras usted está en las instalaciones*.

## NUESTRA PROMESA SOBRE SU INFORMACIÓN MÉDICA

Entendemos que la información médica sobre usted y su salud es personal. Tenemos el compromiso de proteger su información médica. Creamos un expediente de la atención y los servicios que recibe en las instalaciones. Necesitamos estos registros para ofrecerle atención de calidad y cumplir con determinados requisitos legales. Esta Notificación se aplica a todos los registros sobre su atención que se generen en las instalaciones. Cuando se requiera y sea apropiado, nos aseguraremos de que en el desempeño de nuestras obligaciones se revele el mínimo necesario de información.

En esta Notificación se le informará sobre las maneras en las que podremos usar y revelar su información médica. También se describen sus derechos y determinadas obligaciones sobre el uso y la revelación de información médica.

De acuerdo con la ley se requiere que:

Mantengamos la confidencialidad de su información médica. Esta información se conoce también como "información médica protegida" ("PHI", por sus siglas en inglés);

Le entreguemos esta Notificación de nuestras obligaciones legales y normas de confidencialidad con respecto a su PHI; y

Respetemos los términos de la Notificación que está actualmente vigente.

## CÓMO PODREMOS USAR Y REVELAR SU INFORMACIÓN MÉDICA PROTEGIDA

En las siguientes categorías se describen diferentes maneras en las que usamos y revelamos información médica protegida. En cada una de las categorías de los usos o la revelación de datos, explicaremos lo que significan y trataremos de darle algunos ejemplos. No se listan todos los usos o revelación de información de la categoría; sin embargo, todas las formas en que se nos permita usar y revelar información caen dentro de una de las categorías.

---

* "Instalaciones" se refiere a la clínica, hospital o agencia encargada de prestar servicios/tratamiento al cliente.

Para tratamiento

Creamos un registro del tratamiento y los servicios que usted recibe en nuestras instalaciones. Podremos usar su PHI para proporcionarle tratamiento o servicios médicos. Podremos revelar su PHI a los médicos, enfermeras, técnicos, estudiantes de medicina u otro personal que le atiendan en las instalaciones. Por ejemplo, es posible que un médico que le esté atendiendo por un desequilibrio químico necesite saber si usted tiene problemas del corazón porque algunos medicamentos afectan la tensión arterial. Es posible que compartamos su PHI para poder coordinar las diferentes cosas que necesite, como recetas, exámenes de tensión arterial, análisis de laboratorio, y para poder determinar un diagnóstico correcto.

También podremos revelar su PHI a personas fuera de las instalaciones que puedan estar implicadas en su tratamiento, como el administrador de su caso u otras personas, con el fin de coordinar y administrar su atención médica. Información de su salud mental sólo se podrá revelar, sin su autorización, a profesionales de atención médica fuera de estas instalaciones si ellos son los responsables de su atención médica física o mental.

Para pagos

Podremos usar y revelar su PHI con el fin de obtener pago por el tratamiento y los servicios que le prestemos. Por ejemplo, es posible que necesitemos dar a su plan de salud información sobre un medicamento, visita o sesión de tratamiento que usted haya recibido en las instalaciones con el fin de que nos pague su plan de salud. También podremos informar a su plan de salud sobre un tratamiento que usted vaya a recibir a fin de obtener aprobación previa o de determinar si su plan cubrirá el costo del tratamiento.

Para operaciones de atención médica

Podremos usar y revelar su PHI con el fin de poder realizar las actividades necesarias para administrar nuestras instalaciones y asegurarnos de que todos nuestros clientes reciben atención de calidad. Por ejemplo, podremos usar información médica para revisar nuestro tratamiento y servicios, además de evaluar el desempeño de nuestro personal cuando le atienden. Es posible que también combinemos información médica de muchos clientes de las instalaciones con el fin de decidir qué servicios adicionales deben ofrecer las instalaciones, qué servicios no se necesitan y la eficacia de algunos tratamientos nuevos. También podremos revelar información a médicos, enfermeras, técnicos, estudiantes de medicina y otro personal de la instalación para revisiones y con fines educativos.

Recordatorios de citas

Podremos usar y revelar su PHI con el fin de ponernos en contacto con usted y recordarle que tiene una cita para recibir tratamiento o atención médica en las instalaciones.

Alternativas de tratamiento, y productos y servicios relacionados con la salud

Podremos usar y revelar su PHI con el fin de recomendar opciones o alternativas posibles de tratamiento que quizá le interesen. Asimismo, podremos usar y revelar su PHI con el fin de informarle de beneficios o servicios relacionados con la salud que quizá le interesen (por ejemplo, elegibilidad para Medi-Cal o beneficios del Seguro Social).

Personas implicadas en prestarle atención o en pagar por la atención que usted reciba

Podremos revelar su PHI a un amigo o familiar que esté implicado en su atención médica o en el pago relacionado con su atención médica, siempre que usted esté de acuerdo en que se revele la información o que le demos la oportunidad de oponerse a que se revele la información. Sin embargo, si usted no está disponible o no puede indicar si está de acuerdo o no, usaremos nuestro criterio profesional para decidir si esta revelación de la información es conveniente para usted.

Para ayuda en caso de desastre

Podremos revelar su PHI a un organismo que ayude en caso de desastre a fin de que se pueda notificar a su familia sobre su condición, situación y ubicación. Le daremos la oportunidad de que dé o niegue su autorización para revelar la información, excepto si decidimos que necesitamos revelar su PHI para poder responder a una emergencia.

## USO Y REVELACIÓN DE SU INFORMACIÓN MÉDICA EN CASOS QUE NO REQUIEREN SU AUTORIZACIÓN

Investigación científica

Podremos revelar su PHI a los investigadores médicos que la soliciten para proyectos de investigación médica aprobados; sin embargo, dicha revelación de la información deberá realizarse por medio de un proceso especial de autorización previa a la entrega de la PHI a los investigadores, a quienes se les requerirá que protejan la PHI que reciban.

Conforme se requiera por ley

Revelaremos su PHI cuando se requiera hacerlo conforme a las leyes federales, estatales o locales.

Compensación del seguro obrero (Workers' Compensation)

Podremos entregar su PHI en los casos de compensación del seguro obrero o programas similares. Estos programas ofrecen beneficios para lesiones o enfermedades relacionadas con el trabajo.

Riesgos para la salud pública

Podremos revelar su información médica para actividades relacionadas con la salud pública, como las que tienen como objetivo prevenir o controlar enfermedades, prevenir lesiones o discapacidades y reportar el maltrato o abandono de niños, ancianos y adultos dependientes.

Actividades para la supervisión de la salud

Podremos revelar su PHI a una agencia supervisora de la salud para actividades autorizadas por ley, por ejemplo, auditorías, investigaciones, inspecciones, y concesión de licencias. Estas actividades son necesarias para que el gobierno supervise el sistema de salud, los programas gubernamentales y el cumplimiento de las leyes de derechos civiles.

Demandas y disputas

Si usted está involucrado en una demanda o en una disputa, podremos revelar su PHI si recibimos una orden judicial o administrativa. Podremos revelar también su PHI si recibimos una citación judicial, solicitud de entrega de pruebas o algún otro procedimiento legal por parte de un tercero implicado en la disputa, pero sólo si se trató de informarle a usted sobre dicha solicitud (que puede incluir notificarle por escrito) o de obtener una orden para proteger la PHI que se solicita.

Organismos encargados del cumplimiento de la ley

Podremos revelar la PHI a las agencias gubernamentales encargadas del cumplimiento de la ley en los siguientes casos:

- En respuesta a órdenes judiciales, citaciones judiciales o procedimientos semejantes que dicte un tribunal.
- Si un psicoterapeuta cree que es probable que usted represente un peligro grave de violencia en contra de un tercero.
- Para reportar que se le ha dado de alta, si se le detuvo involuntariamente después de que un policía inició una orden de detención de 72 horas para una evaluación y solicitó notificación.
- En determinadas circunstancias, si se le admitió en unas instalaciones y usted ha desaparecido o ha sido transferido a otro lado.

Médicos forenses, examinadores médicos y directores de funerarias

Podremos entregar la PHI a un médico forense o a un examinador médico. Esto puede ser necesario, por ejemplo, para identificar a una persona que ha fallecido o para determinar la causa de la muerte. También podremos revelar información médica sobre clientes de las instalaciones a un director de una funeraria según sea necesario para que desempeñe su trabajo.

Funciones especializadas del gobierno

Podremos revelar su PHI a agentes federales autorizados para usarla en actividades de inteligencia, contrainteligencia y otras operaciones de seguridad nacional autorizadas por ley.

Podremos revelar su PHI a agentes federales autorizados para que puedan proporcionar protección al Presidente de los Estados Unidos, otras personas autorizadas o jefes de estado extranjeros, o para realizar investigaciones especiales.

Presos o detenidos

Si está preso o un agente encargado del cumplimiento de la ley lo tiene detenido, podremos entregar su PHI a la correccional o a dicho agente. Esta revelación de información sería necesaria: 1) para que la institución le preste atención médica; 2) para proteger su propia salud y seguridad o las de otras personas; o 3) para la seguridad y protección de la correccional.

Otros usos de su información médica

Sólo se usará y revelará su PHI con su autorización por escrito en los casos que no se cubran en esta Notificación o las leyes correspondientes. Si nos da su autorización para usar o revelar su PHI, la podrá revocar por escrito en cualquier momento. Si la revoca, ya no podremos usar ni revelar su PHI en los casos que cubre la autorización, excepto que no podremos recuperar la información que hayamos revelado mientras la autorización estuvo en vigencia, y estamos obligados a mantener los registros de la atención que le hemos proporcionado con anterioridad.

## DERECHOS RELACIONADOS CON SU PHI

Usted tiene los siguientes derechos con respecto a su PHI en nuestros registros:

Derecho a revisar y copiar información

Con excepción de algunos casos, usted tiene derecho a revisar y copiar su PHI que tenemos en nuestros registros, en la cual se incluyen generalmente los registros de tratamiento y facturación.

Si desea revisar y copiar la PHI que se pueda usar para tomar decisiones sobre usted, deberá entregar su solicitud por escrito al administrador de su caso o a la persona encargada de su tratamiento. Se le proporcionará un formulario para que haga esta solicitud. Si solicita una copia de su PHI, es posible que le cobremos por los costos de hacer copias, el envío por correo y otros gastos relacionados con su solicitud.

En determinadas circunstancias podremos rechazar su solicitud para revisar y copiar la información. Si se le niega el derecho a revisar y copiar su PHI que tenemos en nuestros registros, podrá solicitar que se revise la denegación. Excepto por las pocas circunstancias que no están sujetas a revisión, personal profesional autorizado por LACDMH, que no esté implicado en la denegación, revisará la decisión. Cumpliremos con los resultados de la revisión.

Derecho a solicitar enmiendas

Si piensa que la PHI sobre usted que tenemos en nuestros registros es incorrecta o no está completa, puede pedirnos que enmendemos la información. Usted tiene derecho a solicitar enmiendas durante todo el tiempo que tengamos la PHI.

Si desea solicitar una enmienda, pida una "Solicitud para enmendar información médica protegida" (*"Request to Amend Protected Health Information"*), llénela y entréguela al administrador de su caso o a la persona encargada de su tratamiento. Debe explicar por escrito los motivos que respaldan su solicitud.

Podremos rechazar su solicitud para hacer una enmienda si no la presenta por escrito o no incluye un motivo que respalde la solicitud. También podremos rechazar su solicitud si nos pide que enmendemos una PHI que:

No hayamos creado nosotros, excepto si nos puede proporcionar una base razonable para creer que la persona o entidad que haya creado la PHI ya no está disponible para efectuar la enmienda;

No es parte de la PHI que mantienen las instalaciones para su uso;

No es parte de la PHI que se le permitiría revisar y copiar; o

Es exacta y completa.

Aunque le rechacemos su solicitud para efectuar una enmienda, usted tiene derecho a presentar una "Declaración de Desacuerdo" *("Statement of Disagreement")* con una descripción de un máximo de 250 palabras sobre cualquier punto o declaración en su registro que usted crea que esté incompleta o sea incorrecta. Si usted indica claramente por escrito que desea que esta declaración pase a formar parte de su registro médico, la adjuntaremos a su registro y la incluiremos siempre que demos información del punto o la declaración que usted piensa que está incompleta o incorrecta.

Derecho a recibir una relación de casos de revelación de información

Tiene derecho a solicitar una lista de los casos en los que se haya revelado su PHI para fines ajenos a nuestras actividades de tratamiento, pago y atención médica (según se describen previamente) y otras excepciones según se estipulan en la ley.

Si desea solicitar esta lista o la relación de los casos en que se reveló información, pida una "Solicitud de una relación de casos de revelación de información" (*"Request for an Accounting of Disclosures"*), llénela y entréguela al administrador de su caso o a la persona encargada de su tratamiento. En su solicitud se deberá indicar un período que no podrá ser mayor de seis años y no podrá incluir fechas antes del 14 de abril de 2003. Recibirá gratis la primera lista que solicite en un período de 12 meses. Podremos cobrarle por el costo de listas adicionales. Le informaremos cuál es el costo y usted podrá optar por retirar o modificar su solicitud en ese momento antes de que se incurra en dicho costo.

Derecho a solicitar restricciones

Tiene derecho a solicitar que se apliquen restricciones especiales adicionales cuando se use o revele su PHI para actividades de tratamiento, pago o atención médica. También tiene derecho a solicitar que sigamos las restricciones especiales adicionales cuando usemos o revelemos su PHI a una persona, por ejemplo un familiar o un amigo, que esté implicada en prestarle atención o en el pago de su atención médica. Por ejemplo, puede pedirnos que no usemos ni revelemos información de que usted está recibiendo servicios en estas instalaciones.

***No estamos obligados a estar de acuerdo con su solicitud.*** Si estamos de acuerdo, cumpliremos con su solicitud, excepto si se necesita la información para proporcionarle un tratamiento de emergencia.

Si desea pedir que se apliquen restricciones, pida una "Solicitud para restricciones adicionales en el uso o la revelación de información médica protegida" (*"Request for Additional Restrictions on Use or Disclosure of Protected Health Information"*), llénela y

entréguela al administrador de su caso o a la persona encargada de su tratamiento. En su solicitud deberá decirnos: 1) cuál información desea restringir; 2) si desea limitar nuestro uso de la información, la revelación de la misma o ambos; y 3) a quién desea que se apliquen las restricciones (revelar información a su cónyuge, por ejemplo).

Derecho a solicitar que le demos información en forma confidencial

Tiene derecho a solicitar que nos comuniquemos con usted sobre sus citas u otros asuntos relacionados con su tratamiento de una manera específica o en un lugar determinado. Por ejemplo, puede pedir que sólo nos pongamos en contacto con usted en su trabajo o por correo.

Si desea solicitar que le demos información en forma confidencial, pida una "Solicitud para recibir información en forma confidencial por medios alternos o en sitios alternos" (*"Request to Receive Confidential Communications by Alternative Means or at Alternative Locations"*). Llénela y entréguela al administrador de su caso o a la persona encargada de su tratamiento. En su solicitud se debe especificar la manera o el lugar en donde desea que nos pongamos en contacto con usted. No le preguntaremos el motivo de su solicitud. Haremos los arreglos apropiados para todas las solicitudes razonables.

Derecho a recibir una copia impresa de esta Notificación

Tiene derecho a recibir una copia impresa de esta Notificación. En cualquier momento puede solicitar que le demos una copia de esta Notificación. Aunque usted haya estado de acuerdo en recibir esta Notificación electrónicamente, de todas formas tiene derecho a recibir una copia impresa de la Notificación.

Puede obtener una copia de esta Notificación en nuestro sitio en la red:
http://www.dmh.co.la.ca.us/

Si desea obtener una copia impresa de esta Notificación, póngase en contacto con su Equipo de Tratamiento.

## CAMBIOS A ESTA NOTIFICACIÓN

Nos reservamos el derecho a cambiar los términos de esta Notificación, y a hacer que entre en vigencia la Notificación revisada o modificada en la información médica que ya tenemos sobre usted, además de cualquier información que recibamos en el futuro. Pondremos a la vista pública, en las instalaciones, una copia de la Notificación vigente, la cual contendrá la fecha de vigencia en la esquina superior derecha de la primera página. Si cambiamos nuestra Notificación, podrá obtener una copia de la Notificación revisada si visita nuestro sitio en la red en http://www.dmh.co.la.ca.us/ o puede pedirla a su Equipo de Tratamiento.

## QUEJAS

Si cree que no se han respetado sus derechos a la confidencialidad, puede presentar una queja con nosotros, con el Condado de Los Angeles o con el gobierno federal. Todas las quejas se deben presentar por escrito. **No se le castigará ni sufrirá represalias por el hecho de presentar una queja.** Si desea presentar una queja con nosotros, o si tiene comentarios o preguntas sobre nuestras normas de confidencialidad, comuníquese con:

**Los Angeles County Department of Mental Health (LACDMH)**

**Patient's Rights Division**
**(Oficina de Derechos del Paciente)**
**550 South Vermont Avenue**
**Los Angeles, CA 90020**
**(213) 738-4949**

Si desea presentar una queja con el Condado de Los Angeles, comuníquese con:

**Los Angeles County Chief Information Office**
**Chief Information Privacy Officer**
**(Oficial de Informática y Privacidad)**
**500 West Temple Street, Suite 493**
**Los Angeles, CA 90012**
**(213) 974-2164**
**Dirección electrónica: CIPO@cio.co.la.ca.us**

Si desea presentar una queja ante el gobierno federal, comuníquese con:

**Region IX, Office of Civil Rights**
**(Oficina de Derechos Civiles)**
**US Department of Health and Human Services**
**50 United Nations Plaza-Room 322**
**San Francisco, CA 94102**
**Voice Phone (415) 437-8310**
**FAX (415) 437-8329**
**TDD (415) 437-8311**

DEPARTMENT OF MENTAL HEALTH

**INFORMATION ONLY**

# CLIENT'S REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF HEALTH INFORMATION

Client Name:_____ Date:_____

Date of Birth:_____ MIS #:_____

1. I understand that DMH may use or disclose my protected health information ("PHI") for the purposes and under the circumstances described in the DMH *Notice of Privacy Practices*, and that otherwise, DMH must not use or disclose my PHI.

2. I understand that I may request that DMH refrain from certain uses or disclosures of my PHI that the law would otherwise allow. Specifically, I understand that I may request that DMH refrain from using or disclosing my PHI for any of the following purposes:

   a. For my treatment;
   b. To obtain payment for services rendered to me;
   c. For its various "health care operations", as defined by federal law;
   d. If I do not object, to family members, individuals involved in my care or payment for my care; and
   e. If I do not object, to disaster relief agencies.

3. I also understand that even though I have the right to ask that DMH not make one or more of these disclosures, DMH does not have to agree to my request.

4. If you ask us to restrict our uses and disclosures of your PHI even more than the law requires, and if we agree to do so, we are required to honor that agreement. We will notify you in writing as to whether or not DMH will agree to or will deny your restriction request. Until a decision is made, we will continue to use and disclose your PHI as allowed or required by law.

5. I hereby request that DMH agree to limit its use or disclosure of my PHI as follows:

   a. The information I want to have specially protected is:

b. I want to limit:

- ☐ The inside use of this information by DMH (i.e., the communication of this PHI among DMH workforce personnel for otherwise lawful purposes).
- ☐ The outside disclosure of this information by DMH (i.e., the communication of this PHI to persons or organizations outside of DMH, for otherwise lawful purposes).
- ☐ Both the inside use and the outside disclosure of this information.

c. Complete, only if applicable: I do not want the following person/entity to receive the information described in paragraph 5.a above: _____

Signature of client or representative: _____

If representative, give relationship: _____

## DENIAL OF REQUEST

Until further notice, as permitted by the federal Privacy Regulations. DMH will not be able to agree to your request for restriction.

Signature of Treatment Provider: _____ Date: _____

# DEPARTMENT OF MENTAL HEALTH

**INFORMATION ONLY**

## LETTER OF DENIAL REGARDING CLIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

{Mr./Ms./Mrs. Client's Name}
{Client's Address}
{City, State Zip Code}

Date of Birth: {Date}

MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your ***CLIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS*** form. DMH has reviewed your request to receive communications involving your health information from us through an alternative means or to an alternative location and has determined that it must deny your request.

| Reason for Denial: |
| --- |
| |

If you have any questions, please contact the Treatment Team or call us at {PHONE NUMBER} .

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Program/Unit Manager
Department of Mental Health
Los Angeles County

DEPARTMENT OF MENTAL HEALTH

**INFORMATION ONLY**

# CLIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

*Note: This form applies only to requests for confidential communications, i.e., when an individual is requesting a special manner of communication based on confidentiality concerns. This form is NOT to be used merely to notify DMH of a change in address or other contact information.*

Client Name:_____ Date:_____

Date of Birth:_____ MIS #:_____

You have the right to request to receive confidential communications of health information by alternative means or at alternative addresses. For example, if you do not want your appointment notices or your bills to go to your home where a family member might see it, you may ask us to communicate with you by another method or at an alternative location, such as a post office box.

We will not ask you the reason for your request. We will accommodate all reasonable requests to receive communications from us by alternative means or at alternative locations.

If you ask us to communicate with you in a different manner or at a different location than we are now using, you must give us an alternative address or other method of contacting you (phone number, email address, etc.). Please specify how or where you wish to be contacted:

Alternate Address (postal or email):

New Phone Number (include area code):

_____

Indicate what method of communication NOT to use: _____

Signature of client or representative: _____

If representative, give relationship: _____

**APPROVAL**

Signature of Treatment Provider: _____ Date: _____

# SECTION II

**INFORMATION ONLY**

# DEPARTMENT OF MENTAL HEALTH

## ACCOUNT TRACKING SHEET

**NOTE: Consult with County Counsel prior to making any non-routine disclosures.**

***(See Accounting of Disclosure of PHI 2.4.1)***

| Date of Disclosure | Name and Address Of Entity Receiving PHI | Description of PHI Disclosed | Statement of Purpose of Disclosure |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

**Name:** _____ **MIS#:** _____

**Facility/Practitioner:** _____

**Los Angeles County – Department of Mental Health**

MH-649B PCP
Revised 5/17/11

# DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE

***For a Healthy Way L.A. Referral, provide the HWLA ID#:*** _____

## Client Information

**MRUN:** _____

Name: _____ DOB: _____

Address: _____ Phone Number: _____

## Referring Physician and Care Coordinator Information

Referring Physician: _____

Name of Clinic: _____

Care Coordinator Name & Title: _____

Phone Number: _____ Fax Number: _____

## DMH Disposition

☐ **Individual accepted for services**
☐ **Individual declined DMH services**
☐ **Unable to contact individual**
☐ **DMH services not indicated** *(If selecting this box, please be sure to include in General Findings the reason DMH services are not indicated at this time, along with any recommended linkage information.)*

**General Findings** (include additional areas of identified need):

**Mental Health Diagnosis(es):**

**Psychotropic medications prescribed by DMH:**

**Treatment Plan Overview** (include planned treatment interventions; if barriers or complications are a focus of concern include below):

## Service Area Navigator Information

DMH SA Navigator: _____

Phone Number: _____ Fax Number: _____

## Responding Provider Information

Print Name & Title of Responding Provider: _____

Signature: _____ Date: _____ Time: _____

Name of DMH Clinic: _____ Telephone #: _____



**Name:** _____ **IS#:** _____

**Agency:** _____ **Provider #:** _____

**Los Angeles County – Department of Mental Health**

# DMH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

**Original Copy – To Agency Initiating Referral**
**NCR Copy – Retained by DMH Program**

# DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

**Purpose:** This form is for the use of DMH Staff when responding to referrals of non-emergency clients by Primary Care Providers (PCP).

**Completion Instructions:** It is important that all information requested on the form be completed.

## INSTRUCTIONS BELOW FOR DMH USE ONLY

**Filing Procedures:**

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.
- Non-eligible Referrals – Maintain a manila folder labeled DMH Referrals/Responses that is in a locked area of the Record Room. File alphabetically by last name and staple to Response. Maintain for a period of seven (7) years from the initial referral date.

MH-649A PCP
Revised 5/17/11

# DEPARTMENT OF MENTAL HEALTH REFERRAL

***For a Healthy Way L.A. Referral, provide the HWLA ID#:*** _____

**Patient Information** (PLEASE ATTACH PATIENT FACE SHEET if available) **MRUN:** _____

**Name:** _____ **DOB:** _____

**Address:** _____ **Phone Number:** _____

**Preferred Language:** _____

**Special Needs** (Wheel Chair, Translator, Hearing, Sight): _____

**Medical Diagnosis(es):**

**Psychiatric Diagnoses** (if known): _____

| **Name of Screening Tool** *(Indicate which screening tool used and attach to Referral Form)* | **Score** (if previously administered ) | **Date of Administration** |
|---|---|---|
| ☐ PHQ 2 ☐ PHQ 4 or ☐ PHQ 9 | | |
| ☐ Other: | | |

**Current Physical Health/Psychotropic Medication(s)** (if available, attach print out of current medications):

**Date Primary Care Provider discussed referral with Patient:** _____

**Reason for Referral to Mental Health:**

- ☐ Depression symptoms but not suicidal, homicidal, or gravely disabled
  ("Gravely Disabled"-unable to provide for his or her basic needs for food, clothing or shelter due to a mental disorder)
- ☐ Anxiety symptoms
- ☐ Social stressors
- ☐ Mood symptoms related to medical diagnosis
- ☐ Other (please explain below)

## Care Coordinator Information

Care Coordinator Name & Title: _____

Phone Number: _____ Fax Number: _____

## Referring Provider Information

Print Name & Title of Referring Provider: _____

Signature: _____ Date: _____ Time: _____

Name of Clinic: _____ Contact Number: _____

**This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.**

**Name:** _____ **IS#:** _____

**Agency:** _____ **Provider #:** _____

**Los Angeles County – Department of Mental Health**

# DMH REFERRAL from HEALTHCARE PROVIDERS

**Original Copy – To DMH Program**
**NCR Copy – Retained by Initiating Agency**

# DEPARTMENT OF MENTAL HEALTH REFERRAL FORM
## from HEALTHCARE PROVIDERS

**Purpose:** This form is for the use of Primary Care Providers (PCP) when making referrals of non-emergency clients to the Department of Mental Health.

**Completion Instructions:** It is important that all information requested on the form be completed.

## INSTRUCTIONS BELOW FOR DMH USE ONLY

**Filing Procedures:**

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.

- Non-eligible Referrals – Maintain a manila folder labeled DMH Referrals/Responses that is in a locked area of the Record Room. File alphabetically by last name and staple to Response. Maintain for a period of seven (7) years from the initial referral date.

MH 602
Revised 2/04

**INFORMATION ONLY**



# AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")**

**CLIENT:**

Name of Client/Previous Names _____ Birth Date _____ MIS Number _____

Street Address _____ City, State, Zip _____

**AUTHORIZES:**

Name of Agency _____

Street Address _____

City, State, Zip Code _____

**DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:**

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

**INFORMATION TO BE RELEASED:**

___ Assessment/Evaluation
___ Laboratory Results
___ Entire Record (Justify)
___ Other (Specify): _____
___ Results of Psychological Tests
___ Medication History/ Current Medications
___ Diagnosis
___ Treatment

**PURPOSE OF DISCLOSURE:** (Check applicable categories)

___ Client's Request
___ Other (Specify):

Will the agency receive any benefits for the disclosure of this information? ___ Yes ___ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

**EXPIRATION DATE:** This authorization is valid until the following date: ____/____/____
Month Day Year

**INFORMATION ONLY**



# AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

**COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")**

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:**

**Right to Receive a Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

**Right to Revoke This Authorization** - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

| | |
|---|---|
| Contact person | Agency Name |
| Street Address | City, State, Zip |

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

**Conditions.** I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**Signature of Client / Personal Representative** _____ Date _____

If signed by other than the client, state relationship and authority to do so: _____

**REVOCATION OF AUTHORIZATION**

**SIGNATURE OF CLIENT/LEGAL REP:** _____

**If signed by other than client, state relationship and authority to do so:** _____

**DATE:** ____/____/____
Month Day Year

DEPARTMENT OF MENTAL HEALTH
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

# FINAL LETTER OF RESPONSE TO CLIENT'S REQUEST FOR REVIEW OF DENIAL OF ACCESS TO HEALTH INFORMATION

{Mr./Ms./Mrs. Client's Name}
{Client's Address}
{City, State Zip Code}

Date of Birth: {Date}
MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

We have completed a separate, independent review of your initial **Request for Access to Health Information** in response to your **Request for Review of Denial for Access.** We have determined that:

☐ Your request has been accepted, and the information is included with this notice. The cost for this service is $ , based on a charge of 25 cents per page, and a bill will be sent to your home of record.

☐ Your request has been accepted, and the following appointment time has been scheduled for your records review:

Date: {Date}
Time: {Time}
Location: {Facility Address}

*If you have any questions or need to reschedule, please contact the Treatment Team or call us at* {Facility Phone No.}

☐ We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

## REASON FOR DENIAL (IF APPLICABLE)

Your request to access your protected health information is denied because:

☐ You are not authorized access to the health information.

DEPARTMENT OF MENTAL HEALTH
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

Other:

## FINAL DENIAL (IF APPLICABLE)

If your request has been denied, either partially or in whole, after submitting a **Request for Review of Denial for Access**, we would like to remind you that you, as stated in the Notice of Privacy Practices, that you have the option to complain to either the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office**
**Chief Information Privacy Officer**
**500 West Temple Street, Suite 493**
**Los Angeles, CA 90012**
**(213) 974-2164**
**Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Region IX, Office for Civil Rights,**
**US Department of Health and Human Services**
**50 United Nations Plaza-Room 322**
**San Francisco, CA 94102**
**Voice Phone (415) 437-8310**
**FAX (415) 437-8329**
**TDD (415) 437-8311**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Department of Mental Health
Los Angeles County

# CLIENT'S REQUEST FOR REVIEW OF DENIAL OF ACCESS

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

**CLIENT:**

| Name of Client | Date of Birth | MIS # |
|---|---|---|

| Street Address | City, State, Zip |
|---|---|

**I am requesting a review of denial of access to my protected health information.**

LACDMH will designate a licensed health care professional, who was not involved in the decision to deny access, to review the determination. We will notify you in writing of the determination of the reviewing health care professional. LACDMH must adhere to the determination of the reviewing professional.

| **Signature of Client / Personal Representative** | Date |
|---|---|

If signed by other than the client, state relationship and authority to do so: _____

| Facility | Practitioner | Date |
|---|---|---|

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at http://www.dmh.co.la.ca.us/ or by sending a written request to:

**Patient's Rights Office**
**Los Angeles County Department of Mental Health**
**550 S. Vermont Ave., 5th Floor**
**Los Angeles CA 90020**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

DEPARTMENT OF MENTAL HEALTH
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

# LETTER RESPONDING TO CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

{Mr./Ms./Mrs. Client's Name}
{Client's Address}
{City, State Zip Code}

Date of Birth: {Date}
MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your **Request for Access to Health Information**. Your request was forwarded to the responsible practitioner for review.

We received your written request, stamped on mm/dd/yyyy, to access your protected health information. We have determined that:

☐ Your request has been accepted, and the information is included with this notice. The cost for this service is $ , based on a charge of 25 cents per page, and a bill will be sent to you home of record.

☐ Your request has been accepted, and the following appointment time has been scheduled to for your records review:

Date: {Date}
Time: {Time}
Location: {Facility Address}

*If you have any questions or need to reschedule, please contact the Treatment Team or call us at* {Facility Phone No.}

☐ We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

DEPARTMENT OF MENTAL HEALTH
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

## REASON FOR DENIAL (IF APPLICABLE)

Your request to access your protected health information is denied because:

☐ You are not authorized access to the health information.

☐ We are not permitted to release health information regarding information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding. **This denial is not subject to the right to review.**

☐ You did not provide all the information we need to complete your request. Please complete the highlighted items identified and return it to us.

☐ You were unable to provide satisfactory personal identification to access your own information.

☐ You were unable to provide satisfactory personal identification as proof of status as a patient's representative (parent, guardian or conservator).

☐ Other:

If we denied your request to access, you have the right to require LACDMH to permit inspection by, or provide copies to, a licensed mental health professional designated by you with your written authorization. If you want to exercise this right, please contact your Treatment Team.

## Request for Review of Denial of Access (IF APPLICABLE)

If we denied your request to access your protected health information, in whole or in part, you may submit a ***Request for Review of Denial of Access***, included with this letter. After completing the form, return it to the Treatment Team or mail it to:

**Los Angeles County Department of Mental Health (LACDMH)**
**Patient's Rights Division**
**550 South Vermont Avenue**
**Los Angeles, CA 90020**

You also have the option to complain to either the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office**
**Chief Information Privacy Officer**
**500 West Temple Street, Suite 493**
**Los Angeles, CA 90012**
**(213) 974-2164**
**Email: CIPO@cio.co.la.ca.us**

---

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Program / Unit Manager
Department of Mental Health
Los Angeles County

# CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

**CLIENT:**

| Name of Client | Birth Date of Client | MIS # |
|---|---|---|

| Street Address | City, State, Zip |
|---|---|

☐ **REQUEST TO ACCESS AND INSPECT MY HEALTH INFORMATION ONSITE**

☐ **REQUEST DMH SEND A COPY OF MY REQUESTED HEALTH INFORMATION TO:**

| Name | FAX Number (include area code) |
|---|---|

| Street Address | City, State, Zip Code |
|---|---|

**INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:**

**INSPECTION PERIOD:** I request information regarding the following time period:

**FROM** _____/____/_____ **TO** _____/____/_____
Month Day Year Month Day Year

☐ **REQUEST SUMMARY OF REQUESTED HEALTH INFORMATION**

**COPY FEES: DMH MAY CHARGE YOU FOR MAKING COPIES OF YOUR HEALTH INFORMATION. THE ASSOCIATED FEES MAY BE 25 CENTS PER PAGE FOR PAPER OR FAX COPY; 50 CENTS PER PAGE FOR MICROFILM.**

**YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:**

**Right to Receive a Copy of This Request** - I understand that I must be provided with a signed copy of the form.

**Right to Request Review of Denial of Access-** I understand that DMH may deny my request to access my health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a ***Request for Review of Denial of Access***. In most circumstances, DMH will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

# CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

**SIGNATURE OF CLIENT:** _____

**OR**

**SIGNATURE OF PERSONAL REPRESENTATIVE:**

_____

**If signed by other than client, state relationship and authority to do so:**

_____

**DATE:** _____/_____/_____
Month Day Year

**FORM(S) OF IDENTIFICATION PROVIDED:**

__ State Driver's License _____

__ State Identification Card _____

__ Birth Certificate _____

__ Military ID _____

__ Other (Provide details) _____

**FACILITY:** _____

**PRACTITIONER:** _____ **DATE:** _____/_____/_____
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our Notice of Privacy Practices. You may also obtain a copy by visiting our website at http://www.dmh.co.la.ca.us/ or by sending a written request to:

**Patient's Rights Office**
**Los Angeles County Department of Mental Health**
**550 S. Vermont Ave., 5th Floor**
**Los Angeles CA 90020**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

DEPARTMENT OF MENTAL HEALTH
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

# LETTER RESPONDING TO REQUEST TO AMEND/CORRECT HEALTH INFORMATION

{Mr./Ms./Mrs. Client's Name}
{Client's Address}
{City, State Zip Code}

Date of Birth: {Date}
MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting to us your **Request to Amend/Correct Health Information**. Your request was forwarded to the responsible practitioner for review.

We received your request to amend/correct your protected health information dated. {Insert Date} .

We have determined that:

☐ We will make the change as you requested and will notify the persons you designated of the change.
☐ We need more time to process your request. We will send you a response to your request by {Insert Date} .

## REASON FOR PARTIAL DENIAL (IF APPLICABLE)

☐ We will make the change that you requested, but only in part, and will notify the persons you designated of the change.

☐ The part of the change that we will make is:

☐ The part of the change that we will not make is (include reason):

# INFORMATION ONLY

Los Angeles, CA 90020

## REASON FOR FULL DENIAL (IF APPLICABLE)

Your request to change your protected health information is denied because:

- ☐ You did not include a reason to support your request.
- ☐ The information we have is deemed accurate and complete.
- ☐ We did not create the information you want changed, and you did not give us a reasonable basis to believe that the originator of the information is no longer available to act on your request to change the information.
- ☐ The information you want changed is not information that you have a right to access.
- ☐ The information you want changed is not part of the designated record set. This means your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.
- ☐ Other:

## YOUR RIGHTS IF WE DENIED YOUR REQUEST TO AMEND (IF APPLICABLE)

If we denied your request to change your protected health information, in whole or in part, you may submit a **Statement of Disagreement**. If you do not want to submit a Statement of Disagreement, you may ask us to include your amendment (change) request and our denial along with all future disclosures of the information that you wanted changed by completing the appropriate section on the **Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures** form.

If you want to submit a **Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures**, please request the form from the Treatment Team. After completing the form, return it to the Treatment Team or mail it to:

**Los Angeles County Department of Health Services (LACDHS)**
**Patient's Rights Division**
**550 South Vermont Avenue**
**Los Angeles, CA 90020**

You have the right to submit a complaint to the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

**DEPARTMENT OF MENTAL HEALTH**
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

**Los Angeles County Chief Information Office**
**Chief Information Privacy Officer**
**500 West Temple Street**
**Suite 493**
**Los Angeles, CA 90012**
**(213) 974-2164**
**Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Region IX, Office for Civil Rights,**
**US Department of Health and Human Services**
**50 United Nations Plaza-Room 322**
**San Francisco, CA 94102**
**Voice Phone (415) 437-8310**
**FAX (415) 437-8329**
**TDD (415) 437-8311**

---

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Department of Mental Health
Los Angeles County

**INFORMATION ONLY**



# REQUEST TO AMEND/CORRECT HEALTH INFORMATION

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

**CLIENT:**

Name of Client _____ Date of Birth _____ MIS # _____

Street Address _____ City, State, Zip _____

**REQUEST DMH SEND THE RESPONSE TO THIS REQUEST TO:**

Name _____ FAX Number (include area code) _____

Street Address _____ Phone Number (include area code) _____

City, State, Zip _____

**PLEASE TELL US WHAT HEALTH INFORMATION YOU WANT TO AMEND/ CORRECT:**

**PLEASE TELL US WHY YOU THINK THE AMENDMENT OR CORRECTION THAT YOU ARE REQUESTING IS APPROPRIATE OR NECESSARY. YOU MUST PROVIDE A REASON:**

# REQUEST TO AMEND/CORRECT HEALTH INFORMATION

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

**If we decide to amend/correct the health information as you requested, we will send the amendment/correction to the persons or organizations you identified below. Please identify any other persons or organizations you believe have received your health information and need to be notified of the amendment/correction that you are requesting:**

_____ _____

**1st Person or Organization** FAX Number (include area code)

_____ _____

Street Address Phone Number (include area code)

_____

City, State, Zip

_____ _____

**2nd Person or Organization** FAX Number (include area code)

_____ _____

Street Address Phone Number (include area code)

_____

City, State, Zip

### INFORMATION ABOUT YOUR AMENDMENT/CORRECTION RIGHTS

**DMH will not process your request for an amendment/correction of your health information if it is not made in writing on this Form or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if extra time is needed), and will inform you in writing as to whether the amendment will be made or denied.**

**If DMH denies your requested amendment, we will tell you in writing how to submit a *Statement of Disagreement*, or a complaint, or how to request that we include your amendment request in your health information that we maintain.**

_____ _____

**Signature of Client / Personal Representative** Date

If signed by other than the client, state relationship and authority to do so: _____

# REQUEST TO AMEND/CORRECT HEALTH INFORMATION

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

**FORM(S) OF IDENTIFICATION PROVIDED:**

___ State Driver's License _____

___ State Identification Card _____

___ Birth Certificate _____

___ Military ID _____

___ Other (Provide details) _____

| Facility | Practitioner | Date |
|---|---|---|
| _____ | _____ | _____ |

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at http://www.dmh.co.la.ca.us/ or by sending a written request to:

**Patient's Rights Office**
**Los Angeles County Department of Mental Health**
**550 S. Vermont Ave., 5th Floor**
**Los Angeles CA 90020**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

DEPARTMENT OF MENTAL HEALTH
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

# LETTER RESPONDING TO CLIENT'S REQUEST FOR ACCOUNTING OF DISCLOSURES

{Mr./Ms./Mrs. Client's Name}
{Client's Address}
{City, State Zip Code}

Date of Birth: {Date}
MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your **Request for Accounting of Disclosures**. We received your written request, stamped on _____ for an accounting of disclosures of your protected health information. We have determined that:

☐ We need additional time to process your request. We will send you an accounting of disclosures by _____.

☐ We have attached a copy of your Request for an Accounting of Disclosures Form with the areas marked that need further information for your request to be processed. Please complete the enclosed Form and return it to us for reconsideration.

☐ You have already received one free accounting of disclosures within the last 12 months. An additional accounting will cost $_____ . Please send a check for this amount, made payable to {Insert Name of Facility} , or bring it to the {Insert Name of Facility} at {Insert Facility Address}

Please include this Response to Request for Accounting of Disclosures Form with your check.

☐ Other:

DEPARTMENT OF MENTAL HEALTH
Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**INFORMATION ONLY**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Program / Unit Manager
Department of Mental Health
Los Angeles County

# REQUEST FOR ACCOUNTING OF DISCLOSURES

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

**CLIENT:**

Name of Client _____ Date of Birth _____ MIS # _____

Street Address _____ City, State, Zip _____

**Address or FAX Number where you want the accounting sent**

Name _____ FAX Number (include area code) _____

Street Address _____ Phone Number (include area code) _____

City, State, Zip _____

**NOTICE TO CLIENT:** Your request for an accounting of disclosures of your protected health information **only** is applicable to the information maintained by the DMH. If you would like to request an accounting of disclosures of your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider.

**REQUEST FOR ACCOUNTING OF DISCLOSURES:**
I request an accounting of disclosures of the protected health information in my designated record set from _____ to _____ (not to exceed 6 years) maintained or created by the following providers associated with the DMH:

| Name of Physician or Other Provider | Facility/Clinic |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# REQUEST FOR ACCOUNTING OF DISCLOSURES

## COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

I understand that the first accounting in a twelve (12) months period is free of charge, but that I can be charged a reasonable fee for any additional accountings.

I understand that that the accounting must include all disclosures, **except** for disclosures:

1. to carry out treatment, payment and health care operations;
2. to individuals of protected health information about them;
3. incident to a use or disclosure permitted by the Privacy Regulations;
4. pursuant to the individual's authorization;
5. to persons involved in the individual's care or for a facility directory;
6. for national security or intelligence purposes;
7. to correctional institutions or law enforcement officials to provide them with information about a person in their custody;
8. as part of a limited data set; or
9. that occurred prior to the compliance date.

_____ _____

**Signature of Client / Personal Representative** Date

If signed by other than the client, state relationship and authority to do so: _____

**INFORMATION ONLY**

# DEPARTMENT OF MENTAL HEALTH

## DMH FAX COVER FOR TRANSMITTING PHI

### FAX DETAILS

Date Transmitted: _____ Time Transmitted: _____

Number of Pages (including cover sheet): _____

Intended Recipient: _____

| TO | FROM |
|---|---|
| Name: _____ | Name: _____ |
| Facility: _____ | Facility: _____ |
| Address: _____ | Address: _____ |
| Telephone #: _____ | Telephone #: _____ |
| Fax #: _____ | Fax #: _____ |

Documents being faxed:

- ☐ Clinical Records
- ☐ Other: _____

### CONFIDENTIALITY STATEMENT

**This facsimile transmission may contain information that is privileged and confidential and is intended only for the use of the person or entity named above. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use or distribution of this information is strictly prohibited. In addition, there are federal civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received the transmission in error, please notify contact person immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.**

### VERIFICATION OF TRANSMISSION OF PHI

Please contact _____ at _____ to verify receipt of this Fax or to report problems with the transmission.

---

I verify the receiver of this Fax has confirmed its transmission:

Name: _____ Date: _____ Time: _____

**DMH Treatment Team Representative**

# DEPARTMENT OF MENTAL HEALTH

**INFORMATION ONLY**

## REPRESENTATION OF RESEARCHER TO REVIEW PROTECTED HEALTH INFORMATION HELD BY LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH TO PREPARE FOR RESEARCH

| Name of requesting individual: | Date: |
|---|---|
| | |

Describe the health information that is the subject of the request to review:

Explain the purpose supporting the need to access the health information:

By signing this form, I hereby represent to the Human Subjects Research Committee (HSRC) and to the Department of Mental Health the following:

a. My review of the health information will be limited as necessary for me to prepare for research.

b. I will not remove the health information from the area allocated to me by the Department to review the health information, and will record the health information reviewed only in a manner that the subjects of the information cannot be identified.

c. My review of the health information is necessary for the research I am conducting.

| Researcher's Name (Print) | Signature | Date |
|---|---|---|
| | | |

| Signature of HSRC Committee Member | Date |
|---|---|
| | |

# DEPARTMENT OF MENTAL HEALTH

**INFORMATION ONLY**

## REPRESENTATION OF RESEARCHER TO REVIEW PROTECTED HEALTH INFORMATION OF DECEDENTS HELD BY LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

| Name of requesting individual: | Date: |
|---|---|
| | |

Describe the health information that is the subject of the request to review:

Explain the purpose supporting the need to access the health information:

By signing this form, I hereby represent to the Human Subjects Research Committee (HSRC) and to the Department of Mental Health the following:

a. I am reviewing the health information only for the limited purpose of research using decedents' health information.

b. My review of the health information is necessary for the research I am conducting.

c. If the Department so requests, I will provide documentation of death of the individuals whose health information I will review.

| Researcher's Name (Print) | Signature | Date |
|---|---|---|

| Signature of HSRC Committee Member | Date |
|---|---|

# SECTION III

MH 501
Revised 1/5/09

# DIAGNOSIS INFORMATION

**Type of Diagnosis Information:**

☐ Admission Diagnosis ☐ Clerical Revision to Admission Diagnosis ☐ Clerical Revision to Current Diagnosis
☐ Clinical Update to Current Diagnosis ☐ Other (please specify): _____

**New/Updated Diagnosis:** (include full *Current* Five Axes Diagnosis)

Note: The medication monitoring computer program will compare both the Principle and Secondary Diagnosis with any prescribed medication. A diagnosis consistent with the usual use of a given medication MUST appear as either the Principle or Secondary Diagnosis in the current/discharge diagnosis fields of the IS. If a diagnosis is inconsistent for the usual use of a medication, the medication MUST be specifically authorized through review and approval procedures.

**Axis I** ☐ Prin ☐ Sec Code _____ Nomenclature _____
(Medications cannot be prescribed with a deferred diagnosis)
☐ Sec Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____

**Axis II** ☐ Prin ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
Code _____ Nomenclature _____

**Axis III** _____ Code _____
_____ Code _____
_____ Code _____

**Axis IV** Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis
Check as many as apply:
1. ☐ Primary Support Group 2. ☐ Social Environment 3. ☐ Educational 4. ☐ Occupational
5. ☐ Housing 6. ☐ Economics 7. ☐ Access to Health Care 8. ☐ Interaction with Legal System
9. ☐ Other Psychosocial/Environmental 10. ☐ Inadequate information

**Axis V** Current GAF: _____ DMH Dual Diagnosis Code: _____

**Justification:**

☐ See Initial Medication Support Service dated _____ ☐ See Assessment Addendum dated _____
☐ Justification from current Diagnostic Manual:

_____ _____ _____ _____
Signature & Discipline Date Co-signature & Discipline (when required) Date

☐ Diagnosis has been entered in the IS by _____ (initials) on _____ (date).



**Name:** **IS#:**
**Agency:** **Provider #:**
**Los Angeles County – Department of Mental Health**

# DIAGNOSIS INFORMATION

MH 651
Revised 05/12/09

# SPECIAL PROGRAM CCCP

**Annual Cycle Month:** (Due prior to the 1st day of the Month)
☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

**Client Long Term Goals: (use client direct quote)**

**Short-term Goals / Objectives**: Must be SMART: Specific, Measurable/Quantifiable, Attainable within this year, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

**Objective # 1** Effective Date: _____

**Clinical Interventions:** Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

**Type of Service:** ☐ MHS* ☐ TCM ☐ Med Sup Other _____

**Client Involvement - Client agrees to participate by:**

**Signature(s)**

| Print Name | Signature & Discipline | Date | Co-signature & Discipline | Date |
|---|---|---|---|---|
| | | | | |

**Outcomes:** To be completed either when the objective is obtained or prior to the beginning of the next cycle month.

Initials: Date:

**Short-term Goals / Objectives:**

**Objective # 2** Effective Date: _____

**Clinical Interventions:**

**Type of Service:** ☐ MHS* ☐ TCM ☐ Med Sup Other _____

**Client Involvement - Client agrees to participate by:**

**Signature(s)**

| Print Name | Signature & Discipline | Date | Co-signature & Discipline | Date |
|---|---|---|---|---|
| | | | | |

**Outcomes:**

Initials: Date:

***MHS includes individual, group, psychological testing, collateral and consultation services.**

**Family Involvement:** ☐ Biological ☐ Other

Name: _____ Telephone Number: _____ Date of contact: _____

Family agrees to participate? ☐ Yes ☐ No (If yes, please specify):

**Additional Client Contacts / Relationships:**

☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds
☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run
☐ Education/AB 3632 ☐ Other _____

**Interpretation**

Prefer a language other than English: ☐ Yes ☐ No
This plan was interpreted: ☐ Yes ☐ No
Language: _____

**Client's Signature to the Care Plan**

Client's Signature: _____
Date: _____
Client offered a copy: ☐ Yes ☐ No
Staff Initials: _____ Date: _____



**Name:** **IS#:**

**Agency:** **Provider #:**

***Los Angeles County – Department of Mental Health***

# Special Program Client Care Coordination Plan

# ADULT SHORT ASSESSMENT



**Interviewed:** ☐ Client and/or ☐ Other (name and relationship): _____

**Special Service Needs:**

☐ Non-English Speaking, specify language needs: _____
Were Interpretive Services provided for this interview? ☐ Yes ☐ No

☐ Cultural Considerations, specify: _____

☐ Physically challenged (wheelchair, hearing, visual, etc.) specify: _____

☐ Access issues (transportation, hours), specify: _____

## I. Reason for Referral/Chief Complaint ☐ See Information on _____ dated: _____

Reason for Referral

Current Symptoms/Behaviors

Impairments in Life Functioning (daily living activities, social, employment/education, housing, financial, etc)

## II. Psychiatric History ☐ See Information on _____ dated: _____

Outpatient and Inpatient, include dates, providers, interventions, and responses ☐ See information on IS Screen Prints

## III. Current Risk and Safety Concern ☐ See Information on _____ dated: _____

| | | | | | |
|---|---|---|---|---|---|
| Current Thoughts of Self-Harm/Suicide | ☐Yes | ☐No | Current Thoughts of Harming Another Person | ☐Yes | ☐No |
| Past Thoughts of Self-Harm/Suicide | ☐Yes | ☐No | Past Thoughts of Harming Another Person | ☐Yes | ☐No |
| Prior Suicide Attempts/If yes, #____ | ☐Yes | ☐No | History of Homicide/Manslaughter | ☐Yes | ☐No |
| Probation/Parole Involvement | ☐Yes | ☐No | History of Injuring Another Person | ☐Yes | ☐No |
| Current/History of Injuring Animals | ☐Yes | ☐No | School Issues or IEP in place | ☐Yes | ☐No |
| Recent Trauma Exposure | ☐Yes | ☐No | Current Substance Use/Abuse | ☐Yes | ☐No |
| Recent Job Loss | ☐Yes | ☐No | Past Substance Use/Abuse | ☐Yes | ☐No |
| Victim of Violence/Abuse | ☐Yes | ☐No | Perpetrator of Violence/Abuse | ☐Yes | ☐No |
| DCFS Involvement | ☐Yes | ☐No | Homeless | ☐Yes | ☐No |

Other (specify):

**For any risk/safety concerns marked yes, please explain. Identify if any safety measures are needed, required or taken.**

## IV. Relevant Medical Conditions ☐ See Information on _____ dated: _____

Hearing Impairment ☐ Yes ☐ No Visual Impairment ☐ Yes ☐ No Motor Impairment ☐ Yes ☐ No
Other Sensory Impairment ☐ Yes ☐ No If yes, specify:
Allergies ☐ Yes ☐ No If yes, specify:
Other Medical Conditions ☐ Yes ☐ No If yes, specify:
Last Physical Exam Date: _____
Other Comments Regarding Medical Conditions:



Name: IS#:

Agency: Provider #:

Los Angeles County – Department of Mental Health

ADULT SHORT ASSESSMENT

# ADULT SHORT ASSESSMENT



## V. Medications

Client is currently on medications: ☐ Yes ☐ No If yes, How many days of medication does the client have left? _____
If yes, specify medications (include name and if there are any side-effects/adverse reactions).

## VI. Substance Use/Abuse

| | | |
|---|---|---|
| ***"MH659 -Co-Occurring Joint Action Council Screening Instrument"*** | | |
| 1. Were any of the questions checked "Yes" in Section 2 "Alcohol & Drug Use"? | ☐ Yes* | ☐ No **If yes, complete A and B below** |
| 2. Were any of the questions checked "Yes" in Section 3 "Trauma/Domestic Violence"? | ☐ Yes | ☐ No **If yes, answer 2a** |
| 2a. Was the Trauma or Domestic Violence related to substance use? | ☐ Yes* | ☐ No **If yes, complete A and B below** |

**A. Alcohol Screening Questions** — **1 Drink = 12 Ounces of Beer**

| | | | | | |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions. | ☐ Never | ☐ Monthly or less | ☐ 2-4 times a month | ☐ 3 times a week | ☐ 4+ times a week |
| 1a. How many drinks containing alcohol do you have on a typical day when you are drinking? | ☐ 1 or 2 | ☐ 3 or 4 | ☐ 5 or 6 | ☐ 7 to 9 | ☐ 10+ |
| 1b. How often do you have six or more drinks on one occasion? | ☐ Never | ☐ Less than monthly | ☐ Monthly | ☐ Weekly | ☐ Daily or almost daily |

**B. Drug Screening Questions**

1. Have you used any drug in the past 30 days that was NOT prescribed by a doctor? ☐ Yes ☐ No

| 2. Drug Type(s) Used (Indicate with an "*" which substances are most preferred.) | Ever Used? Yes | Ever Used? No | Recently Used? (Past 6 Months) Yes | Recently Used? (Past 6 Months) No | Route of Administration or other comments (IV use, smoking, snorting, etc.) |
|---|---|---|---|---|---|
| Amphetamines (Meth, crank, ice, etc.) | ☐ | ☐ | ☐ | ☐ | |
| Cocaine or crack | ☐ | ☐ | ☐ | ☐ | |
| Hallucinogens | ☐ | ☐ | ☐ | ☐ | |
| Inhalants | ☐ | ☐ | ☐ | ☐ | |
| Marijuana | ☐ | ☐ | ☐ | ☐ | |
| Nicotine (Cigarettes, cigars, smokeless tobacco) | ☐ | ☐ | ☐ | ☐ | |
| Opiates (Heroin, codeine, etc.) | ☐ | ☐ | ☐ | ☐ | |
| Over the Counter Meds (Cough syrup, diet aids, etc.) | ☐ | ☐ | ☐ | ☐ | |
| Sedatives (Pain meds, etc.) | ☐ | ☐ | ☐ | ☐ | |
| Other (specify): | ☐ | ☐ | ☐ | ☐ | |

**C. Additional Comments (i.e. frequency, duration of use, etc.):**

## VII. Psychosocial ☐ See Information on _____ dated: _____

Family & Relationships, Dependent Care Issues (Number of Dependents, Ages, Needs & Special Needs), Current Living Arrangement, Social Support Systems, Education, Employment History/Readiness/Means of Financial Support, Legal History and Current Legal Status which may impact linkage/referral.

## VIII. Additional Client Contacts/Relationships: Refer to the "MH 525: Contact Information" form.

☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds ☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run/NAMI ☐ Education/AB 3632
☐ Other _____



Name: IS#:

Agency: Provider #:

Los Angeles County – Department of Mental Health

# ADULT SHORT ASSESSMENT



## IX. Mental Status

### General Description

**Grooming & Hygiene:** ☐ Well Groomed ☐ Average ☐ Dirty ☐ Odorous ☐ Disheveled ☐ Bizarre
**Eye Contact:** ☐ Normal for culture ☐ Little ☐ Avoids ☐ Erratic
**Motor Activity:** ☐ Calm ☐ Restless ☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid ☐ Retarded ☐ Akathesis ☐ E.P.S.
**Speech:** ☐ Unimpaired ☐ Soft ☐ Slowed ☐ Mute ☐ Pressured ☐ Loud ☐ Excessive ☐ Slurred ☐ Incoherent ☐ Poverty of Content
**Interactional Style:** ☐ Culturally congruent ☐ Cooperative ☐ Sensitive ☐ Guarded/Suspicious ☐ Overly Dramatic ☐ Negative ☐ Silly
**Orientation:** ☐ Oriented ☐ Disoriented to: ☐ Time ☐ Place ☐ Person ☐ Situation
**Intellectual Functioning:** ☐ Unimpaired ☐ Impaired
**Memory:** ☐ Unimpaired ☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent ☐ Amnesia
**Fund of Knowledge:** ☐ Average ☐ Below Average ☐ Above Average

### Mood and Affect

**Mood:** ☐ Euthymic ☐ Dysphoric ☐ Tearful ☐ Irritable ☐ Lack of Pleasure ☐ Hopeless/Worthless ☐ Anxious ☐ Known Stressor ☐ Unknown Stressor
**Affect:** ☐ Appropriate ☐ Labile ☐ Expansive ☐ Constricted ☐ Blunted ☐ Flat ☐ Sad ☐ Worries

### Perceptual Disturbance

☐ None Apparent
**Hallucinations:** ☐ Visual ☐ Olfactory ☐ Tactile ☐ Auditory: ☐ Command ☐ Persecutory ☐ Other
**Self-Perceptions:** ☐ Depersonalizations ☐ Ideas of Reference

### Thought Process Disturbances

☐ None Apparent
**Associations:** ☐ Unimpaired ☐ Loose ☐ Tangential ☐ Circumstantial ☐ Confabulous ☐ Flight of Ideas ☐ Word Salad
**Concentration:** ☐ Intact ☐ Impaired by: ☐ Rumination ☐ Thought Blocking ☐ Clouding of Consciousness ☐ Fragmented
**Abstractions:** ☐ Intact ☐ Concrete
**Judgments:** ☐ Intact ☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
**Insight:** ☐ Adequate ☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
**Serial 7's:** ☐ Intact ☐ Poor

### Thought Content Disturbance

☐ None Apparent
**Delusions:** ☐ Persecutory ☐ Paranoid ☐ Grandiose ☐ Somatic ☐ Religious ☐ Nihilistic ☐ Being Controlled
**Ideations:** ☐ Bizarre ☐ Phobic ☐ Suspicious ☐ Obsessive ☐ Blames Others ☐ Persecutory ☐ Assaultive Ideas ☐ Magical Thinking ☐ Irrational/Excessive Worry ☐ Sexual Preoccupation ☐ Excessive/Inappropriate Religiosity ☐ Excessive/Inappropriate Guilt
**Behavioral Disturbances:** ☐ None ☐ Aggressive ☐ Uncooperative ☐ Demanding ☐ Demeaning ☐ Belligerent ☐ Violent ☐ Destructive ☐ Self-Destructive ☐ Poor Impulse Control ☐ Excessive/Inappropriate Display of Anger ☐ Manipulative ☐ Antisocial
**Suicidal/Homicidal:** ☐ Denies ☐ Ideation Only ☐ Threatening ☐ Plan ☐ Past Attempts
**Passive:** ☐ Amotivational ☐ Apathetic ☐ Isolated ☐ Withdrawn ☐ Evasive ☐ Dependent
**Other:** ☐ Disorganized ☐ Bizarre ☐ Obsessive/compulsive ☐ Ritualistic ☐ Excessive/Inappropriate Crying

**Comments on Mental Status:**

## X. Summary

**Summary/ Clinical Impression** (including strengths and attitude towards treatment):

**Diagnosis:**
**Axis I** ☐ Prim ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
**Axis II** ☐ Prim ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
**Axis III** Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____

**Axis IV** 1.☐ Primary support group 2.☐ Social environment 3.☐ Educational 4.☐ Occupational 5.☐ Housing 6.☐ Economics 7.☐ Access to health care 8.☐ Interaction w/legal system 9.☐ Other psychosocial/environmental 10.☐ Inadequate information

**Axis V** GAF _____ **Dual Diagnosis Code:** _____

**Disposition/Recommendations/Plan:**

_____ _____ _____ _____
Signature & Discipline Date Co-Signature & Discipline (if required) Date



**Name:** **IS#:**

**Agency:** **Provider #:**

**Los Angeles County – Department of Mental Health**

ADULT SHORT ASSESSMENT

MH 532A
Revised 06/19/03

# ADULT
# ASSESSMENT ADDENDUM

Please categorize information into one of the following areas when updating the initial assessment:

| | | |
|---|---|---|
| Demographic Data | Medical History | Psychosocial History |
| Presenting Problem/Chief Complaint | Medications | Mental Status Evaluation |
| Psychiatric History | Substance Use/Abuse | Summary and Diagnosis |

| DATE | NOTES |
|---|---|
| | |



**Name:** **MIS #:**

**Agency:** **Prov.#:**

**Los Angeles County - Department of Mental Health**

State of California - Health and Human Services Agency | Department of Mental Health

# APPLICATION FOR 72 HOUR DETENTION FOR EVALUATION AND TREATMENT

MH 302 (Rev. 08/04) Front

*Confidential Client/Patient Information*
See California WIC Section 5328 and
HIPAA Privacy Rule 45 C.F.R. § 164.508

**Welfare and Institutions Code (WIC), Section 5157**, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

☐ **Advisement Complete** ☐ **Advisement Incomplete**

Good Cause for Incomplete Advisement

Advisement Completed By | Position | Date

## DETAINMENT ADVISEMENT

My name is _____

I am a (Peace Officer, etc.) with (Name of Agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (Name of Facility).

You will be told your rights by the mental health staff.

*If taken into custody at his or her residence, the person shall also be told the following information in substantially the following form:*

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

To _____

Application is hereby made for the admission of _____

Residing at _____, California, for 72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the WIC. If a minor, to the best of my knowledge, the legally responsible party appears to be / is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as a WIC 601/602; Conservator. If known, provide names, address and telephone number:

_____

_____

_____

* * * * * * * * * * *

The above person's condition was called to my attention under the following circumstances: (see reverse side for definitions)

The following information has been established: (Please give sufficiently detailed information to support the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself; herself and/or gravely disabled.)

Based up on the above information it appears that there is probable cause to believe that said person is, as a result of mental disorder:

☐ **A danger to himself/herself.** ☐ **A danger to others.** ☐ **Gravely disabled adult.** ☐ **Gravely disabled minor.**

Signature, title and badge number of peace officer, member of attending staff of evaluation facility or person designated by county. | Date / Time | Phone

Name of Law Enforcement Agency or Evaluation Facility/Person | Address of Law Enforcement Agency or Evaluation Facility/Person

☐ Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to Section 8102 WIC.

(officer/unit & phone #) _____

## NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

**NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:**

☐ Person has been referred under circumstances in which criminal charges might be filed pursuant to Sections 5152.1 and 5152.2 WIC.

Notify (officer/unit & telephone #) _____

☐ Weapon was confiscated pursuant to Section 8102 WIC.

Notify (officer/unit & telephone #) _____

SEE REVERSE SIDE FOR INSTRUCTIONS

**APPLICATION FOR 72 HOUR DETENTION FOR EVALUATION AND TREATMENT**
MH 302 (Rev. 08/04) Back

## DEFINITIONS

### GRAVELY DISABLED

**"Gravely Disabled"** means a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing and shelter. SECTION 5008(h) WIC

**"Gravely Disabled Minor"** means a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Mental retardation, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. SECTION 5585.25 WIC

### PEACE OFFICER

**"Peace Officer"** means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer Standards and Training, or any parole officer specified in Section 830.5 of the Penal Code when acting in relation to cases for which he or she has a legally mandated responsibility. SECTION 5008(i) WIC

## INSTRUCTIONS FOR SECTION 5152.1, 5152.2 AND 5585 WIC

**Section 5152.1 WIC**

The professional person in charge of the facility providing 72-hour evaluation and treatment, or his or her designee, shall notify the county mental health director or the director's designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72-hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention if all of the conditions apply:

(a) The peace officer requests such notification at the time he or she makes the application and the peace officer certifies at that time in writing that the person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.
(b) The notice is limited to the person's name, address, date of admission for 72-hour evaluation and treatment, and date of release.
If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information obtained pursuant to the notification requirements of this section, the officer agency, or designee shall destroy that record two years after receipt of notification.

**Section 5152.2 WIC**

Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officer pursuant to Section 5152.1 WIC.

**Section 5585 et seq. WIC**

Section 300 WIC is a minor who is under the jurisdiction of the Juvenile Court because of abuse (physical or sexual), neglect or exploitation.

Section 601 WIC is a minor who is adjudged a ward of the Juvenile Court because of being out of parental control.

Section 602 WIC is a minor who is adjudged a ward of the Juvenile Court because of crimes committed.

**Section 8102 WIC (EXCERPTS FROM)**

(a) Whenever a person who has been detained or apprehended for examination of his or her mental condition or who is a person described in Section 8100 or 8103, is found to own, have in his or her possession or under his or her control, any firearm whatsoever, or any other deadly weapon, the firearm or other deadly weapon shall be confiscated by any law enforcement agency or peace officer, who shall retain custody of the firearm or other deadly weapon.
"Deadly weapon," as used in this section, has the meaning described by Section 8100.

(b) Upon confiscation of any firearm or other deadly weapon from a person who has been detained or apprehended for examination of his or her mental condition, the peace officer or law enforcement agency shall notify the person of the procedure for the return of any firearm or other deadly weapon which has been confiscated.
Where the person is released without judicial commitment, the professional person in charge of the facility, or his or her designee, shall notify the person of the procedure for the return of any firearm or other deadly weapon which may have been confiscated.
Health facility personnel shall notify the confiscating law enforcement agency upon release of the detained person, and shall make a notation to the effect that the facility provided the required notice to the person regarding the procedure to obtain return of any confiscated firearm.

# SECTION IV

MH 517
Revised 05/16/03

# DISCHARGE SUMMARY

**Admission Date:** _____ **Discharge Date*:** _____

**Presenting Information:**

**Services Received and Response:**

**Medication(s):** (Include Dosage & Response) ☐ None

**Disposition and Recommendations:** (If referred, include name of agency(s) or practitioner(s))

Referral Out Code _____

**Diagnosis:** **(check one)**

Axis I ☐ Prin / Sec _____ Code _____

☐ Prin / Sec _____ Code _____

Axis II ☐ Prin / Sec _____ Code _____

Axis III ☐ _____ Code _____

Axis V ☐ Discharge GAF _____ Prognosis _____

| Signature & Discipline | Date | Reviewer's Signature & Discipline | Date |
|---|---|---|---|
| | | | |

*Discharge Date: last service date or last cancelled or missed appointment.



**Name:** **MIS #:**

**Agency:** **Prov. #:**

**Los Angeles County - Department of Mental Health**

DISCHARGE SUMMARY

MH 515
Revised 02/06/08

# PROGRESS NOTE

Date: _____ Telephone Contact: ☐ Y ☐ N Rendering Provider Face-to-Face/Other Time* (Hrs:Mins): _____

Procedure Code: _____ Other Staff Initials: _____ Total Time* (Hrs/Mins): _____

* All travel and documentation time must be recorded as "Other" or "Total Time" Other Staff Initials: _____ Total Time* (Hrs/Mins): _____

MHS Activity Type: ☐ Assessment ☐ Ind Tx ☐ Ind Reh ☐ CoI ☐ PsyT ☐ Team Conf/CaseCon Other Activity Type: ☐ Cris Int ☐ TCM
☐ GrpTx ☐ GrpReh # of Clients Represented: _____

☐ Continued (Sign & complete claim information on last page of note.)

_____ _____ _____ _____
Signature & Discipline Date Co-signature & Discipline Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name: IS#:

Agency: Provider #:

Los Angeles County – Department of Mental Health

PROGRESS NOTE

MH 514
Revised 11/19/96

# CASE PRESENTATION

## VERBAL CONTENT OF PRESENTATION (sample)

**Reason for Presentation**
periodic review, disposition, problem specific, etc.

**Identifying Data**
admission date, personal demographics including living situation, family information

**Presenting Problem(s)**
client's presenting complaint, service staff's perceptions including behavioral and symptomatic manifestations

**History** relevant psychosocial, medical, and psychiatric

**Diagnosis**
review supporting diagnostic criteria

**Current Service Plan**
short and long-term goals, service modality and approach, estimated duration, medications

**Family/Service Staff Relationship**
cultural/language issues, psychodynamics

**Progress Towards Goals**
factors leading to or interfering with change

## DOCUMENTATION

Required minimum: Date of presentation, Reason for presentation, Issues discussed, Service suggestions

Signature (service staff) | Date | Signature (supv., when required) | Date



Name: MIS#:

Agency:

**Los Angeles County - Department of Mental Health**

# CASE PRESENTATION

# CASE PRESENTATION

**Purpose:** This form provides a unique place for the documentation of any one of a variety of formal staff conference activities: Interdisciplinary case conferences, periodic case reviews, problem case conferences, case training conferences, disposition, conferences, transfer conferences, intake conferences, etc. In essence, it is the form that should be used to document any case conference activities that occur in a provider.

**Verbal Content of Presentation:** These sample items are not intended to set minimum standards or requirements for a presentation. It is intended primarily to assist students and new professionals in preparing a presentation. Many conferences will have a focus that does not include all of the elements listed, such as a conference focused on a discharge plan. Other conferences may specifically include areas not noted, but relevant to the type of conference or presentation.

**Recording Procedure:** The Documentation section is intentionally brief. It was designed to highlight only the issues discussed and service suggestions made at the presentation. There are a variety of other places in the service record where summaries of the patient, his/her service, or any other aspects of the case may be found. In the face of ever increasing demands on service time, it seemed unnecessary to repeat this information, thus the focus on the discussion aspect of the case conference and information which may not be available elsewhere in the service record. Individual programs may require additional documentation by specifying required content in service procedures.

If additional space is needed, use a *Progress Notes* page. Cross out any unused space at the end of the case presentation documentation.

**Reason for Presentation:** This should be a brief statement (such as problem specific, periodic review, interdisciplinary case conference, disposition, etc.). If the presentation is problem specific, a brief statement of the problem should follow.

**Signature:** The service staff presenting the case should complete and sign the form. Supervisors are encouraged to review conference documentation of their supervisees. All student/trainee notes must be co-signed by his/her licensed supervisor.

**Filling Procedure:** This form should be filed sequentially in the progress notes section of the service record.