AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

Client Name: _____ Date of Birth: _____
Client ID: _____

The County of Los Angeles ("County") operates and engages in health information exchanges to allow your information to be shared among and between County Programs and their partners to help you get resources and social services that can improve your health. A health information exchange is an electronic system that allows organizations to share information.

"County Programs" are programs that provide services to you or obtain benefits for you through the following County Departments:

- Department of Health Services (DHS)
- Department of Mental Health (DMH)
- Department of Public Health (DPH), including the Substance Abuse Prevention and Control (DPH-SAPC)
- Department of Public Social Services (DPSS)
- Homeless Services & Housing (HSH)
- Justice, Care and Opportunities Department, only for re-entry services

Many types of organizations work as partners of County Programs, some as contractors or subcontractors, to provide, coordinate, or pay for these services or benefits, including:

- Health care providers
- Mental health providers
- Substance use disorder providers
- Social service providers
- Managed care plans
- Housing and assisted living providers
- Meal service providers
- Legal providers who assist you in obtaining benefits or services
- Community organizations that provide or coordinate services, including to persons involved with the justice system

These organizations may need to share your health and/or social services information to:

- See if you are eligible for services or benefits provided by County Programs or through other resources and/or for Medi-Cal enrollment and benefits
- Coordinate your health care and community supports
- Communicate with your treating providers and organizations and social service providers
- Provide you with treatment and related services
- Receive payment for services
- Conduct quality improvement, reporting, and evaluation activities
- Carry out related County Program activities

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

By signing my name below, I agree that my current, past, and future treating providers, non-treating providers listed in Attachment A, and County Programs may disclose my health information, records, social services information, and related data to any County health information exchange. Such data may be used and shared among and between the County Programs. I also agree that County Programs may disclose this information to my current, past, and future treating providers (including County Program subcontractors), and the managed care plans and other organizations that work with County Programs that are listed in Attachment A for the purposes described above.

- I authorize my health and social service information to be shared through any health information exchange operated by or with participation from the County.
- Information that may be shared will include:
  - My general information, such as my age and gender;
  - My medical, mental health, or substance use history;
  - My social service information (including CalFresh, Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC"), General Relief, CalWorks, Cash Assistance Program for Immigrants, Medi-Cal, Homeless Management Information System/Housing Records, and other public benefits that I may apply for and/or receive); and
  - Treatment and/or services I receive.
- I understand that this Authorization will apply to data related to services I receive from County Programs (including their subcontractors).
- I understand that my information will be shared in electronic formats, including through a health information exchange, as described above. My information may also be shared in verbal and written formats.

I specifically authorize my current, past, and future treating providers and County Programs to share the following sensitive information (*check as appropriate*):

☐ Information from health care providers about my mental health diagnosis or treatment that is protected under Welfare and Institutions Code § 5328 _____ (*initial*) (excluding psychotherapy notes)

☐ Information from substance use disorder programs (includes substance use disorder diagnoses and medications, inpatient stays and outpatient visits or residential treatment, provider names and contact information, and names of the treatment programs) that is protected under 42 C.F.R. Part 2 or State law _____ (*initial*)

I may ask for a list of providers and organizations that have received my substance use disorder information by contacting my care manager.

I also authorize County Programs to share my health and social service information with the following family members or other persons so that they may assist in coordinating or paying for my care:

_____	_____
(Name and Telephone Number)	(Relationship)
_____	_____
(Name and Telephone Number)	(Relationship)
_____	_____
(Name and Telephone Number)	(Relationship)

(Please continue on back of form if more room is needed.)

I understand:

- This Authorization will be valid for as long as I receive services from County Programs.
- I have the right to cancel or change this Authorization at any time. I can start this process by talking to my service provider or case/care manager. At that time, I will either cancel my Authorization or complete a new Authorization to reflect the change(s) to the sensitive information that I want to share. If I limit my information sharing, my sensitive information will not be shared from that date forward. Any sensitive information previously shared cannot be recalled. Should I elect not to share any sensitive information, certain care coordination, case management, benefits advocacy or other services may be limited, if my authorization is required by Federal law.
- State and Federal laws already allow health care organizations to share some of my health information (including sensitive information) to treat me, obtain payment, and run their operations without my consent. I understand that this Authorization does not change the information that can be shared under these laws. I also understand that my authorization is required to share my substance use disorder information, if applicable.
- When my information is shared, Federal law or California privacy law may not protect the re-sharing of my information, except for substance use disorder information that is specially protected and may not be re-shared with others.
- My ability to receive medical services, treatment, or public social services does not depend upon whether I sign this Authorization. However, if I choose not to sign this Authorization, County Programs may not be able to share data to coordinate the services I receive, and I may not be able to receive full care coordination, case management, benefits advocacy or related services.
- I have the right to:
    - Inspect or obtain a copy of my health information and social services information that is shared by this Authorization.
    - Refuse to sign this Authorization.
    - Receive a copy of this Authorization.

[*signature on following page*]

I have read this Authorization or it has been read to me. I authorize the use and sharing of my health and social services information as described above.

_____ _____

Client Signature Date

If this Authorization is signed by a person other than the client, please indicate the relationship:

_____

Relationship to Client

_____ _____

Name Date

Attachment A
Non-Treating Providers (for Payment, Benefits Advocacy, etc.)

Health Plans, Federal, State and Local Organizations

Anthem Blue Cross/Care
Health Net
Blue Shield Promise
LA Care
Molina Health Care
Kaiser Permanente
Senior Care Action Network (SCAN)
U.S. Social Security Administration Disability Determination Services
U.S. Veteran's Administration
Centers for Medicare and Medicaid Services
California Department of Health Care Services
California Department of Social Services
California Department of Developmental Services
LA Homeless Services Authority
LA County Department of Children and Family Services
LA County Department of Military and Veterans Affair
LA Cash Assistance for Immigrants Program (CAPI)

CBEST Participant Organizations (Benefits Advocacy)

Inner City Law Center
Legal Aid Foundation of Los Angeles (LAFLA)
Health Advocates
Lutheran Social Services
Los Angeles County Department of Consumer and Business Affairs
Special Services for Groups
St. Joseph's Center
Tarzana Treatment Center
The Catalyst Foundation
Volunteers of America
Watts Community Action Labor Committee (WLCAC)

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

Personal Representative's Name Date

I revoke the Authorization submitted to County Programs as of _____(DATE). This Revocation does not affect any disclosures made prior to receiving this Revocation. This Revocation does not change the information that may be shared under State or federal laws without my consent.

_____ _____

Client Signature Date

If this Revocation is signed by a person other than the client, please indicate the relationship:

_____

Relationship to Client

_____ _____

Name Date

Los Angeles County Health Agency

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

Effective Date: May 30, 2017

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the Los Angeles County (LAC-Health Agency) Departments of Health Services, Mental Health, and Public Health, collectively referred to as the Health Agency. 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.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-Health Agency.

Signature:_____Date: _____
(patient/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 Workforce Member: _____ Date: _____

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign.

☐ Other Reason or Comments:

_____

_____

_____

_____

LA COUNTY Homeless Services & Housing

REQUEST FOR ENRICHED RESIDENTIAL CARE ASSESSMENT

Date: _____

This form is used by HSH facilities and other HSH specialized programs, to request an assessment from the ERC Care Team of an individual who is likely appropriate for placement at a licensed residential care facility. Completing this form does not guarantee that the applicant will be approved for the ERC program. HSH ERC staff will follow-up with the referring party to inform them of the results ERC assessment and if the next step is necessitated.

How do you request an ERC Assessment?

1. Complete Housing for Health ERC Application in the CHAMP system.
2. Upload copies of the client's signed Universal Consent and Notice of Privacy Practices forms.
3. Complete this form, Request for ERC Assessment, and upload all three pages in the CHAMP system.
4. Review the list on page 3 of all required and supplemental documents to be submitted with this request.
5. Upload all requested forms and documents into the CHAMP system or, if you do not have access to the CHAMP system, email the forms to **ERC-Referrals@hsh.lacounty.gov**

Referring Agency Name:	Staff Name/Title:		
Office Phone #:	Cell #:	Staff Email:	
Client's First Name:	Client's Middle Name:	Client's Last Name:	CHAMP ID:

Gender:	Date of Birth:	Age:	Residency Status:	Preferred Language (If other than English):
☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Not specified/option not available			☐ US Citizen ☐ Legal Resident ☐ Other	

Client's current location/address:

_____

_____

Health Insurance (Check all that apply):

☐ Medi-cal ☐ Medicare ☐ Private ☐ None

☐ Unknown Managed Care Provider

CIN#/Subscriber ID:_____

Primary Care Provider: _____

Mental Health Provider: _____

Client's Income (check all that apply):

☐ No Income ☐ Food Stamps/Cal Fresh

☐ General Relief ☐ Unemployment

☐ SSI ☐ Employment

☐ SSDI ☐ CAPI

☐ VA Benefits ☐ CalWORKS

☐ Pending – Date of Application: _____

☐ Other: _____

_____

Monthly income amount: _____

Does the client have a next of kin? ☐ Yes ☐ No

If Yes, provide name(s), relationship(s) to client, and contact information: _____

_____

_____

Does the client have an emergency contact(s)? ☐ Yes ☐ No

If Yes, provide name(s), relationship(s) to client, and contact information: _____

_____

_____

HSH Office Use:

Date received: _____ Date Sent for Assessment: _____ ☐ Approved ☐ Denied Initials: _____

LA COUNTY Homeless Services & Housing

REQUEST FOR ENRICHED RESIDENTIAL CARE ASSESSMENT

Instructions

Please answer the following questions by marking the appropriate box and providing all relevant information. Please upload the completed form into CHAMP or where you do not have access, email to ERC-Referrals@hsh.lacounty.gov

Check all that apply:

1. Is the client: ☐ Legally Blind ☐ Speech Impaired ☐ Cognitively Impaired ☐ Hearing Impaired

2. Does the client use: ☐ Assistive Communication ☐ Sign Language ☐ Hospital Bed ☐ Cane or Walker ☐ Wheelchair
   If client uses a wheelchair, are they able to transfer in/out of the wheelchair: ☐ Independently ☐ Needs Assistance

3. Is the client able to transfer to/from a commode: ☐ Independently ☐ With Proper Equipment ☐ Needs Assistance

4. Does the client need assistance with medication monitoring or dispensing: ☐ Yes ☐ No

5. Is the client incontinent of: ☐ N/A ☐ Bowel ☐ Bladder If indicated: can the client self-care: ☐ Yes ☐ No

6. Does the client use diapers: ☐ Yes ☐ No If yes, can they change themselves independently: ☐ Yes ☐ No

Please Describe Limitations/Concerns Related to Any Impairments Identified Above:

_____
_____
_____
_____

Mental Health:

7. Does the client have aggressive behaviors: ☐ Yes ☐ No If yes, please describe: _____

8. Does the client have violent tendencies? ☐ Yes ☐ No If yes, please describe: _____

9. Does the client have a mental health diagnosis? ☐ Yes ☐ No If yes: what is the diagnosis: _____

   If yes to #9, is the condition stable (well managed): ☐ Yes ☐ No

10. Is the client compliant with taking medications and following through with appointments and other care plans:
    ☐ Yes ☐ No

Please Describe Limitations/Concerns Related to Any Impairments Identified Above:

_____
_____
_____

Cognitive Functioning:

11. Is the client-oriented X's 4? (person, place, time, situation): ☐ Yes ☐ No
    If no, please describe: _____

12. Has client been diagnosed with: ☐ Cognitive impairment ☐ Dementia ☐ Developmental disability ☐ TBI

Describe cognitive impairment or other neurocognitive disorder:

_____
_____
_____
_____

LA COUNTY Homeless Services & Housing

REQUEST FOR ENRICHED RESIDENTIAL CARE ASSESSMENT

13. Does client have a legal surrogate decision maker: ☐ DPOA ☐ LPS Conservator ☐ Probate Conservator ☐ Other

    If yes, include: Name:_____ Agency:_____ Contact:_____

14. Does client have a representative payee: ☐ Yes ☐ No

    If yes, include: Name:_____ Agency:_____ Contact:_____

15. Does client have other court ordered treatment or decision makers that is current, or pending (i.e. temporary conservatorship for LPS, probate, or Riese hearings): ☐ Yes ☐ No ☐ Unknown

    If yes, explain: _____

16. Is the client capable of understanding instructions & consents for health treatment plans: ☐ Yes ☐ No

If clients lacks decision making capacity and has no legal surrogate decision maker, the attending physician must complete a formal capacity declaration form (GC335 and GC335a) and submit/upload documents with ERC request. Refer client to Public Guardian's (PG) Office for conservatorship.

Date of Referral to the Public Guardian's (PG) Office: _____

What steps, if any, have you already taken to find placement for this client:

_____
_____
_____
_____
_____

Other relevant details, barriers or issues regarding this client's housing needs:

_____
_____
_____
_____
_____

Please upload the following required documents in the CHAMP System.

Required:

☐ Request for ERC Assessment
☐ Universal Consent & Notice of Privacy Practices Forms
☐ Pre-placement Appraisal Information Form LIC603
☐ Physician's Report LIC60A with TB Test Results
☐ Existing History & Physical, and Medication List
☐ ERC Payment Responsibilities Form

If Applicable:

☐ DPOA
☐ Advanced Directives or Advanced Care Planning Sheet
☐ POLST
☐ MOCA or MMSE Form
☐ GC335 and GC335a
☐ Award Letter / Income Verification Form
☐ Medical Insurance Verification

ENRICHED RESIDENTIAL CARE PAYMENT RESPONSIBILITIES FORM

(To be reviewed, completed and signed by the client and submitted with the referral packet/assessment)

Name of Client: _____

Clients entering the Enriched Residential Care (ERC) program with income, including but not limited to Supplemental Security Income (SSI), are expected to use their income to pay the monthly room and board rent at licensed residential care facilities. Clients with income will retain the State-determined amount for Personal and Incidental expenses and use whatever remains of their monthly income toward the room and board rent. Clients without income or whose income is not enough to cover the full monthly room and board rent amount will have the full or remaining portion owed to the facility paid by either the Department of Homeless Services & Housing (HSH) ERC program, Department of Mental Health (DMH) ERC program or DMH's contracted Full Service Partnership (FSP) program. Clients without income are expected to work with their case managers and/or the Countywide Benefits Entitlement Services Team (C-BEST) to apply for SSI or the Cash Assistance Program for Immigrants (CAPI), unless it is determined by their case manager that the client is ineligible.

Review and initial next to each of the statements below indicating confirmation that you have reviewed and agree to each statement:

_____ I understand that, if I receive an income, such as SSI, upon entering a licensed residential care facility, I will be expected to use my income for Personal and Incidental expenses up to the State-determined amount and use the remaining income to pay the monthly room and board rent.

_____ I understand that, if I do not have an income upon entering a licensed residential care facility but later obtain SSI or another type of income, I will be expected to begin using my income for Personal and Incidental expenses and for paying the monthly room and board rent.

_____ I agree to notify my case manager and/or licensed residential care facility operator of any changes to my income.

_____ I understand that, if I have an income and refuse to pay my portion of the monthly room and board rent after my placement at a licensed residential care facility, I may be disenrolled from the ERC program.

By signing this form, I am confirming that I have had an opportunity to review the terms of this payment responsibilities form and agree to them.

x _____ _____

Signature of Client/Individual/Legal Representative **Date**

If signed by someone other than the client, print name and state relationship and authority. Please also provide evidence to support your assertion that you may sign on the client's behalf:

_____