Sioux Rivers Regional MHDS Application Form

For individuals living in: Dickinson, Emmet, Lyon, O'Brien, Plymouth, and Sioux Counties

Application Date: ______________________________ **Date Received by Office:** ______________________________

First Name: __________________________ **Last Name:** _______________________ **MI:** _________

Nickname: ___________________________ **Maiden Name:** _____________________ **Birth Date:** ________________

Ethnic Background: ☐White ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other _________

Sex: ☐Male ☐Female **US Citizen:** ☐Yes ☐No **If you are not a citizen, are you in the country legally?** ☐Yes ☐ No

SSN#_____________________ **Marital Status:** ☐Never married ☐Married ☐Divorced ☐Separated ☐ Widowed

Legal Status: ☐Voluntary ☐Involuntary-Civil ☐Involuntary-Criminal ☐Probation ☐Parole ☐Jail/Prison

Are you considered legally blind? ☐Yes ☐No **If yes, when was this determined?** ________________

Primary Phone #: ______________________________________ **May we leave a message?** ☐Yes ☐No

Current Address: ____

Street City State Zip County

Begin Date ________________________

I live: ☐ Alone	☐ With Relatives	☐With Unrelated persons

☐**Use as current Mailing Address:** ☐Yes ☐No **If not,** ____

Previous Address____

Street City State Zip County

Begin Date________________ End Date________________

Current Service Providers:

	Name	Location
1.		
2.		

Current Residential Arrangement: **(Check applicable arrangement)**

☐**Private Residence** ☐**Foster Care/Family Life Home** ☐**Correctional Facility** ☐ **Homeless/Shelter/Street**

☐**Other**________________________________

Veteran Status: ☐Yes ☐No **Branch & Type of Discharge:** ____________________ **Dates of Service:** ______________

Current Employment: **(Check applicable employment)**

☐**Unemployed, available for work** ☐**Unemployed, unavailable for work** ☐**Employed, Full time**
☐**Employed, Part time** ☐**Retired** ☐**Student**
☐**Work Activity** ☐**Sheltered Work Employment** ☐**Supported Employment**
☐**Vocational Rehabilitation** ☐**Seasonally Employed** ☐**Armed Forces**
☐**Homemaker** ☐ **Volunteer** ☐**Other** ________________

Current Employer: __________________________________ **Position:** ______________________

Dates of employment: ______________________ **Hourly Wage:** ________________ **Hours worked weekly:** ______

Employment History: (list starting with most recent to previous.)

Employer	City, State	Job Title	Duties	To/From
1.				
2.				

Education: What is the highest level of education you achieved? ______ # of years ______ Degree

Emergency Contact Person:

Name: ______________________________ **Relationship:** ________________

Address: ________________________________ **Phone:** ________________________

Guardian/Conservator appointed by the Court? ☐Yes ☐No
Protective Payee Appointed by Social Security? ☐Yes ☐No

☐Legal Guardian ☐Conservator ☐Protective Payee
(Please check those that apply & write in name, address etc.)

Name: ____________________________

Address: ____________________________

Phone: ____________________________

☐Legal Guardian ☐Conservator ☐Protective Payee
(Please check those that apply & write in name, address etc.)

Name: ____________________________

Address: ____________________________

Phone: ____________________________

List All People In Household:

Name	Age	Relationship	Social Security Number
1.			
2.			
3.			
4.			
5.			

INCOME: **Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.** *See attachment A
If you have reported no income above, how do you pay your bills? (Do not leave blank if no income is reported!)

____

____

Gross Monthly Income (before taxes): (Check Type & fill in amount)	**Applicant Amount:**	**Others in Household Amount:**
☐ Social Security	______________	______________
☐ SSDI	______________	______________
☐ SSI	______________	______________
☐ Veteran's Benefits	______________	______________
☐ Employment Wages	______________	______________
☐ FIP	______________	______________
☐ Child Support	______________	______________
☐ Rental Income	______________	______________
☐ Dividends, Interest, Etc	______________	______________
☐ Pension	______________	______________
☐ Other	______________	______________
Total Monthly Income:	______________	______________

Household Resources: (Check and fill in amount and location):

Type	Amount	Bank, Trustee, or Company
☐Cash	______	______
☐Checking Account	______	______
☐Savings Account	______	______
☐Certificates of Deposit	______	______
☐Trust Funds	______	______
☐Stocks and Bonds (cash value?)	______	______
☐Burial Fund/Life Ins (cash value?)	______	______
☐Retirement Funds (cash value?)	______	______
☐Other ______	______	

Total Resources: ______

Motor Vehicles: ☐Yes ☐No (include car, truck, motorcycle, boat, recreational vehicle, etc.)
Make & Year: ______ Estimated value: ______
Make & Year: ______ Estimated value: ______
Make & Year: ______ Estimated value: ______

Do you, your spouse or dependent children own or have interest in the following:

House including the one you live in? ☐Yes ☐No Any other real estate or land? ☐Yes ☐No Other?______ ☐ Yes ☐No

If yes to any of the above, please explain:

______

Have you sold or given away any property in the last five (5) years? ☐Yes ☐No **If yes, what did you sell or give away?**

______

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐Applicant Pays ☐Medicaid ☐Family Planning only
☐Medicare A, B, D ☐Medically Needy ☐ MEPD
☐No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name ______
Address ______
______
Policy Number: ______
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: ______ Any limits? ☐ Yes ☐ No
Spend down: ______ Deductible: ______

Secondary Carrier (pays 2nd)

☐Applicant Pays ☐Medicaid ☐ Family Planning only
☐Medicare A, B, D ☐ Medically Needy ☐ MEPD
☐No Insurance ☐Private Insurance ☐ HAWK-I

Company Name ______
Address ______
______
Policy Number______
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: ______ Any limits? ☐ Yes ☐ No
Spend down: ______ Deductible: ______

Referral Source:

☐Self ☐Community Corrections ☐Family/Friend ☐Social Service Agency
☐Targeted Case Management ☐Other ______ ☐Other Case Management

Have you applied for any of the public programs listed below?

(Please check those you have applied for and the status of your referral) Has your application been Approved or Denied? If denied and you appealed, what is the date of appeal ______ Have you applied for reconsideration:______Have you had a hearing with an Administrative Law Judge and what was the date of the scheduled hearing: ______

☐**Social Security**______ ☐**SSDI**______ ☐**Medicare**______

☐**SSI** ______ ☐**Medicaid**______ ☐**DHS Food Assistance:**______

☐**Veterans** ______ ☐**Unemployment**______ ☐**FIP** ______

☐**Other**______ ☐**Other**______

Disability Group/Primary Diagnosis: (If known)

☐Mental Illness ☐Chronic Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

Specific Diagnosis determined by:_______________________________ Date:__________
Axis I: _______________________________ Dx Code: __________________
Axis II:_______________________________ Dx Code:__________________

Why are you here today? What services do you NEED? (this section must be completed as part of this application!)

____
____
____

I certify that the above information is true and complete to the best of my knowledge, and I authorize Sioux Rivers Regional MHDS staff to check for verification of the information provided including verification with Iowa county government and the state of Iowa Dept. of Human Services (DHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the Sioux Rivers Region to establish my ability to pay for the services requested, and to assure the appropriateness of services requested. I understand that information in this document will remain confidential.

____
Applicant's Signature (or Legal Guardian) Date

____
Signature of other completing form if not Applicant or Legal Guardian Date

ATTACHMENT A
Income/Resource/Eligibility Verification
Sioux Rivers Regional Mental Health & Disabilities Services

1. PROOF OF LEGAL RESIDENCE REQUIREMENT

Iowa Code 331,394(1): "County of residence" means the county in this state in which, at the time a person applies for or receives services, the person is living and has established an ongoing presence with the declared, good faith intention of living in the county for a permanent or indefinite period of time. The county of residence of a person who is a homeless person is the county where the homeless person usually sleeps. A person maintains residency in the county or state in which the person last resided while the person is present in another county or this state receiving services in a hospital, a correctional facility, a halfway house for community-based corrections or substance-related treatment, a nursing facility, an intermediate care facility for persons with an intellectual disability, or a residential care facility, or for the purpose of attending a college or university.

- A copy of the applicant's driver's license or picture ID that shows current address, **OR**
- A copy of a recent bill or piece of mail with a legible postmark delivered by the US Post Office to the client at their current address, **OR**
- If application is living in a homeless shelter or community living facility, a letter signed and dated by personnel stating the applicant is residing in that facility.

2. HOUSEHOLD INCOME VERIFICATION REQUIREMENTS

For applications 18 years of age and over: Include income of applicant, applicant's spouse or domestic partner, and any children, stepchildren, or wards over the age of 14 that reside with applicant.

For applications under the age of 18: Include income of application (if over 14), applicant's parents (or parent and domestic partner), stepparents, or guardians who reside with applicant.

- Copies of payroll stubs for past 60 days from all employers. If a payroll stub reflects year-to-date earnings, only the most recent payroll stubs will be required.
- If applicant or spouse/domestic partner is self-employed, provide a copy of most recent Federal tax return completed.
- If applicable, a copy of Supplemental Security (SSI) or Social Security Disability (SSDI) determination, pension payment, and child support amount, etc.
- If an application indicates that no one in the household has any income, written documentation is required from all applicable adult household members stating as such and evidence of outside assistance such as food stamps, financial help from relatives, etc. must be provided.

3. RESOURCE VERIFICATION REQUIREMENTS (Applicant and other applicable household members)

- A copy of all checking account statements for past 2 months
- A copy of all savings account statements for past 2 months
- A copy of a statement from all retirements accounts such as IRAs, 401(k), pension plans, annuities, certificates of deposit, stocks, bonds or trust fund accounts dated no earlier than the previous tax year.

NOTE: If applicant or applicable household member has a legal payee, all income and resource verification documents must be obtained from the payee and attached to completed MHDS application.

CONSENT TO OBTAIN AND RELEASE INFORMATION

Sioux Rivers Regional MHDS

Authorization for Use or Disclosure of Protected Health Information

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

Authorization Section:

Name of Client:		
Date of Birth:	SS#:	Medical Record#:
Daytime Phone #:	Evening Phone #:	
City:	State:	Zip Code:

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above-named client, with the following provider or agency:

____

Name of Person or Agency

____

Complete Mailing Address

Information to be released, obtained and/or shared may include:

☐ Psychiatric Evaluation/Assessment/Admit Report	☐ Individual Comprehensive Plan
☐ Social History	☐ Agency participation, plans, and progress reports
☐ Psychiatric History	☐ Financial Information
☐ Medical record information (including diagnosis information, medications, allergies, and medical history)	
☐ Psychological Evaluation/Report	☐ Face Sheet
☐ Discharge Summaries	
☐ Other (Please specify):	

Information being released will be used for the following purpose:

- o Coordination of Treatment
- o Continuation of Care
- o Determination of Benefit eligibility
- o Referral for New Services
- o Monitoring of Services
- o Other (Please specify):____________________________

I understand this information shall be kept confidential and shall be used for the delivery of my services. I understand that I have a right to see this information at any time. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

☐ Substance Abuse (including alcohol/drug abuse)
☐ Mental Health (other than Psychotherapy Notes)
☐ HIV related information (including AIDS related testing)

X ________________________________ ________________

Signature of Client/Parent/Legal Guardian — Date

This authorization shall expire on:_________

I understand that I may revoke my consent to this release at any time by providing written notification to:

Sioux Rivers-Dickinson/O'Brien Co.
1802 Hill Ave, Ste. 2502
Spirit Lake, IA 51360
Phone: 712-336-0775

Sioux Rivers-Lyon County
315 First Ave., #200
Rock Rapids, IA 51246
Phone: 712-472-8240

Sioux Rivers-Plymouth Co.
19 2nd Ave. NW
LeMars, IA 51031
Phone: 712-546-4352

Sioux Rivers Sioux County
210 Central Ave., SW, Box 233
Orange City, IA 51041
Phone: 712-737-2999

Authorization for the Use or Disclosure of Confidential Information

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 35B, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: ______________________ Date of Birth: ______________ Client #: ____________

Address: ____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, law enforcement agencies, and community non-profit agencies providing financial assistance (a list of the current affiliated case management entities, law enforcement agencies, community non-profit agencies providing financial assistance and other providers is available upon request), **with the exception of the following Iowa counties, Regions or other entities:** ________________________________.

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

Information to be disclosed includes:	**For the following purposes:**
To law enforcement agencies, providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, and/or community non-profit agencies providing financial assistance: Care Team information, Address type, Insurance information, Events, All applications, Employment information, Resources and Income, and Name of person and entity that entered your information. **This does not include any information related to HIV/AIDS related testing, mental health, or substance use disorder treatment information.**	In keeping with national, state and local efforts to enhance care coordination, parties will access/disclose records for the purposes of: coordinating treatment/care, determining benefit eligibility, obtaining authorizations, jail based service coordination, coordinating the funding for services and other benefits available to you, and assisting with state and federal reporting requirements.
To Iowa counties and Regions listed on Exhibit A and/or case management agencies: Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance and county commissions of veteran affairs described in Iowa Code § 252.25 and § 35B.10.	Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations, jail based service coordination, funding for services and abiding by state and federal reporting requirements.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I hereby specifically authorize the release and sharing of information with Iowa Counties and Regions listed on Exhibit A and/or case management agencies, relating to: (check any that apply)
NOTE: This authorization for release of information does not authorize the release and/or sharing of information relating to substance use disorder treatment.

☒ HIV/AIDS Related Testing Information

☒ Mental Health Information (**NOTE:** This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information).

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:
☐ _____/_____/_____ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to the Entity at the address listed at the top of this form, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed: ______________________________ Date: ______________________

Print Name: __________________________ Telephone: __________________

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client
☐ guardian or conservator of a client (if and to the extent authorized under State law)
☐ personal representative of deceased client
☐ other (specify) ______________________

Copy sent to Client/Guardian on: ________________ (date) at following address: ______________________

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE

Notice to Recipients of Mental Health Information: In accordance with Iowa Code Chapter 228, a recipient of mental health information may further disclose this information *only* with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Notice to Recipients of HIV-Related Testing Information: This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code Chapter 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

Iowa Counties:	Floyd	Monroe	Iowa Mental Health and Disability Services Regions:
Adair	Franklin	Montgomery	Central Iowa Community Services
Adams	Fremont	Muscatine	County Rural Offices of Social Services
Allamakee	Greene	O'Brien	County Social Services
Appanoose	Grundy	Osceola	Eastern Iowa MHDS
Audubon	Guthrie	Page	Heart of Iowa
Benton	Hamilton	Palo Alto	MHDS of the East Central Region
Black Hawk	Hancock	Plymouth	North West Iowa Care Connection
Boone	Hardin	Pocahontas	Polk County Health Services
Bremer	Harrison	Polk	Rolling Hills Community Services
Buchanan	Henry	Pottawattamie	Sioux Rivers MHDS
Buena Vista	Howard	Poweshiek	South Central Behavioral Health
Butler	Humboldt	Ringgold	Southeast Iowa Link
Calhoun	Ida	Sac	Southern Hills Regional Mental Health
Carroll	Iowa	Scott	Southwest Iowa MHDS
Cass	Jackson	Shelby	
Cedar	Jasper	Sioux	
Cerro Gordo	Jefferson	Story	
Cherokee	Johnson	Tama	
Chickasaw	Jones	Taylor	
Clarke	Keokuk	Union	
Clay	Kossuth	Van Buren	
Clayton	Lee	Wapello	
Clinton	Linn	Warren	
Crawford	Louisa	Washington	
Dallas	Lucas	Wayne	
Davis	Lyon	Webster	
Decatur	Madison	Winnebago	
Delaware	Mahaska	Winneshiek	
Des Moines	Marion	Woodbury	
Dickinson	Marshall	Worth	
Dubuque	Mills	Wright	
Emmet	Mitchell		
Fayette	Monona		

REVOCATION SECTION

I hereby revoke this Authorization.

Signed:______________________________ Date:______________________

Copy sent to Client/Guardian on: __________________ (date) at following address: ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE FOR HEALTH CARE PROVIDERS

I, ____, do hereby acknowledge receipt of a copy of Sioux Rivers MHDS Region Notice of Privacy Practice.

____ ___________________

Signature of Individual: Date:

NOTICE IS RECEIVED BY THE INDIVDIUAL'S PERSONAL REPRESENTATIVE/GUARDIAN

____ ___________________

Signature of Personal Representative: Date:

____

Legal Authority of Personal Representative

Authorization for the Use or Disclosure of Confidential Information

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

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As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 35B, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: ______________________ Date of Birth: ______________ Client #: ____________

Address: ____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, law enforcement agencies, and community non-profit agencies providing financial assistance (a list of the current affiliated case management entities, law enforcement agencies, community non-profit agencies providing financial assistance and other providers is available upon request), **with the exception of the following Iowa counties, Regions or other entities: ________________________________.**

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

Information to be disclosed includes:	**For the following purposes:**
To law enforcement agencies, providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, and/or community non-profit agencies providing financial assistance: Care Team information, Address type, Insurance information, Events, All applications, Employment information, Resources and Income, and Name of person and entity that entered your information. **This does not include any information related to HIV/AIDS related testing, mental health, or substance use disorder treatment information.**	In keeping with national, state and local efforts to enhance care coordination, parties will access/disclose records for the purposes of: coordinating treatment/care, determining benefit eligibility, obtaining authorizations, jail based service coordination, coordinating the funding for services and other benefits available to you, and assisting with state and federal reporting requirements.
To Iowa counties and Regions listed on Exhibit A and/or case management agencies: Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management Information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance and county commissions of veteran affairs described in Iowa Code § 252.25 and § 35B.10.	Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations, jail based service coordination, funding for services and abiding by state and federal reporting requirements.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I hereby specifically authorize the release and sharing of information with Iowa Counties and Regions listed on Exhibit A and/or case management agencies, relating to: (check any that apply)
NOTE: This authorization for release of information does not authorize the release and/or sharing of information relating to substance use disorder treatment.

☐ HIV/AIDS Related Testing Information

☐Mental Health Information (**NOTE**: This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information).

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:
☐ _____/____/_____ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to the Entity at the address listed at the top of this form, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed:______________________ Date:________________

Print Name:______________________ Telephone:______________

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client
☐ guardian or conservator of a client (if and to the extent authorized under State law)
☐ personal representative of deceased client
☐ other (specify) ____________________

Copy sent to Client/Guardian on: ______________ (date) at following address: ______________________

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE

Notice to Recipients of Mental Health Information: In accordance with Iowa Code Chapter 228, a recipient of mental health information may further disclose this information *only* with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Notice to Recipients of HIV-Related Testing Information: This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code Chapter 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

Iowa Counties:	Floyd	Monroe	Iowa Mental Health and Disability Services Regions:
Adair	Franklin	Montgomery	Care Connections of Northwest Iowa
Adams	Fremont	Muscatine	Central Iowa Community Services
Allamakee	Greene	O'Brien	County Rural Offices of Social Services
Appanoose	Grundy	Osceola	County Social Services
Audubon	Guthrie	Page	Eastern Iowa MHDS
Benton	Hamilton	Palo Alto	Heart of Iowa
Black Hawk	Hancock	Plymouth	MHDS of the East Central Region
Boone	Hardin	Pocahontas	Polk County Behavioral Health and Disability Services
Bremer	Harrison	Polk	Rolling Hills Community Services
Buchanan	Henry	Pottawattamie	Sioux Rivers MHDS
Buena Vista	Howard	Poweshiek	South Central Behavioral Health
Butler	Humboldt	Ringgold	Southeast Iowa Link
Calhoun	Ida	Sac	Southern Hills Regional Mental Health
Carroll	Iowa	Scott	Southwest Iowa MHDS
Cass	Jackson	Shelby	
Cedar	Jasper	Sioux	
Cerro Gordo	Jefferson	Story	
Cherokee	Johnson	Tama	
Chickasaw	Jones	Taylor	
Clarke	Keokuk	Union	
Clay	Kossuth	Van Buren	
Clayton	Lee	Wapello	
Clinton	Linn	Warren	
Crawford	Louisa	Washington	
Dallas	Lucas	Wayne	
Davis	Lyon	Webster	
Decatur	Madison	Winnebago	
Delaware	Mahaska	Winneshiek	
Des Moines	Marion	Woodbury	
Dickinson	Marshall	Worth	
Dubuque	Mills	Wright	
Emmet	Mitchell		
Fayette	Monona		

REVOCATION SECTION

I hereby revoke this Authorization.

Signed:_______________________________________ Date:____________________________

Copy sent to Client/Guardian on: _______________________ (date) at following address: ___________________________________

SIOUX RIVERS MHDS REGION NOTICE OF PRIVACY PRACTICES

November 1, 2022

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.

If you have any questions about this notice, please contact Brenna Koedam, LMHC IADC, Sioux Rivers MHDS Regional Chief Executive Officer at:

211 Central Ave SE
Orange City, IA 51041
(C): 712-209-9979
brennak@siouxcounty.org

Sioux Rivers MHDS Region is required by law to maintain the privacy of your health information and to provide you with this notice of their legal duties and privacy practices with respect to your health information and to notify you following a breach of unsecured health information. This notice is being issued to comply with the requirements of the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA Privacy Rules)

WHO IS THIS NOTICE FOR AND WHAT IS THE PURPOSE OF THIS NOTICE?

This notice is for participants enrolled in services covered by the Sioux Rivers MHDS Regional Management Plan, a legal entity formed by a 28E Agreement between Plymouth, Sioux, Lyon, O'Brien, Dickinson, and Emmet Counties.

For the purpose of this notice, your health (or medical) information (PHI) is information that identifies you and relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present, or future payment for health care furnished to you. It includes genetic information as defined under Title I of the Genetic Information Nondiscrimination Act of 2008.

The following plan is covered by this notice (collectively the "Plans"):

- Sioux Rivers Mental Health and Disability Services Regional Management Plan

The term "we", "our", or "us" in this notice refers to the Plans listed above and may include selected employees of the participating counties, who conduct plan administration functions. The term "you" or "your" refers to employees and dependents who participate in a health plan covered by this notice.

Insurers of health plans are obligated to send a notice of privacy practice under the HIPAA Privacy Rules, you may also receive a privacy notice from an insurer our region's liability insurance provider. The insurer's notice will apply only to the plan it insures. This notice will apply for the self-funded health plans sponsored listed above.

The regional management plan sponsored by Sioux Rivers MHDS is part of an organized health care arrangement. This means that these health plans may share your personal health information (PHI) with each other as needed for the purposes of payment and health care operations, as described in this notice.

The employees of the Sioux Rivers MHDS Region and employees of the participating counties of the 28E Agreement administer the Plan. Certain employees of the participating counties of the 28E Agreement perform administrative services for the Plan. When these employees perform plan administration functions on behalf of the Plan, they keep your PHI separate and do not share it with other employees within the Sioux Rivers MHDS Region or participating counties unless permitted by the HIPAA Privacy Rules.

HOW MAY YOUR HEALTH INFORMATION (PHI) BE USED OR DISCLOSED?

The following categories describe the different ways your PHI may be used or disclosed. Each permitted use or disclosure falls within one of these categories. However, not every specific use or disclosure permitted in each category is described.

Payment: Your PHI will be used for payment purposes. Payment includes, among other things:

- Paying claims from providers for any covered treatment and services provided to you
- Determining disputed claims, eligibility for benefits, coordination of benefits, and cost sharing arrangements
- Asserting our right to subrogation and reimbursement
- Examining medical necessity
- Obtaining payment under stop loss insurance
- Conducting utilization review

*We may not however use or disclose any PHI that is genetic information for underwriting purposes. Substance Use Disorder information may also be further protected by Federal Substance Abuse Confidentiality requirements CFR-42 Part 2.

Health Care Operations: Your PHI may be used to operate and administer the Plan. These operations include, among other things:

- Engaging in care coordination
- Case management
- Disease management
- Risk assessment
- Premium determination
- Audit functions
- Detection of fraud and abuse
- Quality assessments
- Improvement activities

* We may not however use or disclose any PHI that is genetic information for underwriting purposes. Substance Use Disorder information may also be further protected by Federal Substance Abuse Confidentiality requirements CFR-42 Part 2.

Treatment: Your PHI may be disclosed to health care providers (doctors, nurses, technicians, dentists, pharmacists, hospitals, and other individuals who are involved in your care) in connection with your treatment.

Plan Sponsor: Your PHI may be disclosed to our used by Sioux Rivers MHDS, as Plan Sponsor, for the purpose of conducting plan administration functions, as permitted by the HIPAA Privacy Rules. Sioux Rivers MHDS will not, however, use or disclose your PHI created by or received from the Plan for any employment related functions, without your authorization.

Business Associates: Auditors, attorneys, consultants and the like ("business associates") will be hired to assist in operating and administering the Plan. Our business associates may use or disclose your PHI to perform the services for which they have been hired. To protect your PHI, each business associate must sign a contract limiting its ability to use and disclose PHI and requiring it to implement appropriate safeguards.

Communication with You and Your Family: Generally, Sioux Rivers MHDS will not discuss your PHI with your family members without a specific signed authorization, unless it relates to a basic eligibility or enrollment questions. Unless you object, Sioux Rivers MHDS may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only health information relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, Sioux Rivers MHDS will exercise professional judgement to determine whether a disclosure of this type is in your best interest.

Health Education: Your PHI may be used to inform you about treatment alternatives or other health related benefits and services that may be of interest to you.

Judicial or Administrative Proceedings: Your PHI may be disclosed in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received.

As Required by Law: Your PHI may be disclosed if such disclosure is required by law (e.g., to federal governmental agencies, such as Department of Health and Human Services for the purpose of determining compliance with HIPAA Privacy Rules).

Public Health Activities: Your PHI may be disclosed to public health or other appropriate authorities to lessen a serious and imminent threat to the health or safety of you or the public, including abuse of a vulnerable adult or child, subject to certain limitations and conditions.

Parents of Minors: PHI of a minor child, in most cases will be disclosed to a parent or guardian of that minor, subject to certain limitations imposed by State or Federal laws.

Workers' Compensation: Your PHI may be used to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Other Permitted Uses and Disclosures: Your PHI also may be disclosed to prevent abuse, neglect, or domestic violence; for health oversight activities; for the purpose of conducting research; for law enforcement purposes; to coroners, medical examiners, or funeral directors; for purposes of organ donations; to avert a serious threat to health or safety and/or for specialized governmental functions.

Your Authorization: To use or disclose your PHI for reasons other than the categories listed above, we must obtain a signed written authorization from you. You may authorize, in writing, the use or disclosure of your PHI to any person and for any purpose specified in the authorization. You may revoke such authorization in writing at any time, but your revocation will not impact any uses or disclosures that occurred while your authorization was in effect. In certain instances, your services with Sioux Rivers MHDS may be conditioned on you signing and not revoking an authorization.

WHAT ARE YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION (PHI)?

This section describes your rights regarding your PHI. All requests relating to any of the rights described in this section must be made in writing and must be submitted as follows:

For Sioux Rivers MHDS Region, submit requests to:

Sioux Rivers MHDS Region
Privacy Officer
Brenna Koedam, LMHC IADC, Chief Executive Officer
211 Central Ave SE
Orange City, IA 51041
Phone: (712) 209-9979
brennak@siouxcounty.org

Right to Access: You may request to inspect and copy your PHI. If you request a copy, we may charge a fee for the costs of copying, mailing or associated supplies. You will receive written notification if your request is denied. If your PHI is maintained electronically, you have a right to obtain a copy of it in an electronic format. We will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to determine a mutually agreeable form and format. If we cannot agree on an electronic form and format, you will receive a paper copy. You may also choose to have your PHI transmitted directly to an entity or person you clearly designate.

Right to Amend: If your PHI is incorrect or incomplete, you may request that it be amended. Your request must include a reason supporting the amendment. You will receive written notification if your request is denied. If your request is denied, you have the right to submit a written statement disagreeing with the denial, which will be appended to the PHI in question.

Right to an Accounting of Disclosures: You may request a list of the disclosures of your PHI, if any, that have been made other than disclosures made to you or authorized by you for payment or health care operations. Your request must state a time period for which the accounting of disclosures will provided, not to exceed the preceding six years from the date of the request. If you request a list more than once in a 12-month period, you may be charged a reasonable cost-based fee. You will be notified of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions: You may request a restriction of the PHI that is disclosed about you to your family members, or for purposes of payment or health care operations. Generally, the Plan is not required to agree to such a restriction. If we do agree to the request, but we were not required to do so, we will abide by your restriction unless we need to use your PHI to provide emergency treatment. In addition, we may generally elect to terminate the restriction at any time.

A covered entity (such as a health care provider) must comply with a requested restriction if the disclosure is to a health plan for purposes of payment or health care operations and the PHI relates to a health care item or service for which an individual paid in full out of pocket. For example, if you receive medical care and choose to pay the provider for the entire amount of care in full out of pocket, you can request that the provider not disclose such information to the Plans and the provider must agree to such request.

Right to Request Confidential Communications: If disclosure of your PHI could endanger you, you may request that communication with you about health matters occur by alternative means or at an alternative location. For example, you may request that you only be contacted at work or by mail. Your request must include a statement that use, or disclosure may endanger you and specify how or where you wish to be contacted.

Right to Notification of Breach: You have a right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breech" as defined by the HIPAA Privacy Rules.

Right to a Paper Copy of this Notice: You may request a paper copy of this notice at any time by contacting:

Sioux Rivers MSDS Regional Chief Executive Officer
Brenna Koedam, LMHC IADC
211 Central Ave SE
Orange City, IA 51041
Phone: (712) 209-9979
brennak@siouxcounty.org
OR

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Ave. S.W.
Room 509 F HHH Building
Washington, D.C. 20201

This notice becomes effective January 1, 2023 and will remain in effect until we replace it. The Plans are required by law to abide by the terms of this Notice, as may be amended from time to time. We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future.

Appeals Process

How to Appeal a Decision of the MHDS Coordinator (IAC 441-25.21(1))

If the MHS Coordination office makes a decision adverse to you, you may appeal that decision. Adverse decisions may include decisions involving eligibility determinations, funding and/or service levels, placements on waiting list for services. The MHDS Coordinator makes initial decisions regarding eligibility for services and whether a person may be placed on a wait list for the requested service. These Notices of Decision shall be in writing and shall explain the reasons for the decision. If a decision is subject to appeal, the Notice of Decision will tell you that you have a right to appeal, and how to file your appeal.

Step One: Filing your Appeal

Applicants/consumers or their representatives (with consent of the consumer) may appeal an adverse decision by the MHDS Coordinator. The appeal must be in writing and must be filed with the MHDS Coordination office within fifteen (15) business days of the date of the decision. If the appeal is filed late, it cannot be considered. The appeal shall state: (1) the reasons why the MHDS Coordinator's decision should be reversed; (2) the relief requested; (3) your name, address, and telephone number and the name, address, and telephone number of your representative if you have one.

Step Two: Discussing the Problem

After the appeal is filed, the MHDS Coordinator will contact you to schedule a meeting to discuss your appeal. This meeting must be held within 10 business days, unless the parties agree to extend the time to meet. You may bring someone with you to the meeting to help you explain your position. You and the MHDS Coordinator may ask another person to serve as a mediator. At the meeting, the MHDS Coordinator will explain his or her reason for the decision. You may ask questions or give the MHDS Coordinator other information you think is important. You must tell the MHDS Coordinator what you want to happen (a proposed resolution). If you and the MHDS Coordinator reach an agreement, the MHDS Coordinator will issue a revised Notice of Decision within 10 business days. At the end of the meeting, you and the MHDS Coordinator will sign a status form, indicating whether there is a resolution or whether the appeal will continue. A revised Notice of Decision will be issued.

Step Three: The Appeal

If the parties are unable to resolve the problem at the meeting, within 10 business days of the date of the meeting, the MHDS Coordinator will contact an Administrative Law Judge at the Department of Inspections and Appeals (Iowa Code § 10A.801 - Judge). The MHDS Coordinator shall arrange for payment of the cost of the Judge. The Judge will set a pre-hearing conference to discuss hearing procedures and set a time for the hearing. The Judge will provide written notice of the pre-hearing conference, and the hearing. You, the applicant, have the right to present evidence and argument at the hearing. The Judge will consider the evidence, and will issue a written ruling. The decision of the Judge is final.

You may contact another person to assist you with your appeal. This could be an attorney, an organizational representative, or a friend. The MHDS Coordinator will not provide you with legal assistance. Two places that may provide legal assistance include:

- Legal Aid: 1-800-532-1275
- Iowa Protection and Advocacy: 1-800-779-2502