

**KINGS VIEW****MESSAGE TO CONSUMERS:**

Please be advised that this packet is intended to guide you during your over-the-phone screening and assessment with Kings View staff.

There is no need to fill this packet out as it will be for your reference only.

To enroll in services via phone, please call:

(559) 582-4481

Please note the days and times for screenings are:

MONDAY 8:00 AM – 2:00 PM

TUESDAY 8:00 AM – 2:00 PM

WEDNESDAY 8:00 AM – 2:00 PM

THURSDAY 8:00 AM – 2:00 PM

FRIDAY 8:00 AM – 2:00 PM

For an Online Version of the Consumer Packet please visit our website at: <https://www.kingsview.org/services/mental-health/>

KINGS COUNTY
Distribution of Mental Health Plan (MHP) Informing Materials

2 of 45

Name of Client: _____

EHR #: _____

DOB: _____

Date: _____

Beneficiary Preferred Language: _____

Were Materials given/offered in the beneficiary preferred language: _____

Material must be given/offered in preferred language. Where material is not available in preferred language, use on-site interpreter or your entities interpretation services such as Language Line to interpret.

		Informing Materials Provided
Staff Initial	Client Initial	
<i>The following materials are given at intake to all individuals.</i>		
		Notice of Privacy Practices - Tells you how Kings County Behavioral Health and its Providers/Contractors may use or disclose information about your physical and/or mental health. The county is required by federal law to give you this notice.
		Health Information Exchange Participation - Tells you how your health information may be shared with hospitals, behavioral health providers, county health programs, physicians, social workers, and other HIE participants who may provide health or behavioral health services to you.
		Beneficiary Rights - Provides you with information of your right to receive medically necessary specialty mental health services from the MHP.
		Consent to Treat - Outlines the expectations regarding the treatment you may receive. It also explains that the risks, benefits, and alternatives to treatment have been explained to you.
		Taglines and Auxiliary Aides - Assists you in identifying the language that you may need services provided in by way of either on-site bilingual or interpreter services, telephonic interpreter services via a language line, or through an auxiliary aid.
		Non- Discrimination Notice - Informs you that Kings County MHP follows the federal civil rights law, and provides information on how you can file a complaint if you believe you've been discriminated against.
		Grievance and Appeal Form and Procedure - Helps you file a complaint about your services if you need to at some point. The procedure tells you how to file the complaint.
<i>The following materials are given at intake to all individuals accessing child/youth services.</i>		
		Early & Periodic Screening Diagnosis Treatment (EPSDT) Mental Health Services - Explains the Medi-Cal EPSDT services for children and young adults and their caregivers or guardians.

		Therapeutic Behavioral Services (TBS) Information Brochure – Summarizes TBS services that are available to children/youth with serious emotional challenges who may need a supplemental service to their to their mental health services.
		Foster Child Mental Health Bill of Rights - Provides information to the foster child/youth of their rights to receive mental health services.

The following materials are offered to all individuals at intake, and given upon request. A copy of each must also be maintained in the lobby for public use.

		Kings County Behavioral Health MHP “Guide to Medi-Cal Mental Health Services” - Contains information eligibility for specialty mental health services through Medi-Cal, as well as how to access those services, what services are available, what your rights and responsibilities are, and how to file a grievance, appeal, or file for a state fair hearing. <i>This document is over 50 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/</i>
		Medi-Cal Beneficiary Handbook – Kings County – Explains your Medi-Cal specialty mental health services benefits, can answer many of your questions related to services, and contains important phone numbers and information related to Kings County MHP. <i>This document is over 50 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/</i>
		MHP Provider List – Kings County – Contains a list of licensed, registered, and waived clinical providers who are employed by or contracted by the MHP to provide mental health services through Medi-Cal for Kings County residents who meet medical necessity. <i>This document is over 20 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/</i>

The following materials are offered to all 18 years of age and older, at intake, and given upon request.

		Advance Health Care Directive Brochure - Explains your right to make decisions about your medical treatment. It includes how to appoint a person who can make health care decisions for you when you are unable (Health Care Agent), and how to change your directive at any time.
		Do you already have an Advance Health Care Directive or a Durable Power of Attorney for Health Care? Yes No
		If yes, will you provide a copy for our medical record? Yes No

Staff Signature upon Completion: _____ **Date:** _____

Beneficiary Signature upon Completion: _____ **Date:** _____

Instructions:

1. Give client a copy
2. Scan original into the EHR under attachments (title “Informing Materials”)
3. Once scanned, this may be shredded

Legend:

 Screener Completes
 Admissions Completes

INDEX CARD - ALL CAPS			
Client #:			
Sort Name:			
Last,		First	Middle
Legal Name:			
*Last Name:		*First Name:	
Middle:		Suffix:	
*DOB:		Soc Sec #:	
CLIENT IDENTIFYING INFORMATION - use sentence case			
Effective Date:		Admission Status: <input type="radio"/> Admit <input type="radio"/> Pre-Register	
*(6) Referral Source: Circle One		Referral Phone:	
(1) Self		(11) Hospital	(28) Primary Care Provider
(2) Family		(13) Jail	(29) School/College
(3) Friends		(21) Homeless Program	(33) MHSA
(4) Employer		(24) Convalescent Hospital / SNF	(34) CALWORKS
(5) Other		(25) DSS	(41) CPS
(9) Psych Hospital		(26) Probation	(42) Parole
		(27) Outside AOD	(99) Unknown/Not Reported
*Birth Name (if different from above):			
Last Name:		First Name:	
Middle:		Suffix:	
*Physical Address:		Apt. #:	
*City/State/Zip:		*(21) County:	
*Home Phone:		Work Phone:	Ext.
Cell Phone:			
*Mailing Address:		Apt. #:	
*City/State/Zip:			
*Driver's License: <input type="radio"/> Yes <input type="radio"/> No		DL No.:	State:
*Social Security #: (If SSN not entered above)		(8) Reason SSN Not Provided: (*If SSN blank)	
*(7) Gender: Circle One (F) Female (M) Male (O) Other (T) Transgender			*Is DOB: <input type="radio"/> Actual? <input type="radio"/> Estimated?
Born in US: <input type="radio"/> Yes <input type="radio"/> No			
Born in California: <input type="radio"/> Yes <input type="radio"/> No			
Place of Birth:	*(21) County:	*(22) State:	(23) Country:
*Mother's First Name			
*(9) Marital Status: Circle One (D) Divorced/Annulled (M) Married (N) Never Married (P) Domestic Partner (S) Separated (W) Widowed (U) Unknown			
*(10) Ethnicity: Circle One (1) Not Hispanic (3) Cuban (5) Other Hispanic / Latino (2) Mexican / Mexican American (4) Puerto Rican (7) Unknown / Not Reported			

*(11) Race: Circle One			
(3) Mien	(F) Filipino	(N) Native American	(V) Vietnamese
(4) Other Pacific Islander	(G) Guamanian	(O) non-White – Other	(W) White
(A) Asian – Other	(H) Hawaiian Native	(P) Laotian	(Y) Hmong
(B) Black / African American	(I) Cambodian	(Q) SE Asian – Other	(U) Unknown / Not Reported
(C) Chinese	(J) Japanese	(R) Samoan	
(D) Asian Indian	(K) Korean	(T) Eskimo / Alaskan Native	
*(12) Primary Language: Circle One			
(1) American Sign	(C) Chinese Dialect	(K) Korean	(S) Spanish
(2) Other Sign	(D) Cambodian	(L) Lao	(T) Turkish
(3) Samoan	(E) English	(M) Mien	(V) Vietnamese
(4) Other Chinese	(F) French	(N) Thai	(W) Filipino Dialect
(5) Tagalog	(G) Cantonese	(O) Other non-English	(X) Hmong
(6) Mandarin	(H) Hebrew	(P) Polish	(Y) Ilocano
(A) Armenian	(I) Italian	(Q) Farsai	(Z) Portuguese
(B) Arabic	(J) Japanese	(R) Russian	(U) Unknown / Not Reported
*(13) Communication Method: Circle One			
(C) Communication Device	(S) Sign Language	(V) Verbal	
(H) Translator – Hmong	(T) Translator – Spanish	(X) Translator - Other	
*(12) Language Preferred (Individual): Indicate Code (from prim lang above) _____			
**(12) Language Preferred (Caretaker): Indicate Code (from prim lang above) _____			
*Interpreter Needed? <input type="radio"/> Yes <input type="radio"/> No			
*(14) Employment Status: Circle One			
(1) Comp Job 35+ hours/week	(8) Full Time Student	(F) Not in labor Force	
(2) Comp Job <20 hours/week/	(9) Job Training	(H) Resident / Inmate	
(3) Comp Job 20-35 hours/week	(A) PT School / Job Training	(I) Non-Comp Job 35+ hours/week	
(4) Homemaker	(B) Volunteer	(J) non-Comp Job < 35 hours/week	
(5) Rehab 35+ hours/week	(C) Unemployed, seeking work	(K) Other	
(6) Rehab < 20 hours/week	(D) Unemployed, not seeking work	(U) Unknown / Not Reported	
(7) Rehab 20-35 hours per week	(E) Retired		
*(15) Living Arrangement: Circle One			
(01) Family	(13) House or Apt w/ Supervision	(25) Temporary Assignment	
(02) Alone	(14) Supported Housing	(26) Homeless – In transit	
(03) Foster Home – Child	(15) Residential Treatment Center	(27) SNF / ICF / IMD for psych	
(04) SRO – hotel, motel, rooming house	(16) Comm. Treatment Facility	(28) Medical Facility – Hospital	
(05) GP Quarters – dorm, brks, mig camp	(17) Adult Residential / Social Rehab	(29) Correctional Facility – Adult	
(06) Group Home	(18) State Hospital	(30) Correctional Facility – Minor	
(07) CRTS L/T trn house	(19) VA Hospital	(31) Homeless – no county res	
(08) Satellite Housing	(20) SNF / ICF / NH Physical Health	(32) Other Institution	
(09) Alt Hospital 6 beds or less	(21) MH Rehab Center	(33) Friend / Other	
(10) Alt Hospital 7 beds or more	(22) PHF / Inpatient Psychiatric	(34) Board & Care	
(11) House or Apartment	(23) Sober Living	(99) Other	
(12) House or Apt w/ Support	(24) Specialty Transitional	(98) Unknown / Not Reported	
*Number of Children under age 18 the client cares for/responsible for 50% or more of the time?			
*Number of Dependents age 18 or older the client cares for/responsible for 50% or more of the time?			
*(16) Education (highest grade completed):		Special Education: <input type="radio"/> Yes <input type="radio"/> No	
District of Residence:			
*(18) Disability: Circle One			
(D) Developmentally Disabled	(H) Hearing	(O) Other Disability (not AOD)	(V) Vision
(E) Mental Health	(M) Mobility	(S) Speech	(N) None
*Veteran: <input type="radio"/> Yes <input type="radio"/> No	Branch:		

Alias(es)/Maiden Name		
Last Name:	First:	Middle:

EMERGENCY NOTIFICATION INFORMATION

*Name:	*(17) Relationship: See page 4	
Address:	Home Phone:	
City/State/Zip:	Work Phone:	
Employment Place:		

LEGAL INFORMATION

*(24) Legal Consent: See page 4		
**Responsible Person:	**(17) Relationship: See page 4	
Address:	Phone:	
City/State/Zip:		
Employment Phone:	Employment Place:	
Responsible Party SSN:		

MEDICAL INFORMATION - okay to skip

Personal Physician:	Phone:	FAX:
Address:		
City/State/Zip:		
Pharmacy:	Phone:	FAX:
Hospital Preference:		

ADVANCE DIRECTIVE INFORMATION

Advance Directive Given? <input type="radio"/> Yes <input type="radio"/> No

CLIENT CONTACT INFORMATION

May we leave message at home? <input type="radio"/> Yes <input type="radio"/> No
May we leave message at work? <input type="radio"/> Yes <input type="radio"/> No
May we leave message via emergency contact? <input type="radio"/> Yes <input type="radio"/> No
May we leave message on your cell? <input type="radio"/> Yes <input type="radio"/> No
May we contact you by mail? <input type="radio"/> Yes <input type="radio"/> No
NPP Given? <input type="radio"/> Yes <input type="radio"/> No Form Signed Date:
BHA – Consent Form: <input type="radio"/> Yes <input type="radio"/> No Form Signed Date: Obtained By (Agency Name):
If we cannot contact you by mail, then what is an alternative address or method of contact to send you clinical information such as letters and billing information?

Signature of Staff Obtaining Information: who filled out the form						
*Staff ID	*Staff Name	*Date	*Time	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A
Signature of Staff Entering Information (If Different from Above):						
Staff ID	Staff Name	*Date	*Time	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A

Key: * = Required Field ** = Required if the 'Legal Status' selection is Adult with Guardian or Minor with Guardian

(17) Relationship Types		(24) Legal Consent (CSI – Conservatorship/Court Status)	
<u>ID</u>	<u>Description</u>	<u>ID</u>	<u>Description</u>
A	Aunt/Uncle	9	Not Applicable
B	Father	A	Temporary Conservatorship
C	Child	B	Lanterman-Petris-Short
D	Guardian	C	Murphy
E	Spouse	D	Probate
F	Foster Parent	E	PC 2974
G	Grandparent	F	Representative Payee w/out Conservatorship
H	Cousin	G	Juvenile Crt0 Dependent of Crt
I	Caretaker	H	Juvenile Crt, Ward Status Off
J	Sibling	I	Juvenile Crt, Ward Juv Off
L	Nephew/Niece	0	Unknown / Not Reported
M	Mother		
N	Friend		
O	Other Relation		
P	Self		
Q	Legal Representative		
S	Stepparent		
X	Domestic Partner		
R	Unknown / Not Reported		

KINGS VIEW



PRESCRIPTION DRUGS:

Please list prescriptions taken in last six (6) months

(Check here if NONE)

Drug-RX No., Name, Strength	Directions

Have you ever taken someone else's prescription medicine? No
 Yes. If yes, give the name of the drug and reason it was taken _____Have you ever taken any drug that made you sick? Yes No
If yes, explain _____Have you ever had side effects or undesirable effects from drugs you have taken? Yes No
Specify _____

NON-PRESCRIPTION DRUGS (Over The Counter):

Fill in the name of the drug(s) taken for following. Check the box which best describes frequency.

Problem	Name of Drug	Regular	Seldom	Never	Problem	Name of Drug	Regular	Seldom	Never
FOR COLDS & COUGHS					FOR INDIGESTION				
FOR ASTHMA					FOR SLEEP				
FOR CONSTIPATION					FOR SKIN PROBLEMS				
FOR DIARRHEA					FOR DIETING				
FOR HEADACHE/PAIN					FOR STAYING AWAKE				
FOR NERVOUSNESS/TENSION					VITAMINS/SUPPLEMENTS				
OTHER					HERBAL/HOMEOPATHIC				

ALLERGIES:

Are you allergic to:	No	Yes	If yes, name the specific substance(s) and describe reaction			
ANY DRUG?						
ANY FOOD?						
ANYTHING ELSE?						

HAVE YOU EVER HAD HAY FEVER ASTHMA HIVES ECZEMA?DOES ANY MEMBER OF YOUR FAMILY HAVE ALLERGIES? MOTHER FATHER SISTER BROTHER

DRINKING HABITS:

DO YOU DRINK	No	Yes	Regular	Seldom	HOW MUCH?
COFFEE					
TEA					
COKE/PEPSI					
BEER					
WINE					
LIQUOR					

ARE YOU ON A SPECIAL DIET?

 No Yes IF YES, DESCRIBE _____

SOCIAL/RECREATIONAL HABITS:

DO YOU, OR HAVE YOU EVER?	No	Yes	IF YES, IDENTIFY SPECIFIC SUBSTANCE, QUANTITY & FREQUENCY		
SMOKED CIGARETTES					
Smoked Marijuana					
Taken Hallucinogens: PCP or LSD					
Taken Downers: Sleepers or Valium					
Taken Uppers: Amphetamines, cocaine, meth, crank					
Taken Narcotics: Heroin, Codeine, Oxycodone, Vicodin					
Do you have reactions to any medications?					

Signature of Consumer: _____ Date: _____

(Parent or Guardian Signature if Consumer is a child or youth)

LAST NAME:	FIRST NAME:	CHART NO.
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DRUG AND ALLERGY HISTORY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR BEHAVIORAL HEALTH INFORMATION

MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review carefully.

❖ Our Pledge and Responsibilities

Kings View understands your behavioral health information and records are personal and private. We are strongly committed to safeguarding your confidential information, also known as **protected health information**. We create a medical record of your care and services at this agency to ensure high quality care and comply with certain legal requirements. This notice applies to your medical records and related financial information generated and maintained by your Kings View behavioral health service provider as well as any records we receive from your other health care providers.

We are required by federal and state law to:

- Keep your medical records and all your protected health information private and secure.
- Let you know promptly if a breach occurs that may compromise the privacy or security of your protected health information.
- Give you this notice of our legal duties and privacy practices with respect to your protected health information maintained about you.
- To follow the terms of the notice currently in effect.
- Not use or share your protected health information other than as described here unless you tell us we can in writing.

❖ Terms Used in This Notice

- **Authorization** is your written permission to disclose your protected health information to persons or agencies when authorization to disclose the information is legally required. Authorization forms must have all the HIPAA required elements to be valid.
- **Behavioral health services** are treatment, case management, community support, and other related services that address mental health and substance use conditions.
- **Disclosure** is when Kings View releases your protected health information to others outside the Kings View program serving you.
- **Protected health information** is individually identifiable health information – in any form (paper, electronic and verbal) – collected, created, or received by a Kings View behavioral health treatment program.
- **Use** means the work-related sharing and use of your protected health information by Kings View program staff.

❖ Included In This Notice

- Section 1: How Kings View may use and disclose your mental health information and records.
- Section 2: How Kings View may use and disclose your substance use disorder information and records.
- Section 3: Your legal privacy rights regarding access to your information and records maintained by Kings View.
- Section 4: How to get more information about our privacy practices or file a complaint if you believe Kings View has violated your privacy rights.

❖ Changes to This Notice

We reserve the right to change this notice and our privacy practices at any time. Changes will apply to any protected health information we already have and information we receive in the future. Each time you register for new services you will be offered a copy of the current notice. The current notice is posted in all our facilities, available upon request, and on our website www.kingsview.org.

Section 1: How We May Use and Disclose Your Mental Health Information & Records

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

- 1. At your Request.** When requested by you – or your legal representative – and with your written authorization, we may provide your protected health information to any person or entity you choose. For example, you may want us to disclose appointment or financial information to a family member who is involved in your care. Or you may ask us to send certain records to your attorney, a school, probation officer, disability insurance company, or employer.
- 2. Treatment.** We may use your protected health information to provide your mental health treatment including coordinating and managing your care – without your authorization. We may share your information among qualified professionals directly involved in your care. For example, our staff may discuss your care at a case conference. We may also disclose information about you to healthcare professionals outside our agency but only if they have direct responsibility for your medical or behavioral health treatment. For example, we may share information with your primary care physician regarding your medications or to coordinate your care. When you leave our care, we may also disclose information to your new provider. Or we can share limited information with emergency response personnel if you aren't able to speak for yourself.
- 3. Appointment Reminders.** We may use your protected health information to remind you of an appointment with your agreement using the contact information you provide. You may ask us not to remind you of your appointments.
- 4. For Payment.** We will use and disclose your protected health information to bill for the treatment and services you receive here and to collect payment from you, an insurance company, Medi-Cal, or other third party – without your authorization. For example, we may need to give your health plan information about treatment or counseling you received here so they will pay us for the services. We may also tell them about treatment or services we plan to provide in order to obtain prior approval or to determine whether your plan will cover the treatment.
- 5. For Health Care Operations.** We will use and disclose protected health information about you for our own operations. These uses and disclosures are necessary to administer the programs and make sure all our clients receive quality care. For example, we may use health information to review our treatment and services and evaluate the performance of the staff in caring for you. We may also disclose your information to our Business Associates who we've contracted to assist us with our operations and who've signed a confidentiality agreement.
- 6. As Required by Law.** We will disclose your protected health information when required to do so by federal, state, or local law. For example, if we reasonably suspect child, elder or dependent adult abuse or neglect, we are mandated by law to report it. We will make reasonable efforts to notify you in advance. Or your protected health information may need to be disclosed to the Department of Health and Human Services who may investigate to make sure that your privacy rights have not been violated.
- 7. Medical Emergency.** We may disclose your protected health information to emergency medical personnel at the scene of an emergency, in an emergency medical transport vehicle, or other professional person or emergency medical personnel in an emergency room.
- 8. Public Health Activities.** We may disclose your protected health information for public health activities generally including but not limited to:
 - Preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
 - Reporting adverse events or surveillance related to food, medications or defects or problems with products;
 - Notifying people of recalls, repairs, or replacements of products they may be using;
 - Notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- 9. Research.** We may use and disclose your protected health information if approved by an Institutional Review Board (IRB). An IRB is a committee responsible, under federal law, for reviewing and approving human subjects' research to protect the safety of the participants and confidentiality of their information.

- 10. Lawsuits and Other Legal Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your mental health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other legal procedure by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which includes written notice to you) or to obtain an order protecting the health information requested. We may disclose your information to courts, attorneys, and court employees in the course of conservatorship, writs, and certain other judicial or administrative proceedings.
- 11. Law Enforcement.** We may release your protected mental health information to law enforcement agencies:
 - If the police present a valid search warrant;
 - If the police present a valid court order;
 - To identify or locate a suspect, fugitive, material witness or missing person, if required or permitted by law;
 - To report your discharge if you were involuntarily detained after a peace officer initiated a 72-hour hold for psychiatric evaluation and requested notification;
 - To report criminal conduct at our facility or threats of such conduct against our staff or facility; or
 - For the protection of federal and state elected constitutional officers and their families.
- 12. Coroners, Medical Examiners and Funeral Directors.** We may be required by law to report your protected health information to a coroner, medical examiner, or funeral director to permit identification of a body, determine cause of death, or for other official duties.
- 13. Workers' Compensation.** We may use and disclose your mental health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.
- 14. Government Program for Public Benefits.** We may use or disclose your protected health information to help you qualify for government benefit programs such as Medicare, Medi-Cal, Supplemental Security Income, or other benefits or services.
- 15. Inmates.** If you are an inmate or ward in a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official if necessary to provide you with healthcare, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.
- 16. Department of Justice.** We may disclose limited information to the California Department of Justice for movement and identification purposes about certain criminal clients, or regarding persons who may not purchase, possess, or control a firearm or deadly weapon.
- 17. Multidisciplinary Teams.** We may disclose your protected health information to a multidisciplinary team relevant to the prevention, identification, management, or treatment of an abused child or an abused elder or dependent adult.
- 18. Breach Notification.** We will use and disclose your protected health information to tell you there has been unlawful access to your protected health information such as when someone not authorized to see your records looks at them or your information is accidentally lost or is stolen. We are also required to report breaches to state and federal authorities and may need to disclose your protected health information to do so. If this happens, we will notify you in writing.
- 19. Serious Threat to Health or Safety.** We may use and disclose information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.
- 20. Senate and Assembly Rules Committees.** We may disclose your protected health information to the Senate or Assembly Rules Committee for the purpose of legislative investigations.
- 21. Health Oversight Activities.** We may disclose protected health information 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.
- 22. Military and National Security.** We may use or disclose protected health information of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your records to authorized federal officials as necessary for national security and intelligence activities or for the protection of the president or other government official and dignitaries.
- 23. Marketing and Fund Raising.** We will never disclose your protected health information for marketing, fund raising, or sell your personal information.
- 24. Special Categories:** Special legal requirements may apply to the use or disclosure of certain categories of information such as tests for the human immunodeficiency virus (HIV) or treatment and services for substance use disorders (See Section 2: How we may

use and disclose your substance use disorder information)

25. Other Uses and Disclosures Requiring Your Authorization.

Other uses and disclosures of your protected health information not covered by this notice or the laws that apply to Kings View are made only with your authorization. You may revoke an authorization at any time with no explanation, by notifying your program's medical records department. We stop the processing of the authorization to the greatest extent possible immediately upon receipt of a revocation. However, we are unable to take back any disclosures already made with your permission.

Section 2: How We May Use and Disclose Your Substance Use Disorder Information and Records

Information and records maintained by Kings View's *specifically designated substance use disorder (SUD) programs* have additional and stricter privacy protections under federal law *Confidentiality of Alcohol and Drug Abuse Patient Records*. SUD information obtained during general medical or mental health treatment is not subject to these provisions. Examples of Kings View's SUD programs are:

- Medication-Assisted Treatment Services (Suboxone and Methadone)
- Outpatient SUD Counseling Services
- Court Ordered SUD Counseling Services.

Generally, SUD programs cannot tell any person outside the program you attend the program or disclose any information identifying you as having an alcohol or drug issue. All disclosures of your SUD information and records require your valid, written authorization – with the following limited **EXCEPTIONS**:

- 1. At Your Request.** When requested by you, or your legal representative, and with your written authorization, we may provide your SUD protected information to any person or entity you choose. For example, you may want us to disclose appointment or financial information to a family member who is involved in your care. Or you may ask us to send certain records to your attorney, a school, probation officer, disability insurance company, or employer.
- 2. Internal Program Communications.** Only the SUD program staff directly involved in providing or facilitating your treatment are permitted to use and share your SUD information. Staff not needing your information to perform their jobs do not have access to it. Your records may also be disclosed to Kings View's corporate staff who administer the SUD program such as the financial, quality improvement, and compliance departments.
- 3. Medical Emergencies.** Your protected information may be disclosed to medical personnel who need it to treat a condition which poses immediate medical danger to your health and requires immediate medical intervention. Limited information is disclosed but only if you are incapable of providing informed consent. Your SUD protected information cannot be shared with the police or non-medical personnel, including family members who may be at the scene. If you want the SUD program to notify family in the event of a medical emergency occurring at the program, you must complete an authorization form in advance authorizing the program to notify the persons named.
- 4. Court-Ordered Disclosures.** We will disclose your protected SUD information to the court if we are served with a judge-signed court requesting testimony and/or records. A subpoena, search warrant, or arrest warrant alone – even when signed by a judge – is not sufficient to permit us to make a disclosure. The court order must comply with the requirements of 42 CFR Part 2.
- 5. Crime on Program Premises or Against Program Personnel.** When a crime has been threatened or committed on the SUD Program's premises, we are permitted to report the crime to a law enforcement agency and/or to seek its assistance (call 911). Information regarding the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a client in the SUD program. We may report a suspected client to law enforcement if there are reasonable grounds to believe the person being reported did commit the crime. If a staff member is later asked to testify in a subsequent criminal proceeding against the client, the court must issue the proper order compelling the testimony as described in (4) above.
- 6. Suspected Child, Elder and Dependent Adult Abuse/Neglect.** We will report suspected child abuse or neglect to the appropriate local authorities as required by state law. However, after the initial report and written confirmation of that initial report is made no other client information is disclosed even if subpoenaed. Substance abuse by itself is not a condition we report as child abuse or neglect. We report only if there is some reason to suspect actual or imminent harm to the child. The law requires a balance between client confidentiality and child protection. We will tell you in advance if we make a child abuse report.

We are also legally mandated to report elderly and dependent adult neglect and abuse. However, federal law does not permit SUD programs to make these reports without your authorization. If elderly or dependent adult abuse is suspected, we'll first seek your authorization to make the report to the appropriate authorities. If we cannot obtain your authorization, we will make the mandated report without revealing you are a SUD program client or have a substance use disorder issue.

- 7. Program Audits and Evaluations.** We may disclose your SUD information to government agencies that fund or regulate the SUD program when they conduct audits. We may also disclose your information to peer review organizations that review utilization or quality control. The agency conducting the audit or evaluation must agree in writing it will not re-disclose your SUD information except: (1) back to the Kings View SUD program or (2) pursuant to a court order to investigate or prosecute the SUD program (not a client), or (3) to a government agency overseeing a Medicare or Medi-Cal audit or evaluation.
- 8. Qualified Service Organization.** We may disclose your SUD information to individuals or agencies we contract with to assist us in the administration of the SUD program. These contractors are called *Qualified Service Organizations* and provide data processing, electronic health records maintenance, and laboratory analyses as well as legal, accounting, and other professional services. In order for us to disclose protected SUD information about these contractors, we get a written agreement requiring their full compliance with federal law Confidentiality of Patient Drug and Alcohol Patient Records (42 C.F.R. Part 2).
- 9. Legitimate Research.** We may disclose your SUD information to conduct scientific research if the Kings View Chief Compliance and Privacy Officer determines the researcher is qualified to conduct the research. In addition, the researcher must produce a protocol showing numerous safeguards for keeping client information confidential and showing the rights and the welfare of clients are adequately protected. The research must show the benefits of the research outweigh the risks to client privacy. If we do decide to participate in a research project, we will notify you in advance and give you the choice to opt out.

Section 3: Your Privacy Rights

Listed here are your legal rights regarding your behavioral health information and records (mental health and substance use disorder). Medical Records staff at your program will assist you complete the required forms for requests 1-5.

- 1. Inspect and Copy Your Medical Records.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy of your records within 15 days of your written request and may charge a reasonable, cost-based fee.
- 2. Correct Your Medical Records.** You can ask us to correct information you think is factually incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- 3. Confidential Communications.** You may request we communicate with you in a specific way to protect your privacy. For example, you may request that we call you only at your work number or send mail to a special address. We will accommodate all reasonable requests.
- 4. Limit Use and Disclosure.** You can ask us not to use or disclose certain health information for treatment, payment, or our operations. We are not required to agree and may say "no" if it would affect the quality of your care. If you pay for a service out-of-pocket in full, you can ask us not to share that information for the purpose of payment with your health insurer. We will say "yes" to your requests unless a law requires us to disclose that information.
- 5. Accounting of Disclosures.** You can ask for a list (accounting) of the times we disclosed your protected health information for the prior six years from the date you ask, who we disclosed it to, and why.
- 6. Copy of Notice of Privacy Practices.** You can ask your service provider for a paper copy of this notice at any time – even if you agreed to receive it electronically. You may also get the notice from the Kings View website: www.kingsview.org
- 7. Legal Representative.** If you have given someone medical power of attorney, or you have a legal guardian, that person can exercise all your privacy rights on your behalf and make choices about your protected health information. We'll make sure that person has this authority and can act for you before we take any action.

Section 4: Questions and How To Make A Privacy Complaint

Please contact the Kings View Chief Compliance and Privacy Officer if you want more information or have questions about our privacy practices.

If you feel your privacy rights have been violated, you have the right – and we encourage you – to file a complaint. We would appreciate the opportunity to resolve your concern, but you may file a complaint directly with the Secretary of the U.S. Department of Health and Human Services.

➤ For more information or to file a privacy complaint with Kings View, contact:

Kings View

Attention: Chief Compliance and Privacy Officer 1396 W. Herndon Avenue
Fresno, CA 93711

Phone: (559) 256-1080

Email: CompliancePrivacyOfficer@kingsview.org
www.kingsview.org/contact

➤ To file a privacy complaint with the Department of Health and Human Services, contact:

Office of Civil Rights

US Department of Health and Human Services 90 7th Street, Suite 4 – 100
San Francisco, CA 94103

Phone: (415) 437-8310

FAX: (415) 437-8329

TDD: (415) 437-8311

Email: OCRPrivacy@hhs.gov

www.dhhs.gov/ocr/privacy/index.html

Kings View honors your right to express your privacy concerns. You will not be punished, threatened, or penalized in any way for asking questions or for filing a complaint.



Thank you for trusting Kings View with your care.

**ACKNOWLEDGEMENT OF RECEIPT OF
KINGS VIEW - BEHAVIORAL HEALTH SERVICES
NOTICE OF PRIVACY PRACTICES**

- I acknowledge receipt of Kings View's Notice of Privacy Practices for Behavioral Health Services (mental health and substance use disorder).
- I have been offered a copy of the Notice of Privacy Practices but do not wish to receive it at this time.

Signed: _____ Date: _____

Print Name: _____

Relationship (if not signed by client):_____



KINGS COUNTY BEHAVIORAL HEALTH

Lisa D. Lewis, PhD
Behavioral Health Director

Health Information Exchange Participation

Kings County Behavioral Health, and its contracted providers participate in health information exchanges (HIEs), including an HIE operated by the California Mental Health Services Authority (CalMHSA). Through HIEs, your health information may be shared with hospitals, behavioral health providers, county health programs, physicians, social workers, and other HIE participants who may provide health or behavioral health services to you. Some types of your health information, such as certain substance use disorder records, will not be shared with HIE participants unless you authorize such disclosures; other types of health information may be shared without your authorization. If you do not want us to share your health information with HIE participants via the CalMHSA HIE, you may "opt-out" of the HIE by contacting CalMHSA at OptOut@calmhsa.org. Opting out will prevent future sharing of your health information via the CalMHSA HIE, but HIE participants may still be able to access information about you from other sources.

Participación en el Intercambio de Información de Salud

Kings County Behavioral Health y sus proveedores de servicios participan en intercambios de información de salud (HIEs por sus siglas en Ingles). Esto incluye un HIE operado por la Autoridad de Servicios de Salud Mental de California (CalMHSA). A través de los HIEs, su información de salud puede ser compartida con hospitales, proveedores de salud conductual, programas de salud del condado, médicos, trabajadores sociales y otros participantes del HIE que puedan proporcionar servicios de salud o salud conductual. Algunos tipos de su información de salud, como ciertos registros de trastornos por uso de sustancias, no serán compartidos con los participantes del HIE a menos que usted lo autorice; otros tipos de información de salud pueden ser compartidos sin su autorización. Si no desea que compartamos su información de salud con los participantes del HIE a través del HIE de CalMHSA, puede "optar por no participar" en el HIE comunicándose a CalMHSA en OptOut@calmhsa.org. Optar por no participar evitara en un futuro el intercambio de su información de salud a través del HIE de CalMHSA, sin embargo los participantes del HIE aún podrán acceder a su información por otras fuentes.



MENTAL HEALTH PATIENTS' RIGHTS



MOSAIC FOREST

Alice Washington, 2004

Mental health patients have the same legal rights guaranteed to everyone by the Constitution and laws of the United States and California.

YOU HAVE THE RIGHT:

- **To dignity, privacy and humane care**
- **To be free from harm including unnecessary or excessive physical restraint, medication, isolation, abuse and neglect**
- **To receive information about your treatment and to participate in planning your treatment**
- **To consent or refuse to consent to treatment, unless there is a legally- defined emergency or a legal determination of incapacity**
- **To client-centered services designed to meet your individual goals, diverse needs, concerns, strengths, motivations and disabilities**
- **To treatment services which increase your ability to be more independent**
- **To prompt medical care and treatment**

- **To services and information in a language you can understand and that is sensitive to cultural diversity and special needs**
- **To keep and use your own personal possessions including toilet articles**
- **To have access to individual storage space for your private use**
- **To keep and spend a reasonable sum of your own money for small purchases**
- **To have reasonable access to telephones—both to make and to receive confidential calls or have such calls made for you**
- **To have access to letter-writing material and stamps—to mail and to receive unopened correspondence**
- **To social interaction, participation in community activities, physical exercise and recreational opportunities**
- **To see visitors every day**
- **To wear your own clothes**
- **To see and receive the services of a patient-advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services**
- **To religious freedom and practice**
- **To participate in appropriate programs of publicly supported education**
- **To be free from hazardous procedures**
- **And all other rights as provided by law or regulation**

FOR MORE INFORMATION, CONTACT YOUR LOCAL COUNTY PATIENTS' RIGHTS ADVOCATE:

Kings County Patient Rights Advocate
 BHPRA@co.kings.ca.us
 (559) 852-2423

California Office of Patients' Rights
 1831 K Street, Sacramento, CA 95811-4114
 (916) 504-5810, <http://www.disabilityrightsca.org/>
 Department of Health Care Services
 Mental Health Services Division Ombudsman
 (800) 896-4042 or Email: mhombudsman@dhcs.ca.gov

Consent to Treat

Purpose

I would like services for myself or my child from _____ (County) and/or its contracted providers. I understand this document contains information about services that may be provided to me or my child. I understand that I have the right to speak with a provider about the information in this document and ask questions in order to understand this information.

My Rights

I acknowledge I was informed of my/my child's rights as a client and that I was offered the consumer rights document, which contains my/my child's rights as a client.

Privacy Practices

I acknowledge I have been offered a copy of _____ (County)'s Notice of Privacy Practices, which has information about how my/my child's private health information may be used and disclosed under the law. I understand that in certain circumstances information I share must be disclosed. For example, behavioral health providers are mandated to report if there is a reasonable suspicion of child, elder, or dependent-adult abuse or neglect; if there is a threat to my/my child's physical safety; or if there is a threat to the safety of others.

I understand that if my child is receiving services, in certain cases the provider of those services may not be able to share information with me about those services unless my child permits them to do so.

Services

I understand that the services that may be provided focus on mental health and substance use issues. I am aware my/my child's information and records may be shared between mental health and substance use programs and providers for the purpose of providing treatment, to the extent permitted by law.

Risks and Benefits of Services

I understand behavioral health services may have risks and benefits. I am aware that behavioral health services may involve discussing difficult aspects of my or my child's life and making changes to psychiatric medication I or my child may take and/or substance use treatment. I or my child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I or my child may also experience an increase in the symptoms as I or my child work through issues or as my or my child's medications are being changed and/or added to in the course of treatment.

I am also aware behavioral health services have been shown to have benefits. For example, psychotherapy and/or substance use treatment may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychiatric medication may alleviate symptoms of mental health issues.

I understand there are no certainties about what I or my child will experience as I or my child receive services and how successful services will be. I understand behavioral health services require an investment of time and effort from all involved and openness to what change and success may look like.

Services are Voluntary

I understand participation in behavioral health services is voluntary, except for certain situations where _____ (County) is legally required to provide services even if it is involuntary, such as 5150 psychiatric holds or conservatorships.

I understand that even if a court orders me to participate in behavioral health services, I can still choose not to participate in services. I am aware that consequences that may arise due to my decision not to participate in court-ordered services are my responsibility. I understand that I may speak with an attorney, probation officer, and/or Child Welfare Services worker to make the best possible decision regarding participating in court-ordered services.

Eligibility for Services

Eligibility for behavioral health services is determined by a combination of laws, regulations, and local policies. I understand that if an assessment determines that I/my child is no longer eligible for behavioral health services, the reasons will be discussed with me and I will also be provided with a notice of adverse benefit determination (NOABD) that explains these reasons and information on the appeals process. I will then be given referrals to other service providers, as appropriate, that may meet my or my child's needs.

Service Providers

I understand that providers come from different educational and professional backgrounds and have a variety of experience levels and licensure and that providers only provide services that are allowed by law for their specific education, experience, profession, and licensure.

I understand that _____ (County) may utilize some unlicensed professionals that are in the process of completing their requirements for clinical licensure but who are authorized by law to provide mental health services under the supervision of a licensed mental health professional. I understand I or my child may receive services from some of these individuals, who will clearly identify themselves, as well as their supervising provider/clinician. I understand I may call the supervising licensed clinician if I have any questions about this arrangement.

Availability of Providers and Crises/Emergencies

I understand providers are generally available during regular county business hours, which are _____, except during county holidays. I understand that some programs have different hours of availability.

For non-urgent matters after-hours, I understand I or my child can leave messages in the provider's confidential voicemail (if they have one available) or with _____ (County)'s after-hours telephone service. For urgent or crisis situations, I or my child can contact: _____ (County) Crisis Line at: _____.

For emergencies, I understand my family or I should call 911.

Change of Clinician/Provider

I understand I can request a change of mental health provider at any time by completing a Change of Provider form, which is available at all clinics. I understand requesting a change of provider does not guarantee a change, and there may be significant administrative or treatment issues that may not make the change possible. I understand a supervisor or manager will provide me the reason(s) the change is not possible.

Fees and Billing Medi-Cal, Medicare, and/or Insurance

I understand _____ (County) will ask me to provide my financial information on annual basis and this information will be used to calculate service fees that I may be responsible for paying. For substance use treatment services for Drug Medi-Cal Beneficiaries, Drug Medi-Cal funding shall be accepted as payment in full.

I understand any private insurance will be billed by _____ (County) before billing Medicare and/or Medi-Cal. I understand I may consult with my private insurance, Medicare social worker, and/or Medi-Cal eligibility worker if I have any questions about my or my child's coverage, deductibles, and co-pays.

Additional Documents for Medi-Cal Clients

I understand the Guide to Medi-Cal Mental Health Services handbook and/or the County Beneficiary Handbook for Substance Use Disorder Services contains details about behavioral health benefits for Medi-Cal beneficiaries.

Complaints and Grievances

I understand I may file a complaint or grievance if I am dissatisfied with the services I or my child receives from _____ (County) and its contracted providers. I understand I or my child will not be subjected to any penalty for filing a complaint, grievance, or an appeal. I was offered a copy of the Problem Resolution document, which explains how I can file a complaint, grievance, or appeal.

Complaints to the Licensure Board

I understand that the California Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors, marriage and family therapists, licensed educational psychologists, and clinical social workers. I understand that I may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Informed Consent

By signing, I acknowledge that I understand the information contained in this document and I agree to my receipt, or my child's receipt, of behavioral health services in accordance with the terms described above.

Signature: _____

Date: _____

Printed Name: _____

LANGUAGE TAGLINES

English Tagline

ATTENTION: If you need help in your language call [1-xxx-xxx-xxxx] (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call [1-xxx-xxx-xxxx] (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ [1-xxx-xxx-xxxx] (TTY: 711). توفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برييل والخط الكبير. اتصل بـ [1-xxx-xxx-xxxx] (TTY: 711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք [1-xxx-xxx-xxxx] (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ բրայլի գրատիպով ու խոշորատար տպագրված նյութեր: Զանգահարեք [1-xxx-xxx-xxxx] (TTY: 711): Այդ ծառայություններն անվճար են:

ភាសាហាហាត់ជាតាតាស់ខ្សោ (Cambodian)

ចំណាំ៖ បើមួយ ត្រូវ ការជំនួយ ជាតាតា របស់មួយ សូម ទូរសព្ទទៅលេខ [1-xxx-xxx-xxxx] (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាកសារសាស្ត្រជាមក្សរជុំស សម្រាប់ជនពិការត្រូវក្នុង បុរាណសារសាស្ត្រជាមក្សរពុម្ពជំនួយ ទូរសព្ទមកលេខ [1-xxx-xxx-xxxx] (TTY: 711)។ សេវាកម្មទាំងនេះ មែនគឺជាដំឡើង។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 [1-xxx-xxx-xxxx] (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 [1-xxx-xxx-xxxx] (TTY: 711)。这些服务都是免费的。

مطلوب به زبان فارسي (Farsi)

توجه: اگر می خواهید به زبان خود کمک دریافت کنید، با [1-xxx-xxx-xxxx] (TTY: 711) تماس بگیرید. کمکها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه های خط برييل و چاپ با حروف بزرگ، نیز موجود است. با [1-xxx-xxx-xxxx] (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो [1-xxx-xxx-xxxx] (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। [1-xxx-xxx-xxxx] (TTY: 711) पर कॉल करें। ये सेवाएं निःशुल्क हैं।

Nqee Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau [1-xxx-xxx-xxxx] (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau [1-xxx-xxx-xxxx] (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は [1-xxx-xxx-xxxx] (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 [1-xxx-xxx-xxxx] (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 [1-xxx-xxx-xxxx] (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. [1-xxx-xxx-xxxx] (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ລາວ ໄກສາໄລ້ວພາກາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຈ່ວຍເຫຼືອໃນພາກາຂອງທ່ານໃຫ້ໃຫຍ່ເປົ້າເປົ້າ [1-xxx-xxx-xxxx] (TTY: 711). ຍັງມີຄວາມຈ່ວຍເຫຼືອແວະການບໍລິການສໍາວັບຄືນຝຶການ ເຊິ່ງເອກະພາບທີ່ເປັນອັກກອອນບູນແວະມີຕາມີມໃຫຍ່ ໃຫ້ໃຫຍ່ເປົ້າເປົ້າ [1-xxx-xxx-xxxx] (TTY: 711). ການບໍລິການເຫຼົ້ານີ້ບໍ່ຕ້ອງແລຍດ່າວັດຈຸດ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux [1-xxx-xxx-xxxx] (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx [1-xxx-xxx-xxxx] (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ [1-xxx-xxx-xxxx] (TTY: 711), ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬੋਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ [1-xxx-xxx-xxxx] (TTY: 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру [1-xxx-xxx-xxxx] (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру [1-xxx-xxx-xxxx] (линия TTY: 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al [1-xxx-xxx-xxxx] (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al [1-xxx-xxx-xxxx] (TTY: 711). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa [1-xxx-xxx-xxxx] (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa [1-xxx-xxx-xxxx] (TTY: 711). Libre ang mga serbisyo ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข [1-xxx-xxx-xxxx] (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข [1-xxx-xxx-xxxx] (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер [1-xxx-xxx-xxxx] (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер [1-xxx-xxx-xxxx] (TTY: 711). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số [1-xxx-xxx-xxxx] (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số [1-xxx-xxx-xxxx] (TTY: 711). Các dịch vụ này đều miễn phí.

NONDISCRIMINATION NOTICE

Discrimination is against the law. *Kings County Behavioral Health* follows State and Federal civil rights laws. *Kings County Behavioral Health* does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Kings County Behavioral Health provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, braille, audio or accessible electronic formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact *Kings County Behavioral Health* between *Monday through Friday from 8am- 5pm* by calling (559)852-2444. Or, if you cannot hear or speak well, please call 7-1-1. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

HOW TO FILE A GRIEVANCE

If you believe that *Kings County Behavioral Health* has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with the *Patients Rights Advocate*. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact the *Patients Rights Advocate* between *Monday through Friday from 8am- 5pm* by calling (559)852-2444. Or, if you cannot hear or speak well, please call 7-1-1.
- In writing: Fill out a complaint form or write a letter and send it to:
1400 W. Lacey Blvd. Building #13 Hanford, CA 93230
- In person: Visit your doctor's office or *Kings County Behavioral Health* at *1222 W. Lacey Blvd. 2nd floor* and say you want to file a grievance.
- Electronically: Visit *Kings County Behavioral Health's* website at *KCBH.org*

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California State Relay)**.
- In writing: Fill out a complaint form or send a letter to:

**Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413**

Complaint forms are available at:

<https://www.dhcs.ca.gov/discrimination-grievance-procedures>

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex , you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201**

- Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.
- Electronically: Visit the Office for Civil Rights Complaint Portal at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Advance Health Care Directives

What is an Advance Directive?

An Advance Health Care Directive is a legal document that enables people to make their wishes known even when they are incapacitated and unable to communicate. You can use an Advance Directive to spell out your wishes regarding physical and mental health care.

In California, an Advance Directive is made up of two parts: (1) Appointment of an Agent for health care; and (2) Individual Health Care Instructions. Either part is legally binding by itself.

What is a healthcare Agent?

A Healthcare Agent is a person you appoint in your Advance Directive to make health care decisions for you should you lose the ability to make these decisions for yourself. You do not have to appoint an Agent in order to complete an Advance Directive.

What are Individual Health Care Instructions?

Individual Health Care Instructions are verbal or written directions about health care. These can cover both physical and mental health treatment. You can let your health care provider know what you want done and under what circumstances.

What are the benefits from completing an Advance Directive?

Completing an Advance Directive can improve communication between you and your doctor. Completing and filing an Advance Directive is a good way to open a discussion with your health care providers about treatment plans and the full range of choices in treatment.

Completing an Advance Directive creates an opportunity for you to discuss your wishes in detail with family and/or friends. This may help your family and/or your friends advocate more effectively for you if you are ever found to lack the capacity to make health care decisions for yourself.

An Advance Directive can empower you to make your treatment choices known in the event you need health care and are found to be incapable of making health care decisions.

An advance Directive may prevent forced treatment and may reduce the need for long hospital stays.

Who can fill out an Advance Directive?

Any person 18 years or older who has the “capacity” to make health care decisions may fill out an Advance Directive. “Capacity” in this situation means the person understands the nature and consequences of the proposed health care, including the possible risks and benefits, and is able to make and communicate decisions about that health care. Legally a person is assumed to be competent unless proven otherwise.

When does an Advance Directive go into effect?

An Advance Directive goes into effect when your primary physician decides that you lack the capacity to make health care decisions. The fact that you have been admitted to a mental health facility does not, in itself, mean that you lack capacity to make health care decisions.

The Advance Directive is no longer in effect as soon as you regain the capacity to make health care decisions.

Does a health care provider have to follow an Advance Directive?

In general, the law is clear that health care providers must follow your Individual Health Care Instructions, as well as the decisions made on your behalf by a Health Care Agent.

Who can help if an Advance Directive is ignored/not followed?

If a health care provider refuses to follow your Individual Health Care Instructions, or refuses to comply with the decisions of your Agent, contact the County's Patients' Rights Advocate at 1-866-701-5464 and/or Protection & Advocacy, Inc. at 1-800-776-5746. The County Patients' Rights Advocate and PAI can work with you and/or your Agent to make sure that the Advance Directive is followed.



Kings View Counseling Services for Kings County

Hanford Clinic
1393 Bailey Drive
Hanford, CA 93230
559-582-4481

Avenal Clinic
228 E. Kings St.
Avenal, CA 93204
559-386-2295

Corcoran Clinic
1002 Dairy Ave.
Corcoran, CA 93212
559-992-2833

ABOUT YOUR FEE

The amount of money you will be charged for our professional services is based on your ability to pay. We call this amount your yearly deductible, or your UMDAP amount. To figure the amount you will be charged, we use the California Department of Mental Health's schedule called "Uniform Method of Determining Ability to Pay" (UMDAP), which is required by all community mental health centers.

Your YEARLY DEDUCTIBLE (UMDAP) is: \$ _____.

This means the most you will be charged from _____ to _____ is \$ _____.

You may only come for professional services for a short time, but you will be responsible for the charges for any services you receive up to your yearly deductible amount shown above. If your treatment ends before you have used up the deductible, you will only be responsible for the charges for services you received. You can take up to the full UMDAP year to pay your deductible provided you make a payment every month.

Based on your income, your-MONTHLY PAYMENT will be: \$ _____.

You are expected to pay at least this amount every month until your deductible has been paid for the year. If your financial information changes, please notify us. You may call 582-4481 if you have any questions about your bill.

I understand I am expected to pay the amount shown above each month and to notify Kings View if my financial information changes.

Signature of Client

Date

Agent for Mental Health

Date

ABOUT YOUR FREEDOM OF CHOICE

Your acceptance and participation in our Mental Health Service is voluntary and shall not be required for access to other health care services.

In receiving our services, you retain a free choice of providers of other covered services of the Medi-Cal program; you are not limited to service providers of the Short – Doyle system (i.e., you may choose to receive services from any provider of choice, such as a private psychiatrist).

You have the right to request a change of a Mental Health provider, staff person, therapist and/or case manager. I have been informed and acknowledge receipt of a copy of this document, "About Your Freedom of Choice".

I have received a copy of the Confidentiality Statement.

Yes

No

Signature of Client

Date

Agent for Mental Health

Date

NOTICE TO PATIENTS

OPEN PAYMENTS DATABASE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospital be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

I acknowledge that I have received a written notice of the Open Payments Database.

Consumer Signature

Date

Chart number: _____



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KINGS VIEW
Treatment Agreement

OUR GOALS:

- To provide quality mental health services to people who live in Kings County
- To teach you new skills for a healthy life.

TREATMENT: Kings View provides many mental health services. Our main services are skills groups or therapy groups. First you will have an in-depth interview with a therapist. Then we will connect you to the service(s) that will help you to make changes. If we are unable to serve you, then we will refer you to the right provider.

OFFICE HOURS: Our main office, at 1393 Bailey Drive in Hanford, is open from 8:00 AM until 5:00 PM. If you need to talk with your provider, you may call (559) 582-4481 during business hours. If you have a mental health crisis, please call our after-hours line, (559) 582-4484 or 1-800-655-2553 and talk with a crisis worker. The after-hours line is only for a mental health crisis. The crisis worker is unable to look up or reschedule an appointment, so please call during business hours for that kind of information. If you have a life-threatening emergency, please call 911.

TREATMENT PARTICIPATION: It may help you to meet your goals when the important people in your life participate. You decide who will be involved. You and your provider agree on goals to work on for change to happen. It is very important that you commit to your treatment by doing the following:

1. **Attend all appointments on time.** Appointments may be canceled by telling your therapist, doctor, or case manager at least 24 hours before the scheduled session. Remember that poor attendance and tardiness will keep you from meeting your goals. Missing appointments again and again will result in closing your case.
2. **Work together on treatment goals.** Full participation in your treatment is very important. "Full participation" means being on time for each session, finishing homework, and working with your therapist, doctor, or case manager to meet your goals.
3. **Keep a current financial account.** You are responsible for making the payments you agreed to when we opened your case. Accounts that are "overdue" may stop you from getting the treatment you need. If your income or financial health changes, please let your provider know as soon as possible. If you are having a hard time keeping up with payments, you may ask for a "financial adjustment."
4. **Expect Kings View Counseling Services for Kings County to:**
 - Treat you with respect and dignity.
 - Protect your privacy. But remember that everyone who works at Kings View are "mandated reporters." That means we must tell someone if we believe a child or elderly person or an adult who has special needs is being harmed. We may have to tell others about you in crisis or emergency situations, to keep you safe. We may have to tell others about you if you make a dangerous threat, to keep others safe.
 - Provide you with mental health services or referrals that will help you reach your goals.
 - Assign a therapist, doctor, or case manager to help you reach your goals.



Treatment Agreement Acknowledgment

I, _____, am committed to my / my child's treatment.

My signature below signifies that I accept and agree with the conditions of the Treatment Agreement and verifies that I have received a copy of the Treatment Agreement.

Client Signature: _____ Date: _____

Parent /
Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Last Name	Client First Name	Case Number



KINGS COUNTY BEHAVIORAL HEALTH

Lisa D. Lewis, PhD
Behavioral Health Director

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, and professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

AVISO DE QUEJAS

La Junta de Ciencias del Comportamiento (BBS por sus siglas en Inglés) recibe y responde a las quejas sobre los servicios prestados dentro del alcance de la práctica de (terapeutas matrimoniales y familiares, psicólogos educativos con licencia, trabajadores sociales clínicos y consejeros clínicos profesionales). Usted puede comunicarse con la junta en línea en www.bbs.ca.gov o llamando al (916) 574-7830.

My information/ Mi información:

(Provider name, Title) (License or Registration #)/ (**Nombre del proveedor, título**)
(**Licencia o número de registro**)

Clinical Supervisor (if applicable)/ Supervisor clínico (si aplica):

(Name, Title) (License #) (**Nombre, título**) (**Número de licencia**)

For more information on how to file a Medi-Cal grievance, contact Kings County Patient's Rights Advocate at (559)852-2424.

Para obtener más información sobre cómo presentar una queja de Medi-Cal, comuníquese con el Condado de Kings Defensor de los Derechos de los Pacientes al (559)852-2424.

By signing below, I acknowledge receipt of this information. Al firmar a continuación, reconozco haber recibido esta información.

Signature/

Firma _____ Date/Fecha _____





KINGS COUNTY BEHAVIORAL HEALTH

Lisa D. Lewis, PhD
Behavioral Health Director

NOTICE TO CLIENTS

The _____ of the _____
(Name of office or unit) (Name of agency)

receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at Kings County Behavioral Health.

To file a complaint, contact

(Telephone number, email address, internet website, or mailing address of agency)

AVISO DE QUEJAS

El/ La _____ del/ de la _____
(Nombre de oficina o unidad) (Nombre de la agencia)

recibe y responde a las quejas sobre la práctica de psicoterapia de cualquier interno o consejero no registrado proveyendo servicios al departamento de Salud Mental de Kings. Para presentar una queja, puede comunicarse

(Número telefónico, correo electrónico, domicilio, sitio de internet, o dirección postal de la agencia)

My information/ Mi información:

(Provider name, Title) / Nombre del proveedor, título

Clinical Supervisor/ Supervisor clínico:

(Name, Title) (License #) / Nombre, título, número de licencia

For more information on how to file a Medi-Cal grievance, contact Kings County Patient's Rights Advocate at (559) 852-2424.

Para obtener más información sobre como presentar una queja de Medi-Cal, puede comunicarse con el Defensor de los Derechos del Paciente del condado de Kings al (559)852-2424.

By signing below, I acknowledge receipt of this information. Al firmar a continuación, reconozco haber recibido esta información.

Signature/

Firma _____ Date/Fetcha _____



Process, Benefits, and Risks of Psychotherapy

Participating in psychotherapy can result in a number of benefits, including a reduction in feelings of distress and problematic behaviors, greater personal awareness and insight, increased skills for managing stress, and resolution of specific problems. However, sharing personal history or ongoing life challenges may at times create discomfort and may even lead to increased anxiety and depression for a period of time before symptoms improve.

By signing below, I am acknowledging that I have been informed about the process, benefits, and risks of psychotherapy provided by Kings View Behavioral Health Systems, Kings County.

Consumer signature

Date

Burns Depression Checklist *

(Revised)

Instructions: Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.

0—Not at All	1—Somewhat	2—Moderately	3—A Lot	4—Extremely
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Thoughts and Feelings				
1. Feeling sad or down in the dumps				
2. Feeling unhappy or blue				
3. Crying spells or tearfulness				
4. Feeling discouraged				
5. Feeling hopeless				
6. Low self-esteem				
7. Feeling worthless or inadequate				
8. Guilt or shame				
9. Criticizing yourself or blaming yourself				
10. Difficulty making decisions				
Activities and Personal Relationships				
11. Loss of interest in family, friends, or colleagues				
12. Loneliness				
13. Spending less time with family or friends				
14. Loss of motivation				
15. Loss of interests in work or other activities				
16. Avoiding work or other activities				
17. Loss of pleasure or satisfaction in life				
Physical Symptoms				
18. Feeling Tired				
19. Difficulty sleeping or sleeping too much				
20. Decreased or increased appetite				
21. Loss of interest in sex				
22. Worrying about your health				
Suicidal Urges				
23. Do you have any suicidal thoughts?				
24. Would you like to end your life?				
25. Do you have a plan for harming yourself?				
Please Total Your Score on Items 1 to 25 here →				

Burns Anxiety Checklist *

(Revised)

Instructions: Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.

0—Not at All	1—Somewhat	2—Moderately	3—A Lot	4—Extremely
--------------	------------	--------------	---------	-------------

Anxious Thoughts and Feelings				
1. Feeling anxious				
2. Feeling nervous				
3. Feeling frightened				
4. Feeling scared				
5. Worrying about things				
6. Feeling that you can't stop worrying				
7. Feeling tense, agitated, or on edge				
8. Feeling stressed				
9. Feeling uptight				
10. Thoughts that something frightening will happen				
11. Feeling alarmed or in danger				
12. Feeling insecure				
Anxious Physical Symptoms				
13. Feeling dizzy, lightheaded, or off balance				
14. Rubbery or "jelly" legs				
15. Feeling like you are choking				
16. A lump in the throat				
17. Feeling short of breath or difficulty breathing				
18. Skipping, racing, or pounding of the heart				
19. Pain or tightness in the chest				
20. Restlessness or jumpiness				
21. Tight, tense muscles				
22. Trembling or shaking				
23. Numbness or tingling				
24. Butterflies or discomfort in the stomach				
25. Sweating or hot flashes				
Please Total Your Score on Items 1 to 25 here →				

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LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					



KINGS VIEW

1393 Bailey Drive • Hanford, CA 93230 • (559) 582-4481 • Fax (559) 582-6547

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Kings View - Kings County

Internal Use
<input type="checkbox"/> File
<input type="checkbox"/> Request
<input type="checkbox"/> Send

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**1. CLIENT INFORMATION**

First Name	Middle Initial	Last Name	Birth Date (mm-dd-yyyy)	Medical Record #
------------	----------------	-----------	-------------------------	------------------

2. FROM / TO INFORMATION

I authorize Kings View to:

Disclose to and exchange my protected health information with:
 Request from and exchange my protected health information with:
 Use my protected health information:

Name & Job Title	Name of Agency / Entity			
Street Address / PO Box	City	State	Zip	Telephone (optional)
Name & Job Title	Name of Agency / Entity			
Street Address / PO Box	City	State	Zip	Telephone (optional)

3. INFORMATION TO BE DISCLOSED / REQUESTED / USED Check all that apply

<input type="checkbox"/> Behavioral Health / Recovery Services	Client Initials _____
<input type="checkbox"/> All my program records (justify) <hr/> <input type="checkbox"/> Appointment Information <input type="checkbox"/> Attendance / Compliance / Program Status <input type="checkbox"/> Financial / Billing / Insurance <input type="checkbox"/> Screening / Assessment / Diagnosis <input type="checkbox"/> Medical: Orders / Progress Notes / Medications / Lab Reports / Physical <input type="checkbox"/> Referrals / Linkage / Care Coordination	<input type="checkbox"/> Medical / Physical Health Information <input type="checkbox"/> Treatment Plan / Treatment Team Progress Notes <input type="checkbox"/> Transfer / Discharge Summary <input type="checkbox"/> School Records <input type="checkbox"/> Probation / Court / DSS Reports <input type="checkbox"/> Hospitalization Records <input type="checkbox"/> Personal Information / Photo <input type="checkbox"/> Other _____

Time Period: NA Last 12 months Dates: From: _____ To: _____NOTE: Records may include substance use disorder information and HIV test results. These records **WILL NOT** be disclosed unless specifically requested below.

<input type="checkbox"/> Substance Use Disorder Records Client initials _____	<input type="checkbox"/> HIV Test Results Client initials _____
--	--

4. PURPOSE

Client / Legal Representative Request Treatment Other _____

5. DELIVERY OF PHI

Pick Up Mail Fax Verbal Secure Email Electronic/CD/USB Other _____

6. EXPIRATION

If not revoked earlier, this authorization expires one (1) year from the date of signature OR other date or event (specify) _____

7. ADVISEMENTS

- I may inspect and/or obtain a copy of the information being disclosed or used.
- My signing this form is voluntary – my refusal to sign it will not generally affect services I receive from Kings View.
- A photocopy of this form is as valid as the original.
- I am entitled to a copy of this form.
- I understand the minimum necessary will be disclosed or used for my SUD information.
- I may revoke this authorization for any reason at any time, either verbally or in writing, by notifying Medical Records at the Kings View program processing this authorization. My revocation takes effect upon receipt by Kings View except to the extent others have already acted in reliance upon this authorization.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law.

8. CLIENT OR LEGAL REPRESENTATIVE SIGNATURE

By signing below, I acknowledge I have reviewed and fully understand and agree to this authorization form.

➤ Signature Client or Legal Representative	Date (mm-dd-yyyy)
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Printed Name If Legal Representative	Relationship To Client
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9. FORM COMPLETED BY

First & Last Name: _____

10. REVOCATION

➤ Signature of Client / Legal Representative Revoking This Authorization	Effective Date (mm-dd-yyyy)
➤ Signature of Employee Revoking Authorization At Client's Request	Date Requested (mm-dd-yyyy)



Kings County Behavioral Health

Mental Health Provider Directory

May 2025

As a Kings County Medi-Cal beneficiary, if you think you or a family member needs Mental Health services, call the Access Line at 1-800-655-2553 (toll-free). Note that all of the below Providers can accommodate persons with physical disabilities and serve Kings County Medi-Cal beneficiaries. Services may be delivered by an individual provider, or a team of providers, who is working under the direction of licensed practitioners operating within their scope of practice. Only licensed, waivered, or registered mental health providers are listed on the Plan's Provider Directory.

If you require this document in an alternate format (example: Braille, Large Print, Audiotape, CD-ROM), you may request an alternate format, at no cost to the beneficiary, by calling the Access Line at 1-800-655-2553 (toll-free).

Provider Site	Service Type	Populations Served	Cultural Capacity	Non-English Language(s)	Hours of Operations	Disability Access
Kings View Counseling Services 1393 Bailey Dr Hanford, California 93230 http://www.kingsview.org (559-582-4481)	Outpatient Psychiatry, Therapy, and Rehabilitation Services in Individual, Family, and Group Modes	Adults	Multicultural Staff	Spanish	Mon-Fri 8 a.m. to 5 p.m.	Yes
Is provider accepting new clients: Yes						

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Ahmed	Zaheer	Psychiatrist	C 127721	1134330368	No	English	Psychiatry
Alberty	Daniesha	Associate Marriage and Family Therapist	AMFT 125214	1336723220	Yes	English	Quality Assurance Specialist
Aldave	Briana	Licensed Professional Clinical Counselor	LPCC 15098	1174292270	Yes	English, Spanish	Program Manager – MCRT
Anaya	Monique	Associate Clinical Social Worker	ASW 124743	1043020175	Yes	English,	Clinician - MCRT
Areias	Cassondra	Licensed Marriage and Family Therapist	LMFT 106721	1841683729	Yes	English	Clinical Supervisor- Adult Services
Baker	Kimberly	Associate Clinical Social Worker	ASW 105792	1124788377	Yes	English	Clinical Supervisor - MCRT
Bottoms	Mickayla	Associate Clinical Social Worker	ASW 124118	1346088259	Yes	English	Clinician – MCRT

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Cardenas	Maria Veronica	Licensed Marriage and Family Therapist	LMFT 145846	1922337658	Yes	English, Spanish	Clinician – Adult
Carrico	Tracy	Licensed Marriage and Family Therapist	LMFT 42980	1760608889	Yes	English	Clinician – MCRT After Hours
Contreras	Analieze	Associate Clinical Social Worker	ASW 118661	1326757501	Yes	English, Spanish	Clinician - MCRT
Duran	Amber	Associate Professional Clinical Counselor	APCC 11405	1134733751	Yes	English, Spanish	Clinician - Adult
Esparza-Molina	Araceli	Associate Clinical Social Worker	ASW 124710	1528887817	Yes	English	Clinician - Adult
Gacad	Leslie	Nurse Practitioner	95023818	1487350682	Yes	English	Psychiatry
Garivay	Denivie	Associate Marriage and Family Therapist	AMFT 133462	1962075861	Yes	English	Clinician - Access
Gascon	Natalia	Licensed Clinical	LCSW 129344	1801518089	Yes	English	Clinician - Adult

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
		Social Worker					
Gonzalez	Sandra	Licensed Marriage and Family Therapist	LMFT 104755	1962829879	Yes	English, Spanish	Clinical Supervisor - Adult Services
Hall	Stefani	Licensed Psychiatric Technician	LPT 34655	1548751753	Yes	English	Nursing Services – Case Manager
Krumdick	Kameron	Associate Marriage and Family Therapist	AMFT 145402	1730878570	Yes	English	Clinician - Adult
Licon	Anna	Licensed Psychiatric Technician	LPT 36367	1811244528	Yes	English, Spanish	Supervisor - Nursing
Lozares	Marife “Faye”	Licensed Psychiatric Technician	LPT 35677	1912711599	Yes	English	Adult Services Case Manager
Lynn	Nora	Licensed Marriage and Family Therapist	LMFT 49807	1265616320	Yes	English	Assistant Regional Director
Luna	Ashley	Associate Clinical Social Worker	ASW 127974	1811797905	Yes	English	Clinician - MCRT

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Mejia	Natalie	Associate Marriage and Family Therapist	AMFT 125890	1326506965	Yes	English, Spanish	Clinician - MCRT Per Diem
O'Keefe	Abigail	Associate Professional Clinical Counselor	APCC 17792	1215732615	Yes	English	Clinician - Adult
Orozco-Avalos	Ivett	Associate Marriage and Family Therapist	AMFT 138522	1568014074	Yes	English, Spanish	Intake Clinician - Access
Quevedo	Viviana	Associate Marriage and Family Therapist	AMFT 148184	1477363455	Yes	English, Spanish	Clinician - Adult
Randell	Jessica	Doctor of Osteopathy	20A15435	1285020594	No	English	Psychiatry
Raya	Ramiro	Associate Marriage and Family Therapist	AMFT 11215	1912039959	Yes	English, Spanish	Clinician – Juvenile Probation
Reis	Selena	Licensed Psychiatric Technician	LPT 33084	1962128637	Yes	English	Nursing Services

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Rogers	Lisa	Licensed Marriage and Family Therapist	LMFT 99767	1467794206	Yes	English	Regional Director
Rolfsema	David	Licensed Clinical Social Worker	LCSW 16614	1013136175	Yes	English	Clinician - LPS
Schenley	Agnes	Licensed Marriage and Family Therapist	LMFT 41233	1760513766	Yes	English	Clinician – MCRT After Hours
Seechan	Alexis	Associate Clinical Social Worker	ASW 127486	1174323587	Yes	English	Clinician – MCRT
Shahbazian	Randy	Psychiatrist	A85058	1629253836	No	English	Psychiatry
Smith	Anisha	Doctor of Osteopathy	20A9398	1245351568	Yes	English	Psychiatry
Swalef	Jasmine	Associate Professional Clinical Counselor	APCC 10553	1205634656	Yes	English	Clinician – MCRT After Hours

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Taylor	Thomas	Licensed Clinical Social Worker	LCSW 17355	1891910527	Yes	English	Clinician - Adult
Truta	Mircea	Psychiatrist	A75064	1033230537	No	English	Psychiatry
Vazquez	Bethany	Associate Clinical Social Worker	ASW 113374	1285393199	Yes	English	Clinician - MCRT
Vidad	Noelika	Licensed Psychiatric Technician	LPT 40813	1821847369	Yes	English	Nursing Services
Zepeda	Lisa	Licensed Marriage and Family Therapist	LMFT 92541	1104121854	Yes	English	Program Manager- Adult Services