To Whom It May Concern:

Thank you for your interest in Share House. I would like to introduce our program to you, outline eligibility requirements, and describe the application/admission process.

Share House provides a drug-free supportive living environment, life skills groups, peer support services related to the development and utilization of life skills; coordinated referral to clinical services, employment and vocational planning, nutritional and medical care, and housing assistance. Share House serves adult men and women who are suffering from addiction with co-occurring mental illness.

There are 5 main eligibility requirements for admission to Share House:

1) Applicants must have a Severe and Disabling Mental Illness (SDMI) (Mental Health assessment must be less than a year old)
2) Applicants must have a Chemical Dependency diagnosis with a recommendation for 3.1 level of care or Residential Treatment. (Chemical Dependency evaluation must be less than 6 months old)
3) Applicants cannot be registered sexual offenders
4) Applicants must be at least 18 years of age or over.
5) Applicants must have Medicaid coverage.

The process for submitting an application to Share House is as follows:

1) Complete and return the client intake packet, including the application, a person statement, and the signed original of the Acknowledgment of Receipt of Notice of Privacy Practices.
2) Attach copies of Mental Health Evaluation and Chemical Dependency Evaluation or have your provider fax copies to Share House.
3) Attach a copy of your Medicaid card, or Photo ID and Social Security Card, to determine initial eligibility.
4) Program manager interview. This will be done on a case-by-case basis if additional information is required.

An individual will become “active” when all paperwork is turned. If packet is incomplete, you will be notified of what additional information is needed. If you do not respond within thirty (30) days, your application will become “inactive” and you may have to reapply completely.

Once an application packet is determined as being complete, the individual will be notified of the outcome of the application and the applicant will be placed on the wait list. This does not guarantee acceptance into Share House. Acceptance will be contingent on Preauthorization through Medicaid which will be conducted once there is an opening. It is important that you update your information as it changes, especially contact information. When there is an opening you will be notified. If there is no response from you within three (3) business days, you will be removed from the list and another application process will be needed.

Thank you for your interest and please feel free to contact Share House staff with any further questions.

Sincerely,

Patrick Ryan, LAC
Program Manager
Please complete this packet and keep a copy for your records. Once complete, return it to Share House using one of the following methods:

**Mail:** 1335 Wyoming St.  
Missoula, MT. 59801  
**ATTN:** Admissions

**Fax:** **ATTN:** Admissions Patrick Ryan - 406-541-3031

**E-Mail:** pryan@wmmhc.org

**PACKET CHECKLIST:** Be sure the following are included when you submit your application. Items marked with an asterisk (*) are included in this packet. For referrals from within WMMHC, we will accept items if they are in the EMR and are current (within 3 months, unless otherwise noted). Incomplete or out-of-date items will not be accepted and will result in a delay in processing of your application.

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<td>Referral for Residency *</td>
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<td>Client Acknowledgement, Consent, Rights, Behavior *</td>
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<td>Copy of Medicaid Card (OR)</td>
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<td>Copy of Photo ID and Social Security Card</td>
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<td>Mental Health Evaluation (within last 12 months)</td>
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<td></td>
<td></td>
<td>Chemical Dependency Evaluation (within last 3 months)</td>
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</table>

Clinician Name and Date, if EMR
REFERRAL FOR RESIDENCY AT SHARE HOUSE

Name____________________________________Date_____________________

Who referred you to Share House?______________________________________

What is your drug of choice?_____________________________________________

So you have a Severe and Disabling Mental Illness (SDMI)?__________________

    If yes, who is providing mental health care?_____________________________

Do you have a current Chemical Dependency Evaluation?____________________

    If yes, is the recommendation 3.1 level of care?_______________________

Do you have SNAP Benefits?____________________________________________

Do you have Medicaid Coverage?________________________________________

LEGAL:

Do you have any current or pending legal charges?_____Yes _______No

    If yes, please explain:______________________________________________

    ___________________________________________________________________

    ___________________________________________________________________

Have you every been convicted of a violent offense?_______Yes _______No

    If yes, please explain:______________________________________________

    ___________________________________________________________________

    ___________________________________________________________________

Are you currently registered as a violent offender?_______Yes _______No
Have you ever been convicted of a sexual offense?______Yes ______No
If yes, please explain:____________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Are you currently registered as a sex offender?______Yes ______No
Please explain your past legal history in detail (Attach a separate sheet if necessary):
____________________________________________________________________________
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I, the undersigned, have read and understand this application and submit my request for admission into Share House as a resident.

____________________________________________________________________________
Signature                      Date
This statement must be completed in order to consider your application. Give a personal statement of why you believe Share House is an appropriate placement for you at this time. Also describe your goals for recovery and how Share House can help support you in attaining those goals. Please use additional pages if necessary.

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CLIENT DEMOGRAPHICS

Please answer these questions as they apply to the person receiving services. Make sure to print clearly.

Name: ________________________________________________________________

First: ___________________________ Middle: ___________________________ Last: ___________________________

Preferred Name: ___________________________________________________________ Suffix: ___________________________

Date: ___________________________ Social Security Number: ___________________________

Legal Guardian (if applicable): ______________________________________________________

Birthdate: ___________________________ Gender: Male / Female / Other (Circle One)

Contact Preference: work/home/cell*/other ___________________________ Contact Phone: ___________________________

Work Telephone: ___________________________ Cell Phone Number*: ___________________________

Email Address*: ___________________________

*If cellphone or email are indicated as contact preference, a Preferred Method of Appointment Reminders form must be signed and included in Client Demographics- (see Section 4)

Mailing Address: ___________________________________________________________

City, State: ___________________________________________ Zip Code: ___________________________

Physical Address (if different): ______________________________________________________

City of Residence: ___________________________ County of Residence: ___________________________

Prior County of Residence: __________________________________________________________

Emergency Contact Name: ___________________________ Relationship: ___________ Phone Number: ___________

Language Preference: ___________________________

Health Insurance Plan: ___________________________________________________________

What are your goals for treatment? __________________________________________________________

1. What is your race?

□ White/Caucasian □ Black/African American □ American Indian/Alaskan Native
□ Non-Hispanic □ Asian □ Native Hawaiian/Pacific Islander
□ Hispanic: Check One □ More than one race □ Unknown

□ Mexican □ Puerto Rican □ Cuban □ Other

2. What is your marital status?

□ Single-Unmarried □ Divorced □ Separated
□ N/A (client is a minor) □ Married □ Widowed □ Other/Unknown

3. Have you ever served in the military?

□ YES □ NO  Active Combat? □ YES □ NO

Branch: ______________________________________ Type of Discharge? ___________________________

Are you eligible for Veteran's assistance? □ YES □ NO

4. Do you receive Social Security?

□ SSI Due to Mental Illness □ SSDI Due to Mental Illness □ None
□ SSI Not Due to Mental Illness □ SSDI Not Due to Mental Illness
5. **What is your legal status?**

- □ Self/None
- □ Dept. of Child & Family Services
- □ Parent or Grandparent
- □ Other
- □ Youth Court
- □ Youth Treatment Court
- □ Unknown

6. **What is your employment status?**

- □ Full Time
- □ Part Time
- □ Unemployed but able
- □ Disabled/Unable to work
- □ Supported/Sheltered
- □ Disabled/Unable to work
- □ No interest in work
- □ Other: __________________________

7. **Are you currently in school?**

- □ Not in school
- □ Public K‐12
- □ Vocational School
- □ Private K-12
- □ Home School
- □ College Full Time
- □ College Part Time
- □ Other: __________________________

8. **How many years of education have you completed?**

- □ Completed Grade
- □ Completed High School/GED
- □ HS Plus 1 Yr College
- □ HS Plus 2 Yrs College
- □ HS Plus 3 Yrs College
- □ Bachelor’s Degree
- □ Graduate Degree

9. **Who referred you here? (Select one)**

- □ Self
- □ Native American Agency
- □ Non-Psychiatric Physician
- □ Veteran's Administration
- □ Treatment Center
- □ Agency for the Elderly
- □ Other Mental Health Provider
- □ Physician Name ________________
- □ Other __________________________

10. **What is your current living situation? (Select one)**

- □ Living With Family or Friend
- □ Living independently
- □ Nursing Home
- □ Transient
- □ Hotel
- □ Hospitalized
- □ Mental Health Group Home
- □ Shelter
- □ Psychiatric Res. Treatment Facility
- □ Supported Independent Living

- □ Personal Care Home
- □ Jail
- □ Child Foster Home
- □ Adult Foster Home
- □ Homeless
- □ Non Mental Health Group Home
- □ Living Independently with others
- □ Therapeutic Foster Care
- □ Supported Independent Living

- □ Level 1 Outpatient Services CD
- □ Level 2.5 Partial Hosp CD
- □ Level 2.1 IOP Services CD
- □ Level 3.5 Inpatient CD
- □ Level 3.7 Detox CD

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**SECTION 1: Demographics December 2018**  
**UPLOAD: Intake > Client Demographics**
12. Are you coming here voluntarily or are you required to receive services?
   □ Voluntary    □ Forced Voluntary    □ Involuntary, Civil    □ Involuntary, Criminal

13. Are you involved with any of the following Social Service Agencies? (Select all that apply)
   □ Alcohol or Drug Services □ Department of Child & Family Services
   □ Developmental Disabilities □ School/Special Education
   □ Primary Health Care □ Mental Health Center
   □ Bureau of Indian Affairs □ Case Management (not state agencies)
   □ Housing Agency □ Indian Health Services
   □ Juvenile Probation □ Veteran’s Administration
   □ Vocational Rehabilitation □ PLUK (Parents Let’s Unite For Kids)
   □ Other □ None

   Name/phone of Probation /Parole Officer: __________________________________________

15. Do you currently have a pending DUI, MIP, or Dangerous Drug Charge? □ YES □ NO

16. Please complete the substance use screening:

**CAGE Ages 18 and over**

1. Have you ever felt you should cut down or control your drug use or drinking? □ YES □ NO
2. Have people annoyed you by criticizing your drug use or drinking? □ YES □ NO
3. Have you ever felt bad or guilty about your drug use or drinking? □ YES □ NO
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? □ YES □ NO

**CRAFFT Ages 11-17**

1. Have you ever ridden in a car driven by someone, including yourself, who was high or had been using alcohol or drugs? □ YES □ NO
2. Do you ever use drugs or alcohol to relax, feel better about yourself, or to fit in? □ YES □ NO
3. Do you ever use alcohol or drugs by yourself, alone? □ YES □ NO
4. Do you ever forget things you did while using alcohol or drugs? □ YES □ NO
5. Does your family or friends ever tell you that you should cut down on your drinking or drug use? □ YES □ NO
6. Have you gotten into trouble while you were using alcohol or drugs? □ YES □ NO

**PRE-ADOLESCENT Ages 10 and under**

1. Do you have any friends who have used alcohol or drugs of any kind in the past year? □ YES □ NO
2. Have you ever had more than a few sips of alcohol or taken drugs of any kind in the past year?
   - If yes to alcohol, on how many days in the last year have you used alcohol? ________
   - If yes to drugs, on how many days in the last year have you used drugs? ________
MEDICAL HISTORY

Client Name: __________________________________________________________

Please answer these questions as they apply to the person receiving services. Make sure to print clearly and use a blank piece of paper if additional room is needed.

1. Do you have any ongoing medical issues (e.g. diabetes, heart problems, seizures, liver disease)?
   □ YES □ NO □ Explain: __________________________________________________________________________________________________

2. When was your last physical exam? _____________
   Findings: ___________________________________________________________________________________________________________________

3. When was your last dental exam? _____________
   Findings: ___________________________________________________________________________________________________________________

4. When was your last vision exam? _____________
   Findings: ___________________________________________________________________________________________________________________

5. Do you have any current medical providers? □ YES □ NO
   Name: ______________________________________________________ Practice: _____________________ Phone #: ____________________
   Name: ______________________________________________________ Practice: _____________________ Phone #: ____________________

6. Do you have any history of head injuries? □ YES □ NO
   If yes, explain: _____________________________________________________________________________________________________________

7. How many days in the last 30 days have you experienced medical problems? _______________________

8. How troubled or bothered have you been in the last 30 days by these medical problems?
   □ Not at all □ Slightly □ Moderately □ Considerably □ Extremely

9. How important to you now is treatment for these medical problems?
   □ Not at all □ Slightly □ Moderately □ Considerably □ Extremely

10. Do you currently use tobacco products? □ YES □ NO □ NEVER
   If yes, what type, how much, and how often? ______________________________________________________________________________
   If no, did you use medication or aids to quit? □ YES □ NO Date started: ______________________________
   If current user, are you interested in assistance with quitting? □ YES □ NO

11. List your current medications:

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<th>Drug</th>
<th>Helpful Y / N</th>
<th>Dosage</th>
<th>Prescribing physician</th>
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12. What **pharmacy** do you use? ____________________________________________

13. Do you have any allergies? □ YES □ NO
   If yes, please list: ________________________________________________________

14. Do you experience any limitations as a result of any health circumstance? □ YES □ NO
   If yes, please list: ________________________________________________________

15. Have you ever needed reasonable accommodation for the above? □ YES □ NO
   If yes, please explain: ____________________________________________________

16. What things do you do that help you stay healthy? ____________________________

17. Current height: ________  Current weight: ________ Circle if rapid **gain** or **loss**?

18. Have you ever been diagnosed with tuberculosis, ARC, AIDS, or HIV? □ YES □ NO

19. Are you pregnant or suspect you may be pregnant, or are you trying to become pregnant? □ YES □ NO
   If yes, describe any prenatal care you are receiving or problems you may be experiencing. _____________________
   ________________________________________________________________________

20. Have you experienced any of the following?

   | Allergies   | Difficulty Sleeping | Memory Problems |
   | Anemia or Blood Disorder | Epilepsy/Convulsions | Migraine |
   | Asthma | Fibromyalgia | Numbness/Tingling in Arms/Legs |
   | Attention Deficit Disorder | Frequent Headaches | Pancreatitis |
   | Been Unconscious | Gastritis | Pregnancy |
   | Bleeding Problems | Glaucoma | Radiation Treatment |
   | Bruise Easily | Head Injuries | Rheumatic Fever |
   | Cancer or Tumor | Heart Problems | Seizures, Convulsions, Fainting |
   | Chest Pains | Hepatitis A / B | Spells or Blackouts |
   | Chronic Fatigue | Hepatitis C | Serious Dental Problems |
   | Chronic Pain | High/Low Blood Pressure | Sinus Trouble |
   | Cirrhosis of the Liver | IV Drug Use | Stomach/Digestive Issues |
   | Coordination/Balance Problems | Jaundice | Stroke |
   | Diabetes | Kidney Problems | Traumatic Events |
   | | | Ulcer |

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**Thank You!**

This information will help us provide you and your family the best possible care.
AGGRESSIVE BEHAVIOR POLICY
24 Hour Programs

All WMMHC Programs are designed to provide a safe place for our clients and staff. Aggressive behavior does not fit into this philosophy, and will not be tolerated at WMMHC facilities, against WMMHC staff, or other clients.

Aggressive behavior is defined as yelling, pushing, physical fighting, throwing objects, swearing, or acting in a manner perceived to be threatening. If aggressive behavior occurs, WMMHC will follow the following established policies and procedures.

STEP ONE: Behavior will be interrupted and documented by staff. Your treatment team will be notified and will work with you to address the aggressive behavior.

STEP TWO: Behavior will be interrupted and documented by staff. Your treatment team will be notified and you will be required to meet with a member of your treatment team to develop a plan for adherence to the policy.

STEP THREE: Behavior will be interrupted and documented by staff. An MHP or evaluation by other appropriate staff member may be utilized. You will be required to attend a treatment team meeting to evaluate appropriateness for continued participation in the program.

The Executive Director and/or Program Manager may exercise discretion in following this procedure to protect the safety of clients, staff, and the program. At any time, if behavior is deemed as causing imminent danger to yourself or others, authorities may be called to intervene.

Client/Guardian Signature: ___________________________________________ Date: __________

Client and Guardian Printed Name: __________________________________________________________

Staff Signature: ___________________________________________ Date: __________
CLIENT ACKNOWLEDGMENT
CONSENT, RIGHTS, AND BEHAVIOR

Please initial below to indicate you have received, read, and understood the following:

______ Consent for Treatment
______ Client Rights in the State of Montana
______ Grievance Procedure
______ General Aggressive Behavior Policy
______ Smoking and Weapons
______ Notice of Privacy Practices

______ For CSCT clients only - Coordination of Care Verification:
“According to Administrative rule (37.106.1956.4), Medicaid requires providers to inform youth and their parents about mandatory coordination expectations between CSCT, home support services, and outpatient therapy. I am aware that coordination is required among providers and collaboration is intended to improve outcomes for my child.”

CLIENT SIGNATURE: ________________________________________________________________

CLIENT PRINTED NAME: ______________________________________________________________

PARENT/GUARDIAN SIGNATURE: __________________________________________________________

PARENT/GUARDIAN PRINTED NAME: ______________________________________________________

STAFF SIGNATURE: ________________________________________________________________

DATE: __________________________
CONSENT FOR TREATMENT

I consent to behavioral health treatment with WMMHC for myself/minor child/designee.

I understand all clients of WMMHC are eligible to receive a range of services addressing substance use disorders, mental health disorders, and medical issues (as applicable) on a limited basis.

The type and extent of services I/my child receive(s) will be determined through a collaborative treatment team effort and through discussion with me/my child in the development of an individualized treatment plan.

I understand a range of behavioral health professionals, some of whom are in training, provide WMMHC services. Designated licensed staff provides oversight to all professionals in training.

I understand the various treatments offered provide significant benefits and may pose risks, which can be discussed with the treatment team. The process of behavioral health recovery may include relapse.

I understand some areas of WMMHC campuses are under camera surveillance to address safety and security concerns.

I understand the success of treatment is dependent upon motivation to change with the therapeutic support of WMMHC professional staff.

I understand if I am at least 16 years of age, I may consent to receive services from WMMHC without parental consent.

CLIENT RIGHTS

Effective Date April 2017

1. You have the right to be treated in a non-discriminatory manner with dignity and respect while receiving behavioral health services at any WMMHC facility.

2. You have the right to be treated without regard to physical or mental disability, unless such disability makes treatment afforded by the facility non-beneficial or hazardous. Treatment will reflect both your ability to benefit from services and others’ treatment rights.

3. You have the right to practice your religion of choice, insofar as such practice does not infringe on the rights and treatment of others. You have the right to be excused from any religious practice.

4. You have the right to participate in the development of an individual treatment plan and any ongoing planning of your behavioral health services. You have the right to a reasonable explanation, in terms you can understand, of your general condition; treatment objectives; the nature and significant possible adverse effects of recommended treatment; reasons this treatment is considered appropriate; and what, if any, alternative treatment services and types of behavioral health providers are appropriate and available.

5. You have the right to be free from excessive or unnecessary medication. You have the right to give informed consent to take or not take antipsychotic or other medications if they are prescribed to you, unless the court has ordered differently or an emergency situation exists where your life or the lives of others are in danger.

6. You have the right to confidential records. Although you must give written approval to allow your records to be released in most cases, there are some exceptions to this rule under state and federal law.

7. You have the right to request access to your records and the right to request corrections or amendments to your records. These and other privacy rights are explained more fully in WMMHC’s Notice of Privacy Practices.

8. You have the right to the maximum amount of privacy consistent with the effective delivery of services to you.
9. You have the right to appropriate treatment and related services under conditions that are supportive of your personal liberty.

10. You have the right to not be subjected to experimental research or other experimentation without your informed, voluntary, and written consent.

11. You have a right to be free from abuse and neglect, or threats of abuse and neglect, while receiving services at WMMHC.

12. You have the right to a humane psychological and physical environment while receiving services at WMMHC.

13. You have the right to receive information about WMMHC’s client grievance procedure and how to file complaints. You must be allowed to exercise this right and other rights without reprisal, including reprisal in the form of denying you appropriate, available treatment. WMMHC recognizes that some clients may need assistance and/or support in filing their grievance. If clients request assistance in this respect, WMMHC will provide a referral to a local client support group, a family member’s support group, or a state designated advocacy agency.

14. You have the right to communication with family in emergency situations.

15. You have the right to receive services which reflect the awareness of the special needs of gender.

16. You may have additional rights listed in Montana Statute, most of which apply to inpatient settings and jail diversion programs and rights during an involuntary commitment process. A member of your treatment team will explain these rights to you if you have concerns.

**GRIEVANCE PROCEDURE**

WMMHC has established a grievance procedure for clients who believe their rights have been violated by the Center. If you feel your rights have been violated, please see any staff member to request a Grievance Form.

**GENERAL AGGRESSIVE BEHAVIOR POLICY**

All WMMHC Programs are designed to provide a safe place for our clients and staff. Aggressive behavior does not fit into this philosophy, and will not be tolerated at WMMHC facilities, against WMMHC staff, or other clients. Aggressive behavior is defined as yelling, pushing, physical fighting, throwing objects, swearing, or acting in a manner perceived to be threatening. If aggressive behavior occurs, WMMHC will follow the following established policies and procedures.

**STEP ONE:** You/your child will be asked to leave the program/office for the day and you/your child will be referred to a member of your treatment team to address the aggressive behavior.

**STEP TWO:** You/your child will be asked to leave the program/office for one week. Prior to returning, you/your child will be required to meet with a member of your treatment team to develop a plan for adherence to the policy.

**STEP THREE:** You/your child will be asked to leave the program/office for 30 days. Prior to returning, you will be required to attend a treatment team meeting to evaluate appropriateness for continued participation in the program.

The Executive Director and/or Program Manager may exercise discretion in following this procedure to protect the safety of clients, staff, and the program. At any time, if behavior is deemed as causing imminent danger to yourself or others, authorities may be called to intervene.

**NOTE:** Due to the unique nature of 24 hour crisis programs, residential programs, detention centers, and CSCT programs additional policies will apply.

**SMOKING & WEAPONS**

WMMHC is invested in the health and well-being of clients and staff. All WMMHC facilities are non-smoking which include all types of tobacco and e-cigarettes. No firearms or weapons are allowed at any WMMHC facility.
NOTICE OF PRIVACY PRACTICES

Effective Date April 2017

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION, INCLUDING SUBSTANCE USE DISORDER TREATMENT RECORDS, MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT AND LEGAL DUTY

Western Montana Mental Health Center recognizes the importance of maintaining the confidentiality and security of your protected health information or ‘PHI’ (individually identifiable information relating to your past, present or future health condition, provision of health care to you, or payment for that health care). As required by law, we maintain safeguards to protect your health information against unauthorized access, use, or disclosure. We are required to give you this notice to inform you of our legal duties and your rights concerning your protected health information, and how we may use or disclose that information. WMMHC is required by law to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make the revised Notice effective for health information we already have about you and any we receive in the future. A copy of the current notice will be posted in a common area of our facilities. You may also request a copy of this notice at any time or access it on our website (www.wmmhc.org).

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

As a health care provider we use and sometimes disclose your PHI for the purposes of treatment (for example to coordinate your care with another provider), payment (verify eligibility and submit claims) and for health care operations (for example quality assurance and improvement activities). Except as outlined below, we will not use or disclose your protected health information for any other purpose or to any one else unless you have given us your authorization to do so. You may give us authorization to disclose your health information to anyone whom you designate. Your authorization must be in writing, using our Release of Information form designating what information may be released and to whom it may be released. You may revoke an authorization at any time but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect.

Your PHI related to substance use disorder treatment is protected by additional Federal laws and regulations which provide a higher level of protection in some circumstances. For example, under these laws, WMMHC may not say to a person outside WMMHC that you attend the program, nor may WMMHC disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law. Other exceptions to permitted uses and disclosures of information related to substance use are indicated in the following section in this notice.

Uses or Disclosure of Your Protected Health Information Permitted or Required Without Your Authorization

When required by law. For example, we may disclose PHI when a law requires us to report certain information, or in response to a court order provided that certain regulatory requirements are met. We may also disclose PHI as required or permitted by law to report suspected abuse or neglect, and as required by authorities that monitor compliance with privacy laws.

In a medical emergency. We may disclose PHI to medical personnel in cases of medical emergency.

To avert threats to health or safety. In order to avoid a serious threat to health or safety, we may disclose PHI to law enforcement in certain situations such as when a threat is made to commit a crime on the program premises or against program personnel.

For research. We may disclose your information for scientific research if certain requirements are met.

Working with Business Associates. PHI may be disclosed to a qualified service organization or business associate who may perform various functions on our behalf or provide certain types of services such as WMMHC's legal counsel and our electronic health records system vendor. Agreements with such parties subject them to the same legal requirements regarding the protection of your PHI.

Relating to decedents. We may disclose certain information to coroners, medical examiner's and/or funeral directors as consistent with the law.

Public Health / Health Oversight: We may disclose PHI as required to public health authorities and to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure.

Treatment and Payment. We may use and disclose your PHI for treatment and payment purposes (described in the second paragraph of this notice). This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.

Military and Special Government Functions. If you are a member of the armed forces we may release information as required by military command authorities. We may also disclose information to Correctional Institutions or for national security purposes. This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.

Unless you object, we may also disclose your health information that is relevant to a family member, relative, close personal friend or any other person identified by you who is involved in your health care or payment related to your health care. This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.
Disclosures of Your Protected Health Information that Require Your Authorization

We will ask for your written authorization before we use or disclose your protected health information for any purpose other than those describe above. For example, we would require your authorization for the use or disclosure of psychotherapy notes in most cases (please note that progress notes are not considered psychotherapy notes). We would also require your authorization for uses or disclosures for certain types of marketing activities and any disclosure that constitutes a sale of health information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. In most cases, you have the right to inspect and obtain a copy of your health information that we maintain in a designated record set. Usually, this includes health information that is used to make decisions about your care, as well as billing records, but does not include psychotherapy notes or information compiled for use in civil, criminal or administrative proceedings, or in other limited circumstances. You must submit your request in writing using our access request form, and we may charge a fee to cover the cost associated with providing you with a copy. In addition, we may deny your request to inspect and copy your information in certain limited circumstances. Depending on the circumstances of the denial, you may have the right to have this decision reviewed.

Right to Amend. If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend that information for as long as the information is kept by us. To request an amendment your request must be made in writing using our amendment request form. We may deny your request if, for example, we determine that your information is accurate and complete, or if the information was not created by us or is not part of the designated record set.

Right to Request Restrictions. You have the right to request a restriction or limitation on certain uses and disclosures of your health information. WMMHC is not required to agree to restrictions you request except under certain circumstances, but if it does agree, then it is bound by that agreement and may not use or disclose any information you have restricted, except as necessary in a medical emergency. Your request must be in writing and contain: the information you want to limit, whether you are requesting a limitation in the use or disclosure of your information, or both, and to whom you want the limitation applied.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures of your health information made by WMMHC. We are not required to provide an accounting of disclosures made to you, disclosures made pursuant to your authorization or certain other disclosures otherwise permitted or required by law (for example, disclosures made for the purposes of treatment, payment or healthcare operations). Your request must be submitted in writing and must specify a time period which may not exceed six years. The first list you request within a 12-month time period will be free; we may charge a fee for additional lists requested within the same 12-month period.

Right to Choose How We Contact You. You have the right to request that we communicate with you in a certain way or at a certain location. For example you may request that we contact you only by phone or mail or email and only at work or at home. We will accommodate any reasonable requests.

Right to a Paper Copy of this Notice. You also have the right to receive a paper copy of this notice at any time.

Right to be Notified of a Breach. You have the right to be notified if a breach occurs that may have compromised the privacy or security of your information.

QUESTIONS AND COMPLAINTS

You may contact WMMHC if you have a question about this Notice. You may also file a complaint with WMMHC or with the Department of Health and Human Services, Office of Civil Rights if you believe your privacy rights have been violated. You will not be penalized for filing a complaint. To ask a question or file a complaint with WMMHC submit your question or complaint in writing to:

Privacy Office, WMMHC
140 N. Russell St.
Missoula, MT 59801