



Sioux County Community Services

CPC APPLICATION INSTRUCTIONS:

This form consists of TWO (2) parts:

1) CPC Application - FILL OUT COMPLETELY OR ASSISTANCE WILL BE DENIED.

- a. **Sign on page 3** - 2 places (truth in disclosure and verification of receipt of privacy practices)
- b. **Sign on page 4.** This is your consent to release information, used to verify information you provided and for coordination of services requested.

If there are no signatures, then the application can not be processed!

- c. **Return application and verifications listed below*:**

By mail to: Sioux County Community Services, P.O. Box 233, Orange City, IA 51041-0233,

In person to: 210 Central Ave SW, Orange City, Iowa (Main Floor Courthouse)

Via fax to: 1-712-707-9243

2) Notice of Privacy Practices (2 pages) – please keep for your records

THE INFORMATION REQUESTED IS REQUIRED TO MAKE AN ACCURATE DETERMINATION REGARDING YOUR ELIGIBILITY FOR ASSISTANCE!

** In addition to your completed application, PLEASE PROVIDE THE FOLLOWING (CURRENT) VERIFICATIONS:*

GROSS EARNINGS OF ALL FAMILY MEMBERS: The gross amount is the amount before any deductions are taken out of your check. Provide copies of pay stubs for the past 30 days (or a signed statement of earnings) from all employers and a complete copy of your most recent federal tax income tax return.

ANY OTHER INCOME RECEIVED, FROM ALL FAMILY MEMBERS: – Child Support, Social Security, Social Security Disability, SSI, Unemployment wages, Retirement benefits, Veterans Benefits, etc; interest payments on savings, CD's, retirement accounts, annuities, etc. Proof may include copies of checks, bank deposit slips, Notice of Award, bank statements showing direct deposit etc. (You may also include proof of child support paid by the applicant).

RESOURCES: Checking and Savings Accounts, Life Insurance, Money Market Funds, all vehicles, real estate (including your home and any other property owned by you or household member), Certificates of Deposit (CD's), etc. Acceptable proofs are: Copies of recent bank statements showing account activity (checking, savings, etc.), life insurance policy statement(s), CD status/earnings statements, bonds, property tax notifications, etc.

OTHER: If applicant was born outside of the United States provide: Notice of Social Security Number Assignment to Third Party OR Original proof of United States Citizenship or Qualified Legal Alien Status.

You will be contacted by mail and/or telephone regarding your eligibility for financial assistance. You may call this office at (712) 737-2999, between the hours of 8:00 a.m. - 4:30 p.m., Monday-Friday, should you have any questions regarding the application process.

Sincerely,

The Office of Sioux County Community Services

IMPORTANT NOTE: If you are approved for assistance and any information provided by you is subsequently found to be erroneous and/or false, your eligibility for assistance will be revoked AND you will be required to repay any and all dollar amounts paid to providers by Sioux county on your behalf, for any and all services previously approved.

P.O. Box 233 · 210 Central Avenue SW · Orange City, IA 51041-0233

Office Hours: Monday-Friday, 8:00 a.m. – 4:30 p.m., *excepting holidays*

Phone: (712) 737-2999 Fax: (712) 707-9243

CENTRAL POINT OF COORDINATION APPLICATION FORM

* PLEASE PRINT CLEARLY *

APPLICATION DATE ____ / ____ / ____

CPC use only: Date application received ____ / ____ / ____

Applicant Name (Person for whom services/ county funding are being requested) _____

Current Street Address _____ City _____ State _____ Zip Code _____ Phone (include area code) _____
Date of Birth ____ / ____ / ____ Social Security Number _____ Male Female

HOW LONG HAS APPLICANT LIVED AT CURRENT ADDRESS? FROM (MONTH/YEAR) ____ TO (MONTH/YEAR) ____

LIST ALL RESIDENCES FOR THE 5 YEARS BEFORE TO MOVING TO YOUR CURRENT ADDRESS : - use extra paper or back of form if necessary:

Street Address	City	State	Zip Code	From (date):	To (date):
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PLEASE CHECK APPROPRIATE RESPONSE AS IT RELATES TO APPLICANT

ETHNICITY: White, not Hispanic Hispanic African American American Indian or Alaskan native Asian or Pacific Islander Other

MARITAL STATUS: Single, never married Married Divorced Separated Widowed

LIVING ARRANGEMENT: Lives alone Lives with relatives/family Lives with person(s) unrelated to him/her

RESIDENTIAL ARRANGEMENT: Private Residence State MHI State Hospital School Supported Comm Living Foster Care/FLH
 RCF RCF/MR RCF/PMI ICF ICF/MR ICF/MR Correctional Facility
 Homeless/Shelter/Street Other _____

IS APPLICANT LEGALLY BLIND? Yes No **CITIZENSHIP:** U.S. Citizen other (specify): _____

IS APPLICANT, or SPOUSE, A VETERAN OF THE U.S. ARMED FORCES, discharged other than dishonorable? Yes No

APPLICANT HAS LEGALLY APPOINTED (check one): GUARDIAN CONSERVATOR PAYEE NOT APPLICABLE

Guardian/Conservator/Payee Name _____ Relationship to applicant _____
Street Address/City/State/Zip Code _____ Phone Number (include area code) _____

APPLICANT'S SERVICE HISTORY

Have you received **ANY** MENTAL HEALTH and/or SUBSTANCE ABUSE RELATED SERVICES in the PAST 12 MONTHS (i.e. therapy, medication, counseling)? Yes No

IF 'YES', please record the last 12-consecutive month time period that you DID NOT receive mental health/substance abuse services and your address at that time:

From(date): _____ To(date): _____ Address (city, state,zip): _____

CHECK ALL services listed below THE APPLICANT currently receives, OR has received in the past, & list approximate date(s) of services:

Title XIX (19) / Medicaid; date(s): _____
 FIP; date(s): _____
 Food Stamps; date(s): _____
 Substance Abuse Services; date(s): _____
 Counseling of any type, ie. related to behavior, anger management, marital &/or family issues, substance abuse, mental health etc.;;
type/date(s): _____ Service Provider(s): _____
type/date(s): _____ Service Provider(s): _____
 Medication related to mental health, behaviors, substance abuse, etc. date(s): _____
 Other: _____ date(s): _____

★★ IF APPLICANT IS A MINOR CHILD or has not gone 12 consecutive months without MH-DD and/or substance abuse services in his/her own right since turning 18 years of age – you MUST fill out the following information:

Check ALL services listed below that the (custodial) PARENT(S) currently receive, or have received in the past, AND the date(s) of service:

Counseling of any type, ie. related to behavior, anger management, marital &/or family issues, substance abuse, mental health etc.;;
type/date(s): _____ Service Provider(s): _____
type/date(s): _____ Service Provider(s): _____
type/date(s): _____ Service Provider(s): _____
 Medication related to mental health, behaviors, substance abuse, etc. date(s): _____
 Other: _____ date(s): _____
 Other: _____ date(s): _____

EMERGENCY CONTACT

Contact Name _____ Relationship to applicant _____
Street Address/City/State/Zip Code _____ Phone Number (include area code) _____

LIST ALL OTHER PERSONS RESIDING (LIVING) IN HOUSEHOLD

<u>Name</u>	<u>Relationship to Applicant</u>	<u>Birthdate</u>
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

Who referred Applicant to this service? Self Family/Friend(s) Targeted Case Management Other Case Management
 Community Corrections Social Service Agency other than Case Management Other

Applicant's primary disability or diagnosis(s), if known? _____

What services are being requested? _____

What services or supports does Applicant receive now? _____

EDUCATION

TOTAL NUMBER OF YEARS OF SCHOOLING APPLICANT (HAS) COMPLETED _____
For example: Gradeschool=8 Highschool=12 Trade/Tech. School=14 College=16

ARE YOU A STUDENT NOW? Yes No -- If Yes, write in school name and address below:

School Name _____ Address _____ City / State / Zip _____

EMPLOYMENT HISTORY of APPLICANT or PARENT if APPLICANT is a MINOR CHILD

IS APPLICANT (OR PARENT(S) OF APPLICANT, IF A MINOR) CURRENTLY EMPLOYED? Yes No
IF "NO", WHY NOT (must be answered): _____

<u>FROM MOST RECENT JOB BACKWARDS</u>				<u>DATES OF EMPLOYMENT:</u>				<u>CHECK ONE:</u>	
<u>EMPLOYER</u>	<u>Phone Number</u>	<u>CITY,STATE</u>	<u>JOB DUTIES</u>	<u>FROM</u>		<u>TO</u>		<u>FULL TIME</u>	<u>PART TIME</u>
				<u>MONTH</u>	<u>YEAR</u>	<u>MONTH</u>	<u>YEAR</u>		
<u>Current Employer:</u>									
<u>Past Employer(s):</u>									

MEDICAL / INSURANCE INFORMATION

TYPE OF HEALTH INSURANCE: Check ALL that apply
 Self-insured Insured by employer Medicare Medicaid Iowa Hawk-I No insurance Other: _____

INSURANCE ID AND/OR POLICY NUMBER(S), IE. MEDICARE/MEDICAID, BCBS, HAWK-I: _____

COMPANY NAME _____ PHONE NUMBER # _____

DOES THIS INSURANCE POLICY COVER MENTAL HEALTH SERVICES? (CHECK ONE) YES NO NOT SURE

IF 'YES': HOW MUCH IS YOUR YEARLY PER PERSON and FAMILY DEDUCTIBLE (IE. \$250/\$500): _____

HOW MUCH IS YOUR CO-PAYMENT (your share of the bill)? (ie. 20%,50%, \$15.00 per visit): _____

HAS YOUR YEARLY INDIVIDUAL DEDUCTIBLE BEEN MET? YES NO NOT SURE

HAS YOUR YEARLY FAMILY DEDUCTIBLE BEEN MET? YES NO NOT SURE NOT APPLICABLE

IF YOU HAVE A MEDICAID, BUT HAVE A SPENDDOWN, HOW MUCH IS YOUR SPENDDOWN (per 2 months): \$ _____

Primary Physician: _____ Address: _____ Phone: _____

Psychiatrist: _____ Address: _____ Phone: _____

Pharmacy: _____ Address: _____ Phone: _____

FINANCIAL INFORMATION

- ALL FINANCIAL INFORMATION PROVIDED IS SUBJECT TO VERIFICATION PRIOR TO ASSISTANCE ELIGIBILITY DETERMINATION-

*** This information MUST BE PROVIDED for ALL persons residing in applicants' household; include SIGNIFICANT OTHERS & ROOMMATES ***

CURRENT <u>GROSS</u> MONTHLY INCOME ---	PRIMARY WAGE EARNER	SPOUSE/ SIGNIFICANT OTHER	ALL OTHER MEMBER(S) OF HOUSEHOLD	
1. Employment wages	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
2. Unemployment wages	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
3. Public assistance payments (rent/utility)	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
4. Social Security	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
5. Social Security/Disability	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
6. Supplemental Security Income	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
7. Veterans Administration Benefits	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
8. Child Support	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
9. Any Other Income	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
10. Food Stamp Benefit (dollar value).....	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
11. Other _____ (ie. rental, donations):.....	\$ _____	_____	_____	<input type="checkbox"/> Not Applicable
Subtotal:	\$ _____	_____	_____	(TOTAL=\$ _____)

RESOURCE INFORMATION - (LIST FOR ALL HOUSEHOLD MEMBERS)

✓	RESOURCE TYPE	ACCOUNT HOLDER / PROPERTY OWNER / AND DESCRIPTION	ACCOUNT BALANCE/ DOLLAR VALUE	NAME OF FINANCIAL INSTITUTION	TOWN/STATE
	Cash on Hand		\$ _____	N/A	N/A
	Checking Account(s)		\$ _____		
	Savings Account(s)		\$ _____		
	Stocks/Bonds		\$ _____		
	Time Certificate(s)		\$ _____		
	Trust Funds(s)		\$ _____		
	Retirement Account(s)		\$ _____		
	Property(ies) owned other than primary residence: rental prop./ boats/ cars/ horses, goats, etc.	Provide description) _____ _____	\$ _____ \$ _____ \$ _____	_____ _____ _____	_____ _____ _____

DOES APPLICANT HAVE A CASEWORKER ? NO YES → **IF 'YES',** Write his/her name and address below:

Case Worker Name _____ Address (City, State, zip code) _____ County _____

Name of person helping to complete this form: _____ Phone#: _____

Relationship to applicant: Self Parent Spouse Guardian Other(explain) _____

ACKNOWLEDGEMENT OF TRUTH IN REPORTING - * PLEASE READ BEFORE SIGNING *

Your signature below signifies the information included in this application is true and correct. The answers provided will determine eligibility for county funding for the services which you are requesting.

I do further authorize the county Central Point of Coordination Administrator to investigate and verify this information, if needed.

X Signature of applicant or legal guardian _____ Date _____

The County will consider this application without regards to race, sex, age, handicap, religion, national origin, or political belief(s).

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, do hereby acknowledge receipt of a copy of Sioux County's Notice of Privacy Practices, Policy and Procedure on my own behalf as the applicant for services, or on behalf of the applicant whom I represent.

X _____ Date _____
Signature of applicant or legal guardian or personal representative

IN THE EVENT THIS DOCUMENT IS RECEIVED BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE:

Legal authority of personal representative Date

AUTHORIZATION TO RELEASE, OBTAIN, AND/OR SHARE INFORMATION

Consumer Name: _____ **SSN:** _____ **DOB:** _____

I, the undersigned, hereby authorize **Shane Walter, Sioux County CPC,** to release to and/or obtain and/or share the information indicated below, regarding the above named Consumer, with:

<input checked="" type="checkbox"/>	Name or Agency to Release, obtain and/or receive information	Authorizing Signature (and relationship to consumer, if not "self")
	Creative Living Center, P.C.	
	Dept Human Services, State/County: _____	
	Case Management, State/County: _____	
	Central Point of Coordination, County _____	
	Financial institution(s): _____	
	Medical and/or Pharmacy Provider	
	Other (specify): _____	
	Other (specify): _____	

INFORMATION TO BE RELEASED FROM CPC OR INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE -- (PLEASE INITIAL EACH MARKED ITEM):

- | | |
|---|------------------------------------|
| _____ Social History | _____ Medical History |
| _____ Psychiatric Assessments/reports | _____ Treatment Plan |
| _____ Psychological evaluations/reports | _____ Progress Summary |
| _____ Mental Health Services History | _____ Educational/vocational plans |
| _____ Discharge Summary | _____ DHS/Case Management History |
| _____ Financial Records/History | _____ Child Support History |
| _____ Other: _____ | _____ Other: _____ |

THE INFORMATION BEING RELEASED WILL BE USED FOR THE FOLLOWING PURPOSE: (PLEASE INITIAL EACH MARKED ITEM):

- | | |
|--|---------------------------------|
| _____ Coordination of services | _____ Referral for new services |
| _____ Monitoring of services | _____ Other: _____ |
| _____ Eligibility Determination for financial assistance | _____ Other: _____ |

This Authorization shall expire one year (12 months) from this date: ___ / ___ / _____

At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the recipient named and to the County CPC. I understand that any information released prior to the revocation may be used for the purposes listed above, and does not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the recipient named, or the CPC.

X _____ **X** _____
Signature of Consumer or Guardian **Date** **Signature of Witness (if required)** **Date**

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW – (initial and sign)

I specifically authorize the release of data and information relating to: <i>(INITIAL AND CHECK SPECIFIC TYPE OF INFORMATION TO BE RELEASED)</i>	<input type="checkbox"/> Substance Abuse _____
	<input type="checkbox"/> Mental Health _____
	<input type="checkbox"/> HIV-related _____

X _____ **Date** _____
Consumer signature

Copy given to consumer? YES NO REFUSED Date: ___ / ___ / _____

Send Information requested to: Sioux County Community Services, PO Box 233, Orange City, IA 51041-0233
Or fax to: Shane Walter, Sioux County CPC @ 1-712-737-2999

Applicant:					
Date:					

Please list the amounts below, ALL considered as standard household expenses: shelter (housing & utilities), food, insurance, transportation etc., irregardless of the source of income (employed or self-employed), or who pays the expenses, (ie. list home

Each household is expected to have at a minimum: a monthly mortgage or rent payment (unless the home is fully paid for), property tax payment (homeowner only), if a home owner, utility expenses, a primary vehicle, vehicle and home insurance expenses, and

<u>Description of Expected Expenses</u>	<u>Property / Vehicle Value (Vehicle) Make, Model, Year</u>	<u>Amount Owed</u>	<u>Amount of Payment</u>	<u>Frequency of Payment (#/year)</u>	<u>For Office use Only: Automatic monthly payment calculation</u>
Home Mortgage or Rent Payment					
Property Taxes (or Escrow Payment)					
Additional Assessment (explain)					
Monthly Utility Average (if all paid on same bill)					
OR: Utilities - Natural Gas					
Utilities - Propane					
Utilities - Water, Sewage, Trash					
Utilities - Electricity					
Vehicle Payment - Family primary vehicle					
Vehicle Payment - Family 2nd vehicle					
Vehicle Payment - 3rd vehicle (if applicable)					
Vehicle Maintenance/Repair					
Home Owners or Renters Insurance					
Vehicle Insurance					
Health/Dental/Eye Insurance Premium					
Life Insurance Premium					
Monthly Food/Household Supply					
School Lunches (children)					
School Fees (children)					
School Tuition					
Musical Instrument Rental (children)					
Child Care					
Medical Expenses: Pharmacy					
Medical Expenses: OTC, Dr, Equipment etc.					
Clothing					
Credit Card Payments					
Other(name):					
Totals:					
Estimated Monthly Income:					

SIOUX COUNTY NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this Notice of Privacy Practices contact Sioux County's Privacy Officer: Shane A. Walter, Community Services Director, P.O. Box 233, Orange City, IA 51041, (712)737-2999, mh-dd@siouxcounty.org.

This Notice of Privacy Practices describes how Sioux County may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

The County is required to abide by the terms of this Notice of Privacy Practices. Changes to policies and procedures will be made as necessary and appropriate to comply with changes in the HIPAA law. The County may change the terms of this notice at any time, provided that the changes are in compliance with regulations and properly documented. The new notice will be effective for all protected health information that the County maintains at that time. Upon request, the County will provide you with a copy of the revised Notice of Privacy Practices which you may pick up at our office, receive by mail, or access on our website www.siouxcounty.org. In the event that you request to receive this Notice of Privacy Practices via email transmission and we are aware that the transmission has failed, a paper copy will be sent to you at the address you provide. If you elect to receive an electronic copy of this notice you may also request, and are entitled to receive, a paper copy of this Notice.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by the County for the purpose of providing or accessing health care services for you. Your protected health information may also be used and disclosed to pay your health care bills and to support the business operation of the County.

The following categories describe ways that the County is permitted to use and disclose health care information. Examples of types of uses and disclosures are listed in each category. Not every use or disclosure for each category is listed; however, all of the ways the County is permitted to use and disclose information falls into one of these categories:

- 1) **Treatment:** The County may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, the County would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example is that protected health information may be provided to a facility to which you have been referred to ensure that the facility has the necessary information to treat you.
- 2) **Payment:** The County may use and disclose health care information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. The County may also discuss your protected health information about a service you are going to receive to determine whether you are eligible for the service, and for undertaking utilization review activities. For example, authorizing a service may require that your relevant protected health information be discussed with a provider to determine your need and eligibility for the service.
- 3) **Healthcare Operations:** The County may use or disclose, as-needed, your protected health information in order to support its business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, the County may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to provide information about alternate services or other health-related benefits.

The County may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the County. Whenever an arrangement between the County and a business associate involves the use or disclosure of your protected health information, the County will have a written contract that contains terms that will protect the privacy of your protected health information.

- 4) **Limited Data Sets / De-Identified PHI:** The County may provide de-identified PHI for the purposes of research, public health, or health care operations. Whenever an arrangement between the County and a business associate involves the use or disclosure of your de-identified protected health information, the County will have a written contract that contains terms that will protect the privacy of your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that the County has taken an action in reliance on the use or disclosure indicated in the authorization.

The County may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then the County may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- 1) **Others Involved in Your Healthcare** - Unless you object, the County may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, the County may disclose such information as necessary if the County, based on its professional judgment, determines that it is in your best interest. The County may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, the County may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
- 2) **Emergencies** - The County may use or disclose your protected health information in an emergency treatment situation. If this happens, The County shall try to obtain your acknowledgment of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

The County may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- 1) **Required By Law** - The County may use or disclose your protected health information to the extent that the use or disclosure is required by law. You will be notified, as required by law, of any such uses or disclosures.
- 2) **Public Health** - The County may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. The County may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- 3) **Communicable Diseases** - The County may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease.
- 4) **Health Oversight** - The County may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- 5) **Abuse or Neglect** - The County may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, the County may disclose your protected health information if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- 6) **Food and Drug Administration** - The County may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
- 7) **Legal Proceedings** - The County may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- 8) **Law Enforcement** - The County may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on county premises, (6) medical emergency (not on the county's premises) and it is likely that a crime has occurred and (7) In response to a law enforcement official's request for such information for the

purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that only the following information, if available, is disclosed: (A) Name and address; (B) Date and place of birth; (C) Social security number; (D) ABO blood type and rh factor; (E) Type of injury; (F) Date and time of treatment; (G) Date and time of death, if applicable; and (H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos. EXCLUDING disclosure for the purposes of identification or location any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

- 9) **Coroners, Funeral Directors, and Organ Donation** - The County may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- 10) **Research** - The County may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- 11) **Marketing** - The County may disclose your protected health information as it pertains to marketing in a face to face encounter with you, by means of a promotional gift or service of nominal value; or when making a marketing communication to you concerning the health related products and services the County provided the County is a) identified as the party making the communication and b) it is prominently stated if the County has received, or will receive, direct or indirect remuneration for making the communication. The communication must, except when it is contained in a newsletter or general communication device, contain instructions describing how you may opt out of receiving future such communications. Communication with you must explain why you received it and how the product or service relates to your health. You may opt out of receiving any further marketing communications from the county by sending a written request to the County Privacy . Send to: Attention Shane Walter, Sioux County CPC, P.O. Box 233, Orange City, IA 51041.
- 12) **Fundraising** - Only demographic information and dates of health care may be disclosed without your authorization to a business associate or to an institutionally related foundation for the purpose of raising funds. You may opt out of receiving any further fundraising communications by sending a written request to the County Privacy Officer. Send to: Attention Shane Walter, Sioux County CPC, P.O. Box 233, Orange City, IA 51041.
- 13) **Criminal Activity** - Consistent with applicable federal and state laws, the County may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The County may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- 14) **Military Activity and National Security** - When the appropriate conditions apply, the County may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. The County may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- 15) **Workers' Compensation** - Your protected health information may be disclosed by the County as authorized to comply with workers' compensation laws and other similar legally-established programs.
- 16) **Inmates** - The County may use or disclose your protected health information if you are an inmate of a correctional facility and the County created or received your protected health information in the course of providing care to you.
- 17) **Required Uses and Disclosures** - Under the law, the County must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine County compliance with the requirements of 45 C.F.R. section 164.500 et. seq.

MITIGATION OF HARMFUL EFFECTS

The County will mitigate, to the extent practicable, any known harmful effect due to inappropriate use or disclosure of protected health information by the County or any of our business associates and inform those responsible for the breach to require prevention of future actions that would have harmful effects.

EFFECT OF PRIOR CONSENTS

The County will use or disclose protected health information about an individual pursuant to an individual's signed consent, authorization, or other express legal permission collected before the applicable compliance date of the HIPAA privacy rule. In addition, the County will NOT make any use or disclosure that is expressly excluded from the consent, authorization, or other express legal permission obtained from an individual, and will comply with all limitations or restrictions placed by the consent, authorization, or other express legal permission obtained from an individual.

YOUR RIGHTS

The following are a list of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as the County maintains the protected health information. A "designated record set" contains medical and billing records and any other records that the County uses in making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the County Privacy Contact if you have questions about access to your medical record.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means you may ask the County not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The County is not required to agree to a restriction that you may request. If the County believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If the County does agree to the requested restriction, it may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the County. You may request a restriction in writing to the County Privacy Officer.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM THE COUNTY BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

The County will accommodate reasonable requests. The County may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. The County will not request an explanation from you as to the basis for the request. Please make this request in writing to the County Privacy Contact.

RIGHT TO REQUEST AN AMENDMENT TO YOUR PROTECTED HEALTH INFORMATION

This means you may request an amendment of protected health information about you in a designated record set for as long as the County maintains this information. In certain cases, the County may deny your request for an amendment. If the County denies your request for amendment, you have the right to file a statement of disagreement with the County and the County may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures the County may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS

You may file a complaint to the County or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the County. You may file a complaint against the County by notifying the County Privacy Officer. The County will not retaliate against you for filing a complaint. You may contact the County Privacy Officer, **Shane A. Walter, Community Services Director** at **(712)737-2999** or **mh-dd@siouxcounty.org** for further information about the complaint process.

This notice was published on and is effective as of April 14, 2003