Mental Health and Disabilities Services Region
Serving residents of Clay, Kossuth, Osceola, Palo Alto, Winnebago, and Worth Counties

The Care Connections of Northern Iowa (CCNIA) Governance Board (each county has one Supervisor representative) has reviewed and approved the region's Management, Annual Service and Budget Plan. The CCNIA, as of July 1, 2014, provides the funding of mental health and/or disability services for individuals currently administered by each county's Community Services office.

If there are other options for healthcare coverage to assist with payment of your services, you will be asked to pursue those funding sources as the Region is considered the funder of last resort.

General Eligibility Guidelines:

- ✓ *The individual is a resident of this state and currently residing in one of the counties comprising the CCNIA Region. If under the age of 18, the custodial parent is a resident of the state of Iowa and the child is physically present in the state and residing in one of the counties comprising the CCNIA region.*
- ✓ *The individual is a United States citizen or in the United States legally.*
- ✓ *Gross income 150% or below federal poverty guidelines. Applicants with income above 150% and not more than 500% are eligible for regional funding with an individual copayment.*
- ✓ *Resources that are equal to or less than $2,000 in countable value for a single-person household or $3,000 for a multi-person household.*
- ✓ *Diagnosis of mental illness or intellectual disability, or a child diagnosed with a serious emotional disturbance.*

As a regional system, we ask you to complete the enrollment/renewal process. As you complete the enrollment, we ask you to provide the following:

- ✓ *A completed, signed, and dated Care Connections of Northern Iowa Regional Application*
- ✓ *Authorizations to Release Information to agencies/individuals involved with your care*
- ✓ *Verification of All Household Income (pay stubs, explanation of benefit forms, etc.)*
- ✓ *Verification of Resources (bank statements for checking and savings, Trust fund, Stocks, and/or Bonds, Certificates of Deposit, cash)*
- ✓ *If you have a legal guardian, a copy of the Guardianship papers*
- ✓ *Copies of all health Insurance Cards*

To document the determination of your disability, a copy of your most recent psychiatric and /or psychological evaluation is needed. If you do not have a copy, please sign an authorization to release information to the clinician who can provide this for our records.

Along with authorizations to release information to your service providers, Care Connections requests an authorization to release information to the Department of Human Services be signed. The Region has consistent contact with this state agency, who provider oversight through its Mental Health and Disability Services Bureau for regional administration and funding for mental health and disability services.

Care Connections is compliant with the Health Insurance Portability and Accountability (HIPAA) Act which outlines the handling of your private health care information.

Please complete, sign and return the enclosed documents and any requested information to CCNIA Enrollment at the Clay County Courthouse 215 W. 4th St., Suite 6, Spencer, Iowa 51301 or to intake@ccnia.org by _____. *If we have not heard from you by that date listed above, we will assume you are no longer interested in applying for services and will code this request as a "no service."*

We look forward to continuing our work with you and your service providers within the regional administrative structure.

If you have specific questions about the region, please contact Care Connections of Northern Iowa at 712-264-3945 or at intake@ccnia.org

Care Connections of Northern Iowa Application Form

For individuals living in: Clay, Kossuth, Osceola, Palo Alto, Winnebago, and Worth Counties

Application Date: _____ **Date Received by Office:** _____

First Name: _____ **Last Name:**_____ _____ **MI:** _____

Nickname: _____ **Maiden Name:** _____

Birth Date: _____ **Ethnic Background:** ☐ White ☐ African American ☐ Native American ☐ Asian ☐ Hispanic ☐ Other _____

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

SSN# _____ **State ID:** _____

Marital Status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

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

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

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

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

Current Residence: _____
Street City State Zip County

Date you moved here:_____ Reside: ☐ Alone ☐ With Relatives ☐ Unrelated Persons **County of Residence:** _____

Current Mailing Address: ☐ Yes ☐ No **If not,** _____
Street Address City State County

Current Residential Arrangement: (Check applicable arrangement)

☐ Private Residence ☐ Supported Comm. Living ☐ State MHI ☐ Homeless/Shelter/Street
☐ Foster Care/Family Life Home ☐ RCF ☐ Correctional Facility
☐ Other_____

Current Service Providers:

Name: **Location:**

1._____

2._____

3._____

Current Employment: (Check applicable employment)

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

Current Employer: _____ **Position:**_____
Dates of Employment: _____ **Hourly Wage:** _____ **Hours worked weekly:** _____

Employment History:

Employer	City, State	Job Title	Duties	To/From
1.				
2.				
3.				

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

Emergency Contact: _____ **Relationship:** _____

Address: _____ **Phone:** _____

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

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

Name: _____

Address: _____

Phone: _____

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

Name: _____

Address: _____

Phone: _____

List all People In Household:

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		

INCOME: Proof of income is required with this application such as: pay-stubs, tax-returns, recent bank statements, etc. If you have reported no income below, how do you pay your bills? (Do not leave blank if no income is reported)

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

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

	Amount:	BANK, TRUSTEE, OR COMPANY
☐ Cash	_____	_____
☐ Checking Account	_____	_____
☐ Savings Account	_____	_____
☐ Certificates of Deposit	_____	_____
☐ Trust Funds	_____	_____
☐ Stocks and Bonds (cash value?)	_____	_____
☐ Burial Fund/Life Ins (cash value?).	_____	_____
☐ Retirement Funds (cash value?)	_____	_____
☐ Other _____	_____	_____
☐ Other_____	_____	_____

Total Resources: _____

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

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

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

If yes to any of the above, please explain: _____

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

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

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

Company Name _____

Address _____

_____

Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No
Spend Down: _____ Deductible: _____

Secondary Carrier (pays 2nd)

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

Company Name _____

Address _____

_____

Policy Number_____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No
Spend Down: _____ Deductible: _____

Referral Source:
☐ Self ☐ Community Corrections ☐ Family/Friend ☐ Social Service Agency
☐ Targeted Case Management ☐ Other _____ ☐ Other Case Management

Have you applied for any of the public programs listed below?
(Please check those you have applied for and the status of your referral) Please advise if your application has been Approved or Denied. If you appealed the denial, please advise of the date of appeal _____ Please advise if you have applied for reconsideration. Please advise if you have had a hearing with an Administrative Law Judge and the date of the scheduled hearing:_____

☐ **Social Security**_____ ☐ **SSDI**_____ ☐ **Medicare**_____
_____ _____
_____
☐ **SSI** _____ ☐ **Medicaid**_____ ☐ **DHS Food**
_____ _____ **Assistance:**_____

☐ **Veterans** _____ ☐ **Unemployment**_____

_____ _____

☐ **FIP** _____ ☐ **Other**_____ ☐ **Other** _____

_____ _____ _____

Disability Group/Primary Diagnosis:

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

Specific Diagnosis determined by:_____ **Date:**_____

Axis I: _____**Dx Code:** _____

Axis II:_____ **Dx Code:** _____

Name and location of your current general physician: _____

Name and location of your current Pharmacy: _____

As a signatory of this document, I certify that the above information is true and complete to the best of my knowledge, and I authorize the Care Connections of Northern Iowa staff to check for verification of the information provided including verification with Iowa county government and the state Iowa Dept. of Human Services (DHS) staff.

I understand that the information gathered in this document is for the use of Care Connections of Northern Iowa in establishing my ability to pay for services requested, and in assuring the appropriateness of services requested. I understand that information in this document will remain confidential.

_____

Applicant's Signature (or Legal Guardian) **Date**

_____

Signature of other completing form if not Applicant or legal Guardian **Date**

FOR REGIONAL OFFICE USE ONLY:

- ☐ Verification of All Household Income
- ☐ Copies of Guardianship Papers
- ☐ Releases of Information
- ☐ HIPAA Signature Form
- ☐ Psychological Evaluations/Reports
- ☐ Copies of All Health Insurance Cards
- ☐ Diagnosis Sheet

Care Connections of Northern Iowa
215 W. 4th St. Suite 6 Spencer IA 51301

PHONE: 712-264-3945
FAX: 712-262-9016
EMAIL: intake@ccnia.org
WEB: ccnia.org

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Authorization for the Use or Disclosure of Confidential Information

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

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

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

AUTHORIZATION SECTION

Client Name: _____ Date of Birth: _____ Client #: _____

Address: _____

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

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

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

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby specifically authorize the release and sharing of information with Iowa Counties and Regions listed on Exhibit A and/or case management agencies, relating to: (check any that apply)

NOTE: This authorization for release of information does not authorize the release and/or sharing of information relating to substance use disorder treatment.

☐ HIV/AIDS Related Testing Information

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

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

☐ _____/____/_____ (specify date).

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

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

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client

☐ guardian or conservator of a client (if and to the extent authorized under State law)

☐ personal representative of deceased client

☐ other (specify) _____

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

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

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

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

EXHIBIT A

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

REVOCATION SECTION

I hereby revoke this Authorization.

Signed:_____ Date:_____

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

Release of Information

CLIENT _____

ADDRESS:_____DATE OF BIRTH: _____

I, the undersigned, hereby authorize the staff of Care Connections of Northern Iowa to release and / or obtain the information indicated below, regarding the above named consumer, with:

DHS

Name of Person or Agency

Complete Mailing Address

The information being released will be used for the following purpose:

- ☑ Planning and implementation of Services
- ☑ Coordination of services
- ☑ Monitoring of services
- ☑ Referral for new or other services
- ☐ Other (Specify)_____

Your eligibility for services or funding ☑ **is** ☐ **is not** dependent upon signing this release. {See CFR 164.508(b)(4)}

INFORMATION TO BE RELEASED FROM COMMUNITY SERVICES:		**INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:**	
Yes	No	Yes	No
☑	☐ SOCIAL HISTORY	☑	☐ SOCIAL HISTORY
☑	☐ PROGRESS SUMMARY REPORT	☑	☐ EDUCATIONAL/VOCATIONAL PLANS
☐	☑ INDIVIDUAL COMPREHENSIVE PLAN	☑	☐ PROGRESS SUMMARY
☑	☐ ANNUAL REVIEW	☑	☐ PSYCHOLOGICAL EVALUATION/ REPORTS
☑	☐ DISCHARGE SUMMARY	☑	☐ PSYCHIATRIC ASSESSMENT / REPORTS
☐	☐ RE-RELEASE OF 3RD PARTY INFO (Specify)	☑	☐ MEDICAL HISTORY
(Your information will not be re-released without a signed authorization)			
☑	☐ TREATMENT PLAN	☑	☐ DISCHARGE SUMMARY
☐	☐ OTHER (Specify)_____	☐	☑ RE-RELEASE OF 3RD PARTY INFO
(Specify)_____		☐	☐ FINANCIAL DOCUMENTATION
		☐	☑ OTHER (Specify)_____

This authorization shall expire on:_____(Not to exceed 12 months)

At that time, no express revocation shall be needed to terminate my consent. I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to Care Connections of Northern Iowa. 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 any disclosure of information carries with it the potential for un-authorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named of Care Connections of Northern Iowa.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW: I specifically authorize the release of data and information relating to Mental Health.

Signature of Client or Legal Guardian:_____ Date: _____

_____

Relationship if NOT The Client

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAWS:

I specifically authorize the release of data and information relating to:

☐ Substance Abuse (must be signed by the consumer) ☐ HIV-Related Information

_____ _____ _____ _____

Client Signature **Date** **Guardian Signature** **Date**

In order for this information to be released, you must sign here and on the signature line above.

Copy given to Client on:_____ *OR* Client refused copy on:_____

Release of Information

CLIENT _____

ADDRESS:_____DATE OF BIRTH: _____

I, the undersigned, hereby authorize the staff of Care Connections of Northern Iowa to release and / or obtain the information indicated below, regarding the above named consumer, with:

Mental Health Agency

Name of Person or Agency

Complete Mailing Address

The information being released will be used for the following purpose:

- ☑ Planning and implementation of Services
- ☑ Coordination of services
- ☑ Monitoring of services
- ☑ Referral for new or other services
- ☐ Other (Specify)_____

Your eligibility for services or funding ☑ **is** ☐ **is not** dependent upon signing this release. {See CFR 164.508(b)(4)}

INFORMATION TO BE RELEASED FROM COMMUNITY SERVICES:

Yes	No	
☑	☐	SOCIAL HISTORY
☑	☐	PROGRESS SUMMARY REPORT
☑	☐	INDIVIDUAL COMPREHENSIVE PLAN
☑	☐	ANNUAL REVIEW
☑	☐	DISCHARGE SUMMARY
☑	☐	RE-RELEASE OF 3RD PARTY INFO (Specify)

(Your information will not be re-released without a signed authorization)

☑	☐	TREATMENT PLAN
☑	☐	OTHER (Specify)_____

(Specify)___Diagnostic_____

INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:

Yes	No	
☑	☐	SOCIAL HISTORY
☑	☐	EDUCATIONAL/VOCATIONAL PLANS
☑	☐	PROGRESS SUMMARY
☑	☐	PSYCHOLOGICAL EVALUATION/ REPORTS
☑	☐	PSYCHIATRIC ASSESSMENT / REPORTS
☑	☐	MEDICAL HISTORY
☑	☐	DISCHARGE SUMMARY
☐	☑	RE-RELEASE OF 3RD PARTY INFO
☑	☐	FINANCIAL DOCUMENTATION
☐	☐	OTHER (Specify)_____

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Signature of Client or Legal Guardian:_____ Date: _____

_____

Relationship if NOT The Client

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☐ Substance Abuse (must be signed by the consumer) ☐ HIV-Related Information

_____ _____ _____ _____

Client Signature **Date** **Guardian Signature** **Date**

In order for this information to be released, you must sign here and on the signature line above.

Copy given to Client on:_____ *OR* Client refused copy on:_____

Release of Information

CLIENT _____

ADDRESS:_____DATE OF BIRTH: _____

I, the undersigned, hereby authorize the staff of Care Connections of Northern Iowa to release and / or obtain the information indicated below, regarding the above named consumer, with:

MCO

Name of Person or Agency

Complete Mailing Address

The information being released will be used for the following purpose:

- ☑ Planning and implementation of Services
- ☑ Coordination of services
- ☑ Monitoring of services
- ☑ Referral for new or other services
- ☐ Other (Specify)_____

Your eligibility for services or funding ☑ **is** ☐ **is not** dependent upon signing this release. {See CFR 164.508(b)(4)}

INFORMATION TO BE RELEASED FROM COMMUNITY SERVICES:		**INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:**	
Yes	No	Yes	No
☑	☐ SOCIAL HISTORY	☑	☐ SOCIAL HISTORY
☑	☐ PROGRESS SUMMARY REPORT	☑	☐ EDUCATIONAL/VOCATIONAL PLANS
☑	☐ INDIVIDUAL COMPREHENSIVE PLAN	☑	☐ PROGRESS SUMMARY
☑	☐ ANNUAL REVIEW	☑	☐ PSYCHOLOGICAL EVALUATION/ REPORTS
☑	☐ DISCHARGE SUMMARY	☑	☐ PSYCHIATRIC ASSESSMENT / REPORTS
☐	☑ RE-RELEASE OF 3RD PARTY INFO (Specify)	☑	☐ MEDICAL HISTORY
(Your information will not be re-released without a signed authorization)			
☑	☐ TREATMENT PLAN	☑	☐ DISCHARGE SUMMARY
☐	☑ OTHER (Specify)_____	☑	☐ RE-RELEASE OF 3RD PARTY INFO
(Specify)_____		☑	☐ FINANCIAL DOCUMENTATION
		☐	☐ OTHER (Specify)_____

This authorization shall expire on:_____(Not to exceed 12 months)

At that time, no express revocation shall be needed to terminate my consent. I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to Care Connections of Northern Iowa. 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 any disclosure of information carries with it the potential for un-authorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named of Care Connections of Northern Iowa.

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Relationship if NOT The Client

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I specifically authorize the release of data and information relating to:

☐ Substance Abuse (must be signed by the consumer) ☐ HIV-Related Information

_____ _____ _____ _____

Client Signature **Date** **Guardian Signature** **Date**

In order for this information to be released, you must sign here and on the signature line above.

Copy given to Client on:_____ *OR* Client refused copy on:_____

CARE CONNECTIONS OF NORTHERN IOWA NOTICE OF PRIVACY PRACTICES

March 21, 2014 Amended May 26, 2020

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

If you have any questions about this notice, please contact Melissa Loehr, CCNIA Regional Chief Executive Officer at 215 W. 4th St. Suite 6. Spencer, IA 51031 or 712-264-3945.

Care Connections of Northern Iowa is required by law to maintain the privacy of your Health Information and to provide you with this notice of their legal duties and privacy practices with respect to your Health Information and to notify you following a breach of unsecured Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules").

WHO SHOULD READ THIS NOTICE?

This notice is for participants enrolled in services covered by the regional Management Plan of the Care Connections of Northern Iowa, a legal entity formed by a 28 E Agreement between Clay, Kossuth, Osceola, Palo Alto, Winnebago, and Worth Counties.

WHAT IS HEALTH INFORMATION?

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

WHAT GROUP HEALTH PLANS ARE COVERED BY THIS NOTICE?

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

- Care Connections of Northern Iowa (CCNIA) Regional Management Plan

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

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

The regional management plan sponsored by Care Connections of Northern Iowa is part of an organized health care arrangement. This means that these health plans may share your Health Information with each other as needed for the purposes of payment and health care operations, as described in this notice.

HOW ARE THE PLANS ADMINISTERED?

The CCNIA Management Plan does not have employees. Instead, employees of the participating counties of the 28 E Agreement or, retained by Care Connections of Northern Iowa, administer the Plan. Certain employees of Participating Counties of the 28E Agreement perform administrative services for the Plans. When these employees perform plan administration functions on behalf of the Plans, they keep your Health Information separate and do not share it with other employees within the Care Connections of Northern Iowa unless permitted by the HIPAA Privacy Rules.

HOW MAY YOUR HEALTH INFORMATION BE USED OR DISCLOSED?

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

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

- paying claims from providers for any covered treatment and services provided to you;
- determining disputed claims, eligibility for benefits, coordination of benefits, and cost sharing arrangements;
- asserting our right to subrogation and reimbursement;
- examining medical necessity;
- obtaining payment under stop loss insurance; and
- conducting utilization review.

We may not however use or disclose any Health Information that is genetic information for underwriting purposes.

Example
When you obtain a covered health service, your provider may submit Health Information to us, and we may create or access Health Information to arrange payment of the claim.

Health Care Operations. Your Health Information may be used to operate and administer the Plans. These operations include, among other things, engaging in care coordination, case management, disease management, risk assessment, premium determination, audit functions, detection of fraud and abuse and quality assessments and improvement activities. We may not however use or disclose any Health Information that is genetic information for underwriting purposes.

Example
If you are diagnosed with a chronic disease, your Health Information may be used for purposes of disease management. This means you may be contacted by our disease management specialists about possible treatment alternatives.

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

Example
Your Health Information may be disclosed to your pharmacist who may request it to coordinate a pending prescription with prior prescriptions.

Plan Sponsor. Your Health Information may be disclosed to or used by the Care Connections of Northern Iowa, as Plan Sponsor, for the purpose of conducting plan administration functions, as permitted by the HIPAA Privacy Rules. Care Connections of Northern Iowa will not, however, use or disclose your Health Information created by or received from the Plan for any employment related functions, without your authorization.

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

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

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

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

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

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

Parents of Minors. Health Information of a minor child, in most cases, will be disclosed to a parent or guardian of that minor, subject to certain limitations imposed by State law.

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

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

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

WHAT ARE YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION?

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

For Care Connections of Northern Iowa, submit requests to:

Care Connections of Northern Iowa
Privacy Officer
Anna Miller
215 W. 4th St., Suite 6
Spencer, IA 51301
Phone: 712-264-3945
Email: amiller@CCNIA.org

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

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

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

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

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

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

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

Right to a Paper Copy of This Notice. You may request a paper copy of this notice at any time by contacting the Care Connections of Northern Iowa Regional Chief Executive Officer at 215 W. 4th St. Suite 6. Spencer, Iowa 51301 (712)264-3945.

Complaints. If your privacy rights have been violated, you may file a complaint with the Care Connections of Northern Iowa Privacy Official or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. Complaints must be made in writing and submitted either to:

Care Connections of Northern Iowa
Privacy Officer
Anna Miller
215 W. 4th St., Suite 6
Spencer, IA 51301
Phone: 712-264-3945
Email: amiller@CCNIA.org
or

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

WHEN IS THIS NOTICE EFFECTIVE?

This notice becomes effective July 1, 2020 and will remain in effect until we replace it. The Plans are required by law to abide by the terms of this Notice, as may be amended from time to time. We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for Health Information we currently maintain as well as any information received in the future

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

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practice, Policy, and Procedure.

_____

Signature of Individual

_____

Date

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

_____

Signature of personal representative Date

_____

Legal authority of personal representative