HEALTH AND HUMAN SERVICES DEPARTMENT

Phone: (503) 434-7523 | Fax (503) 434-9846
TTY: (800) 735-2900 | https://www.yamhillcounty.gov
Adult Behavioral Health: 627 NE Evans Street | McMinnville, OR 97128

WELCOME TO ADULT BEHAVIORAL HEALTH SERVICES

We recognize that mental health and alcohol and drug use may affect many areas of your life. Yamhill County Health and Human Services (YCHHS) aims to embrace and create hope.

Our goal is to help you identify your strengths and needs. Then, we want to find ways to address the concerns that brought you in. Our main focus will be helping you recover from mental health and/or alcohol or drug use. We also know these have many causes. Such as physical, emotional, or social factors. These are difficult but treatable problems. Our services are intended to be a whole-person care model. We address several of your concerns at once. We seek to increase care coordination and work as part of your team with primary care, emergency care, and other agencies involved in your care.

Individuals respond to stress and learn new coping skills differently. We offer a variety of treatment methods. Those include individual and group counseling, educational classes, peer support, life skills, health management, medications, transition skills, and recovery planning. Treatment is designed to give you chances to make choices that will support your recovery.

Many of our services are short-term. They are intended to address primary needs. An assessment will help identify needs, how to treat those, and the length of services. Treatment may sometimes last longer. Or services are added. We will work together to close you to services when the concerns that brought you here cause fewer problems in your life. We believe in recovery. We believe in helping you manage your own behaviors or symptoms. It will be important for you and your providers to work as a team to best address your needs within the planned number of sessions.

GETTING STARTED:
We have an open-access process. Our goal is for you to be able to walk in and be open to services on the same day. Walk-in access is 8 a.m. to 3 p.m., Monday through Friday. First, you will complete orientation paperwork. Next, there will be an assessment. The process will likely take about two hours. We encourage you to return the next day if there are no more walk-in openings. If you have any questions, please call our main office at **503-434-7462** Monday through Friday, 7:30 a.m. to 5:30 p.m. We will be happy to help.

We are in-network for OHP/YCCO, Providence, and United/Optum Insurance. If you have other insurance or no insurance, please inquire with us.

For services at our Newberg location, please call them directly at **503-538-8970**.

Most of all, we want to welcome you. If there is anything we can do to help make your treatment better, please let us know.

HEALTH AND HUMAN SERVICES

BEHAVIORAL HEALTH RESOURCE LIST

This form is available in alternative formats including large print, Spanish and oral presentation.

NEED HELP NOW? CALL 9-1-1
IF SOMEONE IS BEING HURT OR IS IN DANGER RIGHT NOW, CALL 911 IMMEDIATELY!

Suicide & Crisis Help Lines - available 24/7

Suicide and Crisis Lifeline	Call, text or chat 988. *Military Call: 988 then press 1 Text: 838255	https://988lifeline.org/ https://www.veteranscrisisline.net Online chat available

Mental Health Support

Yamhill County Behavioral Health	Adult Behavioral Health	503-434-7523	https://www.yamhillcounty.gov/Adult-Services
	Family and Youth Services	503-434-7462	https://www.yamhillcounty.gov/Youth-Services
Lines for Life	Mental Health Support	24/7 1-844-842-8200 TTY: 1-800-799-4889	https://www.linesforlife.org/get-help-now
	Military Helpline	888-457-4838 Text: MIL1 to 839863 between 9-3 pm	https://www.linesforlife.org/get-help-now/military ***Online chat available***
	Youth Line	(877-968-8491) Text: teen2teen to 839863	https://www.theyouthline.org ***Online chat available***
	Alcohol & Drug Helpline	(800-923-4357)	https://www.linesforlife.org/recovery-resources
	Racial Equity Support Line	(503-575-3764)	https://www.linesforlife.org//racial-equity
	Senior Loneliness Line	(503-200-1633)	https://seniorlonelinessline.org/
LGTBQ - Youth Line	1-866-488-7386 Text START to 678-678	https://www.thetrevorproject.org ***Online chat available***	
Reach Out - Oregon Family Support	1-833-732-2467 Monday-Friday 12-7 pm (except holidays)	https://www.reachoutoregon.org ***Online chat available***	

Substance Use, Addiction & Recovery Support

Overdose Prevention & Treatment	1-800-662-HELP (4327) Text 435748 (HELP4U)	https://findtreatment.gov/
Never Use Alone	1-877-696-1996	https://neverusealone.com/ ***Online chat available***
Poison Control	1-800-222-1222	https://www.poison.org/ ***Online chat available***
Oregon Gambling Helpline	877-695-4648	https://www.opgr.org/ ***Online chat available***
National Gambling Helpline	1-800-Gambler	https://www.ncpgambling.org/help-treatment ***Online chat available***

BEHAVIORAL HEALTH RESOURCE LIST

Declaration for Mental Health Treatment (adults):
Oregon has a form that you can fill out and sign now to protect yourself when you may be in crisis and are unable to make your own treatment decisions. It is entirely your choice whether or not you want to have a Declaration. This needs to be done on an official form, which can be found at:

https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9550.pdf

(you can ask a staff member to provide you a printed copy)

Oregon Voter Registration (adults):
Per the National Voter Registration Act, YCHHS can help you become registered to vote. Applying to register or declining to register to vote will not affect your services provided by YCHHS. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

- Online voter registration: https://sos.oregon.gov/voting/Pages/registration.aspx
- Mail-in voter registration card: https://sos.oregon.gov/elections/Documents/SEL500.pdf
  (you can ask a staff member to provide you a printed copy)

Voluntary LEDS Medical Database:
Informing Law Enforcement Response to Emergency Situations Individuals with mental illness can voluntarily Disclose their medical information to YCHHS. The information will be entered into the Law Enforcement Data System (LEDS) to help responding agencies assist persons with a qualifying illness or condition to obtain medical, mental health and social services when responding to a request for an emergency service. The information will be accessed only to provide necessary information to responding law enforcement officers and other emergency personnel to assist in an emergency situation.

The database:

- Provides law enforcement access to behavioral health information, and
- Enables an informed response when law enforcement encounters individuals having behavioral health issues.

Enrollment Information
If you or a family member are interested in finding out more about enrolling in this database, the form for enrollment is available online at https://apps.state.or.us/Forms/Served/le3466.doc to complete and return the YCHHS. *(you can ask a staff member to provide you a printed copy)*

In order to be eligible for enrollment, the individual must:

- Have a qualifying illness or condition,
- Provide their express written consent, and
- Have the consent of the person authorized to make medical decisions for the individual (if any). This is required for individuals who are under 14 years of age, or who are subject to a guardianship, advanced directive for health care, declaration for mental health treatment or power of attorney.

HEALTH AND HUMAN SERVICES

BEHAVIORAL HEALTH RIGHTS AND RESPONSIBILITIES

This form is available upon request in alternative formats including large print, Spanish and oral presentation.

As a client of Yamhill County Health and Human Services (YCHHS), you have the right to:

1. Be treated with dignity and respect;
2. Have religious freedom;
3. Access services that are client directed, as well as sensitive and respectful of culture and trauma;
4. Receive services that promote recovery, resilience, wellness, and independence;
5. Be free from abuse or neglect;
6. To report any incidents of abuse or neglect without retaliation;
7. Be informed of our policies service agreements, and service fees. You also have the right to have someone present who can assist you with understanding this information;
8. Have an opportunity to make a declaration for mental health treatment, when legally an adult;
9. Have an opportunity to make a declaration for mental health treatment, when legally an adult;
10. Have expected outcomes, and the possible risks and benefits of treatment, explained to you;
11. Confidentiality, including the right to approve or decline the disclosure of your personal information, except as required by law or third-party payment contract;
12. Consent to, or decline, treatment prior to the start of services, except in a medical emergency or as otherwise allowed by law. Minor children may give informed consent to services if:
    Under age 18 and married;
    Age 16 or older and emancipated by the court; or
    Age 14 or older for outpatient services (excludes residential programs, day or partial hospitalization programs);
13. Participate in your assessment and service plan development and reviews;
14. Have family and/or a guardian involved in treatment planning and services;
15. Be provided a copy of your service plan;
16. Ask for a no cost second opinion by another provider;
17. Receive treatment in the most appropriate and least restrictive or intrusive setting;
18. Interpreter services;
19. Medication that is specific to my clinical needs, including medications used to treat opioid use disorders;
20. Prior notice of a transfer, except in cases where this might put any person at risk of harm;
21. Receive a copy of your medical record upon request;
22. Be free from seclusion and restraint;
23. Decline participation in experimentation;
24. Be informed at the start of services and periodically thereafter of the rights within Oregon Administrative Rule (OAR) 309-019-0115;
25. File grievances, including appealing decisions resulting from the grievance;
26. Exercise all rights set forth in ORS 109.610 through 109.697 if a child;
27. Exercise all rights set forth in ORS 426.385 if committed to the Oregon Health Authority;
28. Exercise all rights described in OAR 309-019-0115 without any form of reprisal or punishment; and
29. Refer to the Member's Handbook if your insurance is Yamhill Community Care (YCC).

As a client of YCHHS, I agree to:

1. Schedule and arrive on time for appointments. When unable to attend, I will cancel with at least 24 hours' notice;
2. Participate in the development of my service plan;
3. Review progress toward treatment goals with my provider and to make changes, as needed;
4. Be an active participant in my treatment;
5. Communicate with staff about any problems or concerns;
6. Take medications as prescribed and to notify YCHHS of any changes to outside prescriptions;
7. Seek help for medical, mental health, and/or substance use issues, as these may interfere with my treatment;
8. Pay any fees at the time of service;
9. Report any change in insurance or my financial situation;
10. Treat staff, residents, and visitors with dignity and respect [regardless of our individual differences]. Not behave or speak in a way that might offend others, harm others, or make anyone feel unsafe; and
11. Refrain from any form of disrespect, violence, or intimidation (verbal, sexual, or physical) to any person. This includes racial, ethnic, or other types of harassment, whether verbal or physical in nature.

Mandatory Abuse Reporting: YCHHS employees are required by law to report suspected abuse or neglect. These reports require the disclosure of protected health information.

HEALTH AND HUMAN SERVICES

Client Name: _____ DOB: _____

CONSENT TO TREATMENT FORM

You can get this form in different ways, like in large print or other languages.
If you need help with this form, just ask us.

Welcome to Yamhill County Health and Human Services (YCHHS)! We want you to be aware of your rights during the treatment process and how to resolve any issues if they arise. Before we move forward in the process, we want you to have the chance to make an informed decision about doing so. The term "informed decision" means making a decision based on information that you have about different options. This form provides some possible risks and benefits of behavioral health services so that you are able to make an informed decision about moving forward with services. By signing this form, you are agreeing (or consenting) to treatment based on some basic information about our services.

Services that may be provided:

- Case Management
- Groups
- Skills Training
- Therapy
- Supported Employment/Education
- Peer Support
- Medication Management

Possible benefits of getting services:

- You may have improvement in your mental health and/or alcohol or drug symptoms or behaviors over time.
- You may gain or improve skills for managing any symptoms or behaviors that cause problems in your life.
- You may gain the results you want. Such as improving your social life, family relationships, or your functioning in work or schoolwork, or any other areas of your life.

Possible risks of getting services:

- May not gain the outcomes you are hoping for.
- Mental health symptoms and/or alcohol or drug use may increase in the short term at the beginning of treatment.
- If prescribed any medication, you may feel uncomfortable side effects.
- You may not connect well with your counselor. We suggest at least four meetings together to decide if it is a good fit.

Please review and initial that:

_____ I have the right to refuse to sign this consent.
If I refuse to sign this consent, or I revoke it in the future, YCHHS will not provide any treatment to me. Exceptions to this include certain types of emergencies or as required by law.

_____ I understand that this consent is in effect until I revoke it or close to treatment.

_____ I opt-in for telehealth/telemedicine services if I want to gain services this way (where available).*

_____ I acknowledge receipt or declination of the YCHHS Behavioral Health Information and Policies packet. I understand these documents can be provided upon request, in print and alternative formats and are available on our website at https://www.yamhillcounty.gov/Health-Human-Services

I give my informed consent to engage in treatment at Yamhill County Health and Human Services Behavioral Health.

Signature of Individual/legal guardian: **Date:** **Relationship to client:**

☐ Legal Guardian Documentation on File

*YCHHS providers will meet HIPAA privacy, 42 CFR Part 2, and security and privacy standards.

Can I Plan Now For The Mental Health Treatment I Would Want If I Were In Crisis?

A Guide to Oregon's Declaration for Mental Health Treatment

Oregon Health Authority
ADDICTIONS AND MENTAL HEALTH DIVISION

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact AMH at 503-945-5763 or 1-800-875-2863 (TTY).

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ANSWERS TO QUESTIONS

Planning for Your Mental Health Treatment

Can I plan now for the mental health treatment I would want if I were in crisis?

Yes. You can plan now for a time when you may be unable to make your own mental health treatment decisions.

How can I plan ahead?

Oregon has a form that you can fill out and sign now to protect yourself when you may be in crisis and are unable to make your own treatment decisions. This form is called a **Declaration for Mental Health Treatment**.

Who decides if I am unable to make my own treatment decisions?

Only a court or two physicians can decide if you are unable to understand and make decisions about your mental health treatment.

*A **Declaration** form is used only when you are unable to understand and make decisions about your mental health treatment.*

What kind of advance planning does Oregon's Declaration for Mental Health Treatment allow me to make?

You can make choices about your future mental health care. You can describe the kind of care that you want to receive. You can also describe the kind of care you do not want to receive.

You can also provide additional information about your mental health treatment needs.

*It is wise to prepare this part of the **Declaration** carefully. You may want to discuss this section with your physician or mental health provider.*

Can I ask someone to speak for me when I am in crisis and can't speak for myself?

Yes. You can choose an adult to represent you. This should be someone you trust who can make decisions about your mental health care when you cannot do so for yourself. Of course, the person you name must agree to do so.

On the **Declaration** form the person you choose is called a Representative.

Do I have to choose a lawyer?

No.

Can my representative make mental health treatment decisions that change my own wishes for treatment?

No. Your representative *must* follow your wishes. It is wise to talk to your representative about your wishes.

Even if you have not made your wishes known, your representative must make decisions for that are as close as possible to the kind of decision you would make yourself if you were capable of doing so.

Your physician is not required to give you the medicine you have chosen in your **Declaration** form if your physician believes that it is not good for you. However, your physician must have your representative's *permission* to give you a medicine that is *not listed* in the **Declaration**.

This is why it is important for you to choose someone who knows you well and whom you trust.

How can I make sure that my instructions will be followed?

In order for your instructions to be followed, you or your representative *must* give copies of your completed **Declaration** form to your physician or mental health provider. Your representative should keep a copy, and it is wise to keep a copy for yourself.

Can my instructions ever be changed?

Whether or not you have signed a **Declaration** form, if you are on an emergency psychiatric hold, or if you have been committed by a court, your physician may still give you medicine that you didn't want. Your physician can only do this under very strict legal guidelines.

If I make out and sign a Declaration for Mental Health Treatment will it be good forever?

No. A signed **Declaration for Mental Health Treatment** only will be valid for 3 years and must be renewed. However, should you become incapable of making mental health treatment decisions during these 3 years the **Declaration** will remain until the time — whenever that may be — that you regain capacity to make your own decisions.

Can I change my written instructions for mental health treatment or cancel my Declaration form?

Yes. As long as you are able to understand the information given to you about the choices that you may make for your mental health treatment, you may change your written mental health treatment instructions or cancel your **Declaration** form.

Of course, in order to make sure that your wishes are followed, you *must* give your physician or mental health provider a new **Declaration** form that includes the changes you wish.

However, if a court or two physicians decide that you are *unable to understand your mental health treatment options and you are not capable of making choices about your mental health treatment,* you will not be permitted to change your written instructions or to cancel your **Declaration** until the time that you regain capacity to understand your treatment options.

But, this is why you have written out your future wishes on this **Declaration for Mental Health Treatment** form: *You want to protect yourself when you are in crisis and are unable to make your own treatment decisions.*

If I move out of the state of Oregon, will my Declaration form be valid?

It depends on where you go. Each state has its own rules.

Can anyone force me to make out a Declaration for Mental Health ?

No. *No one,* no insurer, no physician, no mental health treatment provider, nor any other person is permitted to attempt to force you to make out a **Declaration** form. It should be your *free choice* to make out and sign the **Declaration for Mental Health Treatment**.

Witnesses who sign your **Declaration** form should be people whom you know and trust. They can verify that you signed the form by your own free choice, *without being forced.*

INSTRUCTIONS

It is entirely your choice as to whether or not you want to have a **Declaration For Mental Health Treatment (Declaration)**.

Before you fill out your **Declaration**, you should carefully read the "NOTICE TO PERSON MAKING A **Declaration** FOR MENTAL HEALTH TREATMENT" as well as the "NOTICE TO PHYSICIAN OR PROVIDER," which are found on pages 8 through 9 of the **Declaration** form. These notices give you some general information about the **Declaration**.

Once you make your **Declaration**, it stays in effect for three years unless you revoke it. After three years, it is not valid. You need to sign a new **Declaration**. If you are incapable at the end of three years to sign a new **Declaration**, the **Declaration** stays in effect until you are capable again.

If you decide that you do not want to have a **Declaration** or you want to change it, you can. To revoke the **Declaration**, you tell your doctor, your provider and anyone else who has your **Declaration** that you do not want it to be in effect. To be safe, you should do this in writing or get all the copies of the **Declaration** and tear them up. Also, you carmot revoke your **Declaration** during a time when you have been found incapable.

If there is anything in this document that you do not understand after reading the notices and the following instructions, then you should ask an attorney to explain it to you.

How To Fill Out A Declaration For Mental Health Treatment Form

First Things First

First, you must be mentally competent to make a **Declaration**. Second, you need an official form to fill out. You cannot make a legal **Declaration** without one, The form attached to these instructions is official and will be valid if it is correctly filled out, signed and witnessed.

To be valid and effective the form must:

a. Contain your name.

b. Be signed and dated by you.

c. Be signed and dated by two witnesses who were present when you signed the **Declaration**. *They must believe you are mentally competent at the time you sign the form.*

d. Contain your instructions about mental health treatment.

Follow these steps to make a legally valid ***Declaration for Mental Health Treatment***:

Step 1 - Name

Print or type your name legibly on the first line of the form after the word “I”.

Step 2 - Choice of Decision Maker

In the next section, you must choose who will make decisions for you if you become incapable of giving consent for mental health treatment. You can choose either the person who will be treating you or a “Representative”. Place your initials on the line next to your one choice.

Although the form does not say so, some people cannot act as your "Representative". People who CANNOT be your "Representative" are:

- Your doctor, mental health service provider, or an employee of your doctor or provider, unless you are related to that person.
- An owner, operator, or employee of a health care facility where you live or are a patient, unless you are related to that person.

If you do not appoint a "Representative" or if the person you appoint does not accept appointment or is disqualified from serving, all of the other instructions in the **Declaration** are still valid.

Step 3 - Appointed Representative

If you choose a "Representative", then fill in each blank with the information requested about that person on page 3 of the form. If you choose to designate someone to be the alternate to your "Representative", then complete the information regarding the alternate "Representative" also on page 3 of the form.

Step 4 - Directions For Mental Health Treatment

The next part of the form, which is entitled "DIRECTIONS FOR MENTAL HEALTH TREATMENT" is where you put your instructions about the mental health treatment you want and don't want. Your directions may include your wishes regarding medications, admission and staying at a mental health treatment facility (for no longer than 17 days), convulsive treatment as well as outpatient services. This section is divided into 3 separate parts, which are addressed in this instructions section as Step 4A, Step 4B and Step 4C.

Step 4A - Mental Health Treatments That You Consent To

On page 4 of the form, under the "DIRECTIONS FOR MENTAL HEALTH TREATMENT" is where you put instructions about what types of mental health treatment you want to approve. If you want specific instructions to be followed by a provider or your "Representative", those instructions must be put here.

- If you want to give consent for certain types of drugs, then you should specify which particular medications you approve.
- If you want to give consent to any drug the doctor may recommend, state "I give consent for any medication that my doctor recommends for me."
- If you want to limit your consent in any way, such as to maximum dosage, or you want certain information considered such as allergies you may have, you may add these instructions or information. You may specify your conditions or limitations. You may also state why a specific medication in a specified dosage should be used.
- If you have a "Representative", it will be assumed that your "Representative" must consent to the dosage and type of medication.
- If you agree to short-term inpatient treatment, you may so specify. You may also specify the particular facility and/ or provider you consent to for this short-term inpatient treatment.
- You may agree to convulsive treatment, which includes "shock treatment" or "ECT"(Electroconvulsive treatment). If you want to make a decision in advance about this sort of treatment, you may do so in this section or in Step 4B. You may include a limitation on the number or type of treatments you consent to or a direction to consult your "Representative" for these decisions.

- If you state that you consentto any sort of mental health treatment, you will not necessarily receive it. A doctor must first recommend the treatment for your condition. Your consent does not give a doctor the right to make improper recommendations.

Step 4B - Mental Health Treatments That You Do Not Consent To

The next set of spaces for you to fill in on the form, at the top of page 5, is where you put instructions about what types of mental health treatment you do not consent to. If you want specific instructions to be followed by a provider or your "Representative", then those instructions must be put here. You should be aware that you may be treated without consent if you are held pursuant to civil commitment law or are in an emergency situation where your life or health is endangered.

- If you do not want to give consent for certain types of drugs or dosage, state that "I do not consent to the administration of the following medications: " and write down the names or types of drugs you are refusing.
- If you want to refuse to consent to taking all drugs, write: "I refuse to consent to taking all medications".
- If you want to explain your refusal of consent, this can be specified. For example, you may corroborate your refusal by documenting the adverse effects, allergies or mis-diagnosis you have experienced from a particular medication and/ or mental health treatment.
- If you do not agree to short-term inpatient treatment, you may so specify. You may also specify that you do not agree to a particular facility and/or to a particular provider for this short-term inpatient treatment.
- If you do not agree to convulsive treatment and want to make a decision in advance about this sort of treatment, which includes "shock treatment" or "ECT" (Electroconvulsive treatment), you may so state.

Step 4C - Additional Information About Your Mental Health

At the top of page 6 is where you put additional information about your mental health needs. You may include anything relevant to your wishes regarding your mental health treatment in this section. The form asks you to consider mental health history; physical health history; dietary requirements; religious concerns; people to notify; and other matters of importance. “Other matters of importance” could be anything related to the treatment that you feel may improve your mental health.

- For example, you can say, that when you are really upset, what calms you down the most is to sit quietly in a dark room, with the door left open. On the other hand, you can specifY that the worst thing for you when you are really upset is to be placed in a locked room. The doctor does not have to follow these instructions, but if the doctor is aware of what works and what does not work, s/he may be willing to treat you according to your wishes.
- If you recognize through your experience that regular participation in a consumer run drop-in center provides you with the greatest sense of relief, then you can request that your therapy include participation in a consumer run drop-in center. Your choice does not guarantee that any such program will be available.
- If you would like to ensure that somebody is or is not told that you are in crisis/ in the hospital, then you may so specify.

Step 5 - Your Signature

Sign and date the form at the bottom of page 6. Do this in front of two witnesses. Your signature must appear in this place for any part of the directive to be effective.

Step 6 - Affirmation of Witnesses

Have your two witnesses sign and date the form on page 7 in the section headed ***"Affirmation of Witnesses"***.

Some people CANNOT act as witnesses. People who CANNOT act as your witnesses include:

- Your "Representative" or alternate "Representative". Anyone you appoint in Step 2 ("Choice of Decision Maker") cannot be a witness.
- A physician or mental health service provider who is treating you, or a relative of a person who is treating you. Your case manager, any doctor who is treating you while you are in the hospital, your counselor or private psychiatrist cannot serve as witnesses.
- The owner or operator of the facility where you live, or a relative of one of these people. For example, if you live in a group home, the owner or staff of the group home cannot serve as witnesses. The same is true of staff at nursing homes, foster homes, board and care homes, etc.
- A person related to you by blood, marriage or adoption.

<u>When the witnesses sign the form they acknowledge that:</u>

(1) you signed the **Declaration**;

(2) *they believe you were mentally competent at the time you signed the form;* and

(3) *they believe that you were not under duress, fraud or undue influence at the time you signed the form.*

Step 7 - Others' Signatures

If you have a "Representative", then make sure that your "Representative" has signed and dated the acceptance of appointment on page 7. Likewise if you have an alternate "Representative", make sure that your alternate "Representative" has signed and dated the acceptance of appointment on page 7.

Step 8 - Hand Out Copies

Make sure that you give copies of the completed form to any doctor, provider, or facility from which you expect to need treatment. If you have appointed a representative, make sure that this person also has a copy. Your instructions cannot be followed if they are not known to exist.

Declaration for Mental Health Treatment

Attention: This is a legal document which contains important information regarding the affected person's preferences or instructions for mental health treatment.

Declaration for Mental Health Treatment

I, _____, being an adult of sound mind, willfully and voluntarily make this **Declaration** for mental health treatment. I want this **Declaration** to be followed if a court or two physicians determine that I am unable to make decisions for myself because my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means treatment of mental illness with psychoactive medication, admission to and retention in a health care facility for a period up to 17 days, convulsive treatment and outpatient services that are specified in this **Declaration**.

Choice of Decision Maker

If I become incapable of giving or withholding informed consent for mental health treatment, I want these decisions to made by: (INITIAL ONLY ONE)

_____ My appointed representative consistent with my desires, or, if my desires are unknown by my representative, in what my representative believes to be my best interests.

_____ By the mental health treatment provider who requires my consent in order to treat me, but only as specifically authorized in this **Declaration**.

Appointed Representative

If I have chosen to appoint a representative to make mental health treatment decisions for me when I am incapable, I an naming that person here. I may also name an alternate representative to serve. Each person I appoint must accept my appointment in order to serve. I understand that I am not required to appoint a representative in order to complete this **Declaration**.

I hereby appoint: NAME _____

ADDRESS _____

_____

TELEPHONE# _____

to act as my representative to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

(OPTIONAL)

If the person named above refuses or is unable to act on my behalf, or ifl revoke that person's authority to act as my representative, I authorize the following person to act as my representative:

NAME _____

ADDRESS _____

_____

TELEPHONE# _____

My representative is authorized to make decisions that are consistent with the wishes I have expressed in this **Declaration** or, if not expressed, as are otherwise known to my representative. If my desires are not expressed and are not otherwise known by my representative, my representative is to act in what he or she believes to be my best interests. My representative is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of medical records relating to that treatment.

Directions for Mental Health Treatment

This **Declaration** permits me to state my wishes regarding mental health treatments including psychoactive medications, admission to and retention in a health are facility for mental health treatment for a period not to exceed 17 days, convulsive treatment and outpatient services.

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes are: **I CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENTS:** (May include types and dosage of medications, short term inpatient treatment, a preferred provider or facility, transport to a provider or facility, convulsive treatment or alternative outpatient treatments.)

I DO NOT CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENT: (Consider including your reasons, such as past adverse reaction, allergies or misdiagnosis. Be aware that a person may be treated without consent if the person is held pursuant to civil commitment law.)

ADDITIONAL INFORMATION ABOUT MY MENTAL HEALTH TREATMENT NEEDS: (Consider including mental or physical health history, dietary requirements, religious concerns, people to notify and other matters of importance.)

YOU MUST SIGN AND DATE HERE FOR THIS DECLARATION TO BE EFFECTIVE:

Signature and Date: _____

Affirmation of Witnesses

I affirm that the person signing this **Declaration**:

a. Is personally known to me;

b. Signed or acknowledged his or her signature on this **Declaration** in my presence;

c. Appears to be sound mind and not under duress, fraud or undue influence;

d. Is not related to me by blood, marriage or adoption;

e. Is not a patient or resident in a facility that I or my relative owns or operates;

f. Is not my patient and does not receive mental health services from me or my relative; and

g. Has not appointed me as a representative in this document.

Witnessed by:

_____

[Signature of Witness (Printed Name of Witness)/Date]

_____

[Signature of Witness (Printed Name of Witness)/Date]

Acceptance of Appointment As Representative

I accept this appointment and agree to serve as representative to make mental health treatment decisions. I understand that I must act consistently with the desires of the person I represent, as expressed in this **Declaration** or, if not expressed, as otherwise known by me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document gives me authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by a court or two physicians. I understand that the person who appointed me may revoke this **Declaration** in whole or in part by communicating the revocation to the attending physician or other provider when the person is not incapable.

_____

[Signature of Representative (Printed name) and Date]

_____

[Signature of Alternate Representative (Printed name) and Date]

Notice to Person Making A Declaration for Mental Health Treatment

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about certain types of mental health treatment: psychoactive medication, short-term (not to exceed 17 days) admission to a treatment facility, convulsive treatment and outpatient services. Outpatient services are mental health services provided by appointment by licensed professionals and programs. The instructions that you include in this declaration will be followed only if a court or two physicians believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held pursuant to civil commitment law.

You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint has a duty to act consistently with your desires as stated in this document or, if not stated, as otherwise known by the representative. If your representative does not know your desires, he or she must make decisions in your best interests. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your representative at any time. A "representative" is also referred to as an "attorney-in-fact" in state law but this person does not need to be an attorney at law.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. ***YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT OR TWO PHYSICIANS.*** A revocation is effective when it is communicated to your attending physician or other provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Notice to Physician or Provider

Under Oregon law, a person may use this declaration to provide consent for mental health treatment or to appoint a representative to make mental health treatment decisions when the person is incapable of making those decisions. A person is "incapable" when, in the opinion of a court or two physicians, the person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions. This document becomes operative when it is delivered to the person's physician or other provider and remains valid until revoked or expired. Upon being presented with this declaration, a physician or provider must make it a part of the person's medical record. When acting under authority of the declaration, a physician or provider must comply with it to the fullest extent possible. If the physician or provider is unwilling to comply with the declaration, the physician or provider may withdraw from providing treatment consistent with professional judgment and must promptly notify the person and the person's representative and document the notification in the person's medical record. A physician or provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of this declaration is not subject to criminal prosecution, civil liability or professional disciplinary action resulting from a subsequent finding of the declaration's invalidity.

This Guide to Oregon's Declaration for Mental Health Treatment and Form was developed pursuant to Oregon Revised Statutes (ORS) 127.700 through 127.736.

For additional information contact:

Addictions and Mental Health Division
500 Summer Street NE, E-86
Salem, Oregon 97301-1118
503-945-5763

NAMI-Oregon
4701 SE 24th Street, Suite E
Portland, Oregon 97202
503-230-8009 or 1-800-343-6264

Disability Rights Oregon
610 SW Broadway, Suite 205
Portland, Oregon 97205
503-243-2081

We suggest you fill out this card and put it in your wallet.

Emergency Medical Information
Name: _____
I have written a **Declaration for Mental Health Treatment** which is on file at:
_____
Immediately contact my Representative at:
_____
Name Phone
or Alternate Representative at:
_____
Name Phone

State of Oregon
Oregon Health Authority
Health Services
Addictions and Mental Health Division

State of Oregon

Declaration for Mental Health Treatment

Dated _____

Oregon Health Authority

ADDICTIONS AND MENTAL HEALTH DIVISION

Please feel free to copy and distribute this booklet.

OHA9550 rev 12/12

HEALTH AND HUMAN SERVICES

NOTICE OF PRIVACY PRACTICES

This form is available upon request in alternative formats including large print, Spanish and oral presentation.

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.**

Your Rights

You have the right to:

- Get a printed copy of your medical record
- Request a correction be made to your medical record
- Request how we communicate with you about your private information
- Ask that we limit what information about you is shared
- Get a list of those with whom we have shared your information
- Request a copy of this privacy notice at any time
- Have someone make choices on your behalf
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

Your Choices

YCHHS is committed to maintaining the confidentiality of those we work with. In general, your information will remain private as far as the law allows. Your permission is required for us to:

- Share your personal information with anyone outside of YCHHS
- Sell any of your personal information
- Use any of your personal information for marketing

There are some situations when your information can be disclosed unless you ask that it not be. In these cases, only the information related to the situation would be used:

- Communication with a person you have asked to be involved in your care, or payment for your care, while you are present, in emergency situations, and/or to notify of your death
- Coordination of care and/or notifying family members or friends of your condition or location in the case of a disaster
- Behavioral health care coordination

➤ **See page 3** for more information on these choices and how to exercise them

Our Uses & Disclosures

We may use and share your information for the following:

- Providing, managing, and coordinating your treatment
- Managing and supporting how our agency functions
- Billing purposes
- Helping with public health and safety issues
- Research purposes
- Compliance with the law
- Responding to organ and tissue donation requests
- Working with a medical examiner or funeral director
- Addressing workers' compensation, law enforcement, and other government requests
- Responding to lawsuits and legal actions

➤ **See page 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a printed copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this. • We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Request a correction be made to your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request how we communicate with you about your private information	• You can ask us to contact you in a specific way (for example, requesting that we only call your home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what information is used or shared	• You can ask us not to use or share certain health information for treatment purposes, payment, and/or our program operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item, you can ask us not to share that information with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we have shared your information	• You can ask for a list (or accounting) of the times we' have shared your health information. That list can go back six years prior to the date when you make this request. It will show with whom we have shared any information and why. • We will include all the records shared except for those about your treatment, payment, and health care operations. Certain other disclosures (such as any you had requested) will also be left out. We will provide one list, per year, for free. Any requests for additional copies within a 12-month period will have a reasonable, cost-based fee.
Request a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide it to you promptly.
Have someone make choices on your behalf	• If you have a legal guardian or have given someone medical power of attorney, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you believe your privacy rights have been violated	• If you feel that your rights have been violated by a YCHHS employee, you can make a complaint at 627 NE Evans, McMinnville, OR 97128 or by contacting us at 503-434-7523. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you have some options about what we can share.

If you have a clear preference for how we share your information in the situations described below, please let us know. Whenever possible, we will accommodate your requests.

In these cases, you have both the right and choice to request that we not:	• Share any information with a family member or friend, who is involved in your care, or payment for your care, at times when you are present, in an emergency situation and/or to notify the person of your death. • Share information about your condition and location in the case of a disaster. *Unless you specifically ask that we not share any information in these situations, such as if you were found unconscious, we may share the least information possible if we believe it would be in your best interest. We may also share your information in situations where there is a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Sharing your psychotherapy notes

Our Uses & Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Providing, managing, and coordinating your treatment	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Managing and supporting how our agency functions	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Billing purposes	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Helping with public health and safety issues	We can share health information about you for certain situations, such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Research purposes	• We can use or share your information for health research.
Compliance with the law	• We will share information about you if state or federal laws require it, such as if the Department of Health and Human Services requests information in order to see whether we are complying with federal privacy law.
Responding to organ and tissue donation	• We can share health information about you with organ procurement organizations.
Working with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Addressing workers' compensation, law enforcement, and other government requests	• We are required to share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Responding to lawsuits and legal actions	• We are required to share health information about you in response to a subpoena or a court or administrative order.

I. Yamhill County Health & Human Services (YCHHS) may only use or release substance abuse records if the person or business receiving the records has a specialized agreement with YCHHS.

II. YCHHS follows the requirements of federal and state privacy laws including laws about protecting information related to drug and alcohol abuse and treatment and to mental health condition(s) and treatment.

III. If YCHHS releases information to someone else with your approval, the information may not be protected by the privacy rules and the person receiving the information may not have to protect the information. They may release your information to someone without your approval.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy.
- We will not use or share your information other than as described here without your written permission to do so. If you give us permission to use or share your information, you may change your mind at any time. Please let us know this in writing.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this Notice. If this happens, the changes will apply to all information we have about you. A copy of the most current Notice will be on our website and available at the front desk.

This Notice of Privacy Practices applies to the following organizations.

This notice applies to Yamhill County Health & Human Services and its business associates.

To use any of the privacy rights listed above or to request this notice in Spanish or other format, you may contact:
Telephone: 503-434-7523
Fax: 503-434-9846
TTY: 1-800-735-2900

Oregon Voter Registration Card

Clear Form | Print | Save As

SEL 500 rev 01/2024

you may use this form to

→ register to vote
→ update your information

If you are not yet 18 years of age, you will not receive a ballot until an election occurs on or after your 18th birthday.

1 Print with a black or blue pen to complete the form.

2 Sign the form.

3 Mail or drop off the form at your County Elections Office.

Your County Elections Office will mail you a Voter Notification Card to confirm your registration.

The deadline to register to vote is the 21st day before an election.

Only registered voters are eligible to sign petitions.

qualifications

Are you a citizen of the United States of America? ☐ yes ☐ no

Are you at least 16 years of age? ☐ yes ☐ no

If you mark no in response to either of these questions, do not complete this form.

personal information **required information*

last name* | first* | middle

Oregon residence address, city and zip code (include apt. or space number)*

date of birth (month/day/year)* | county of residence

phone | email

mailing address, including city, state and zip code (required if different than residence)

oregonvotes.gov

☎ **1 866 673 8683**
se habla español

TTY **1 800 735 2900**
for the hearing impaired

You must provide your valid Oregon Driver License, Permit or ID number. A suspended Driver License is valid, a revoked Driver License is not valid.

-or-

If you do not have valid Oregon ID, provide the last four digits of your Social Security number.

-or-

If you do not have valid Oregon ID or Social Security number, provide a copy of one of the following that shows your name and current address.

acceptable identification

→ valid photo identification
→ a paycheck stub
→ a utility bill
→ a bank statement
→ a government document
→ proof of eligibility under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) or the Voting Accessibility for the Elderly and Handicapped Act (VAEH).

Oregon Driver License/ID number

Provide a valid **Oregon Driver License, Permit or ID**:

☐ ☐ ☐ ☐ ☐ ☐ ☐

☐ *I do not have a valid **Oregon Driver License/Permit/ID**. The last 4 digits of my Social Security Number (SSN) are:*

x x x - x x - ☐ ☐ ☐ ☐

☐ *I do not have a valid Oregon Driver License/Permit/ID or a SSN. I have attached a copy of **acceptable identification**.*

political party

☐ Not a member of a party

☐ Constitution
☐ Democratic
☐ Independent
☐ Libertarian
☐ No Labels
☐ Pacific Green
☐ Progressive
☐ Republican
☐ Working Families
☐ Other _____

information disclosure

Information submitted on an Oregon Voter Registration Card is public record. However, information submitted in the Oregon Driver's License section is, by law, held confidential.

assistance

If you need assistance registering to vote or voting please contact your County Elections Official. See reverse for contact info.

signature *I swear or affirm that I am qualified to be an elector and I have told the truth on this registration.*

sign here _____ date today _____

If you sign this card and know it to be false, you can be fined up to $125,000 and/or imprisoned for up to 5 years.

registration updates *Complete this section if you are updating your information.*

previous registration name | previous county and state

home address on previous registration | date of birth (month/day/year)

Secretary of State
Salem OR 97310-0722

County Elections Offices

Baker County
1995 3rd St, Ste 150
Baker City OR 97814-3365
541 523 8207

Benton County
4500 SW Research Way, 2nd Flr
Corvallis OR 97333-1093
541 766 6756

Clackamas County
1710 Red Soils Ct, Ste 100
Oregon City OR 97045-4300
503 655 8510

Clatsop County
820 Exchange St, Ste 220
Astoria OR 97103-4609
503 325 8511

Columbia County
230 Strand St
St. Helens OR 97051-2040
503 397 7214 or 503 397 3796

Coos County
250 N Baxter St
Coquille OR 97423-1875
541 396 7610

Crook County
300 NE 3rd St, Rm 23
Prineville OR 97754-1919
541 447 6553

Curry County
94235 Moore St, Ste 212
Gold Beach OR 97444-9705
541 247 3297 or 877 739 4218

Deschutes County
1300 NW Wall St, Ste 202
Bend OR 97703-1960
541 388 6547

Douglas County
PO Box 10
Roseburg OR 97470-0004
541 440 4252

Gilliam County
PO Box 427
Condon OR 97823-0427
541 384 2311

Grant County
201 S Humbolt, Ste 290
Canyon City OR 97820-6186
541 575 1675

Harney County
450 N Buena Vista Ave, Ste 14
Burns OR 97720-1565
541 573 6641

Hood River County
601 State St
Hood River OR 97031-1871
541 386 1442

Jackson County
1101 W Main St, Ste 201
Medford OR 97501-2369
541 774 6148

Jefferson County
66 SE "D" St, Ste C
Madras OR 97741-1739
541 475 4451

Josephine County
PO Box 69
Grants Pass OR 97528-0203
541 474 5243

Klamath County
305 Main St
Klamath Falls OR 97601-6332
541 883 5134

Lake County
513 Center St
Lakeview OR 97630-1539
541 947 6006

Lane County
275 W 10th Ave
Eugene OR 97401-3008
541 682 4234

Lincoln County
225 W Olive St, Ste 201
Newport OR 97365-3811
541 265 4131

Linn County
PO Box 100
Albany OR 97321-0031
541 967 3831

Malheur County
251 "B" St W, Ste 4
Vale OR 97918-1375
541 473 5151

Marion County
PO Box 14500
Salem OR 97309-5036
503 588 5041 or 800 655 5388

Morrow County
PO Box 338
Heppner OR 97836-0338
541 676 5604

Multnomah County
1040 SE Morrison St
Portland OR 97214-2417
503 988 8683

Polk County
850 Main St, Rm 201
Dallas OR 97338-3179
503 623 9217

Sherman County
PO Box 243
Moro OR 97039-0243
541 565 3606

Tillamook County
201 Laurel Ave
Tillamook OR 97141-2311
503 842 3402

Umatilla County
216 SE 4th St, Ste 18
Pendleton OR 97801-2699
541 278 6254

Union County
1001 4th St, Ste D
La Grande OR 97850-2100
541 963 1006

Wallowa County
101 S River St, Ste 100
Enterprise OR 97828-1363
541 426 4543

Wasco County
511 Washington St, Rm 201
The Dalles OR 97058-2237
541 506 2530

Washington County
2925 NE Aloclek Dr, Ste 170
Hillsboro OR 97124-7523
503 846 5800

Wheeler County
PO Box 327
Fossil OR 97830-0327
541 763 2374

Yamhill County
414 NE Evans St
McMinnville OR 97128-4607
503 434 7518

HEALTH SYSTEMS DIVISION
Member Services

Oregon Health Plan Complaint Form

If you are enrolled in a coordinated care organization (CCO), please call your CCO first with any complaints.

If you still have a complaint about Oregon Health Plan (OHP) services, fill out this form and send it to OHP Client Services, PO Box 14015, Salem OR 97309.

Your name:	Your phone number:
Member's name (*if you are not the member*):	Member's Medicaid ID number, or Date of Birth:
What happened? When did it happen? Who was involved? *(Attach any documents such as notices, denials of service, doctor's bills, etc., which might help us investigate your complaint.)*	
What do you want us to do to fix it?	
Attach additional pages, if needed.	

NOTICE: If you do not agree with a denial you received for OHP services, you will need a different form. To learn more, visit our Complaints and Appeal page at www.oregon.gov/OHA/healthplan/pages/complaints-appeals.aspx.

COMPLAINT PROCESS

Yamhill County Health & Human Services

You can get this document in a larger print size or in a different format. You can also get this document in some languages other than English. If interested, ask the reception for this.

A complaint is when a client shares they are not satisfied with the services of Yamhill County Health and Human Services (YCHHS).

YCHHS knows that disagreements can occur about services. Our goal is to encourage clients to voice their concerns and reach agreed upon solutions. A committee reviews the complaints and solutions to find ways we can improve services. Individuals have the right to share concerns without fear of retaliation.

If you have a complaint, you are encouraged to talk directly with the staff involved. You may give the feedback verbally or in writing. You may request help from staff or someone else to share a complaint. It will be helpful to know the solution you desire to your complaint. YCHHS' goal is to provide a resolution for each complaint within 5 working days from getting it, and have up to 30 calendar days.

If you believe the issue behind your complaint could cause harm to your life, health, or ability to function, you may request a faster review. In such cases, YCHHS will review and respond in writing to your complaint within 48 hours of receiving the complaint.

The following is listed in steps**,** yet you may start anywhere in the process**.**

1. Share the complaint with the staff person involved.

2. You may share the complaint with your therapist.

3. If you are not able to speak with the staff involved, or do not have a therapist, you may share the complaint with the manager.

4. You may complete a Complaint Form which is available in the waiting room. You may also get a Complaint Form from your therapist, reception, or other staff. Once the Complaint Form is complete you may follow the instructions on the form or give it to any staff, the manager, or mail to the following address.

   Mail to: Yamhill County HHS Attention: Quality Manager
   627 NE Evans St.
   McMinnville, OR 97128

5. You may share your concerns with the Director of YCHHS at (503) 434-7523.

6. If you are not satisfied with the complaint resolution, you may appeal it in writing within 10 business days.

IF YOU ARE…	CONTACT	PHONE NUMBER
Yamhill County Health and Human Services Client	YCHHS Complaint's Representative	(503) 434-7523 (Adult McMinnville) (503) 434-7462 (Youth McMinnville) (503) 538-8970 (Newberg)
Oregon Health Plan & Non-Oregon Health Plan Clients	Health Systems Division	1-800-527-5772 (Toll Free)
	Disability Rights Oregon	(503) 243-2081 or 1-800-452-1694 (Toll Free)
Yamhill Community Care Organization Member (YCCO) for Mental Health and Substance Use Disorder Services	YCCO Complaint's Representative	1-855-722-8205 (Toll Free)
	OHP Client Services Unit	1-800-273-0557 (Toll Free)
Experiencing a problem with, or seeking information about programs or services provided by Department of Human Services	Governor's Advocacy Office	(503) 945-6904 or 1-800-442-5238 (Toll Free)
Developmental Disabilities Client	Developmental Disability Services	(971) 701-5299
	Disability Rights Oregon	(503) 243-2081 or 1-800-452-1694 (Toll Free)
Oregon Health Plan Member or Representative Requesting an Administrative Hearing	State Department of Human Services	Local DHS Office
	YCCO Complaint's Representative	1-855-722-8205 (Toll Free)
	Health Systems Division	1-800-527-5772 (Toll Free)
Contacting Licensing Boards	Oregon Board of Licensed Social Workers	1-866-355-7050 (Toll Free)
	Oregon Board of Licensed Professional Counselors and Therapists	(503) 378-5499
	Mental Health & Addiction Certification Board of Oregon MHACBO	(503) 231-8164
	Oregon Board of Psychology	(503) 378-4154
	Oregon State Board of Nursing	(503) 673-0685

HEALTH AND HUMAN SERVICES

Fee Schedule
Implementation on July 1, 2024
Please discuss questions with managers.

Attached is an updated "Fee Policy" which reflects Yamhill County Behavioral Health rates effective July 1, 2024. We have recalculated our Usual and Customary rates and adjusted them accordingly.

Review the "Fee Policy" carefully, as all clinical and reception staff will need to be aware of these rate changes. Please take every opportunity to ensure clients are aware that billing statements from July 1st forward will reflect the new rates.

Suggested "To Do's" for each office:

- ❑ Designate Staff to collect old copies and replace with new fee policy and sliding fee scales. The previous Fee Policy should be disposed of (recycled).
- ❑ Notify primary fee setting staff of the change, as well as others that set fee agreements.
- ❑ Announce the changes in staff meetings.
- ❑ Post notice mailed with this document in waiting areas.
- ❑ Insert this revised document into all new client orientation packets.
- ❑ Review any other forms or documents that may reference rates (i.e. CD RDL, AODAG, etc.).

- The updated Usual and Customary Rates on page 2 of this memo affect the current Fee Contract for clients and they may see a slight decrease in their bills, except if they have a "Flat" fee (for example: $5.00).
- Also available to staff are new sliding fee schedules to estimate the cost of individual, 1.0 hour groups and 1.5 hour groups. Please remember that they are simply a resource for your use when completing the Fee Contract form. Use the percent column whenever possible on a fee agreement.

If you have any questions about the above information, please contact your supervisor.

HEALTH AND HUMAN SERVICES

Yamhill County Health and Human Services (YCHHS) is funded by tax dollars and user fees. The fees are calculated based on the cost of providing the service. We are directed by our governmental funding sources to limit services to individuals of low and moderate incomes who are unable to access private services.

YCHHS offers a sliding fee program to all who are unable to pay for their services. While no client is turned away because of inability to pay for services, we will charge fees to those clients who can pay. YCHHS will base sliding fee program eligibility on a person's ability to pay and not discriminate on the basis of age, gender, race, sexual orientation, gender identity, creed, religion, disability, or national origin. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule to determine eligibility based upon an individual's or family's gross monthly income and number of dependents. This is typically determined at the time of the first visit.

The program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their behavioral health care services (uninsured or underinsured). In addition to quality healthcare, patients are entitled to speak with a clinician to work with the patient and/or guarantor to find reasonable payment alternatives. Whenever possible, we will bill private insurance companies, but the client is ultimately responsible for the portion not paid by insurance up to the amount on our sliding fee schedule.

1. Clients are expected to enter into a signed fee contract for payment of services.
2. Payment is requested on a "pay as you go" basis. This means that the amount, once it is agreed upon, should be paid at the time of each appointment. This way, the client will avoid the accumulation of a large balance and save the cost of billing.
3. The clinic's fees are based on the following schedule:

Provider Type	Service Type	In-Office Rate	Out-Of-Office Rate	
MD/NP	Assessment	$ 534.00		Per Hour
	Consultation, Evaluation, Individual Therapy, Med Management	$ 388.00		Per Hour
RN	Med Management	$ 321.00	$ 473.00	Per Hour
QMHP	Assessment	$ 386.00	$ 568.00	Per Hour
	Case Management, Consultation, Family/Marital Therapy, Individual Therapy	$ 281.00	$ 413.00	Per Hour
	Group Therapy	$ 88.00		Per Hour
	Screening	$ 351.00	$ 516.00	Per Hour
QMHA	Case Management, Individual Skills Training	$ 265.00	$ 390.00	Per Hour
	Group Skills Training	$ 83.00		Per Hour
	Screening	$ 331.00	$ 488.00	Per Hour
	Supported Employment	$ 212.00	$ 403.00	Per Hour
CMA	Individual Skills Training	$ 205.00		Per Hour
QMHP School Services	Assessment	$ 429.00		Per Hour
	Case Management, Consultation, Family/Marital Therapy, Individual Therapy	$ 286.00		Per Hour
	Group Therapy	$ 132.00		Per Hour
	Screening	$ 357.00		Per Hour
Other	ACT Services	$ 195.00	$ 385.00	Per Hour
	BSS Contract Rate	$ 98.00		Per Hour
	CANS MH Assessment	$ 737.00		Each
	Early Intervention	$ 1,193.00		
	OT Assessment	$ 772.75	$ 970.75	Each
	Peer-Assisted Crisis (PAC)	$ 815.00		Per Day
	Reports & Correspondence	$ 30.00		Each
	Transitional Treatment Recovery Services (TTRS)	$ 236.00		Per Day
	Urinalysis	$ 66.25		Each

Approved by BOC 06/20/2024 BO# 24-170 Effective July 1, 2024
Please note these fees are subject to change. Check with staff for current rates.
Fees are rounded up to the nearest dollar. Sliding fees are approximates and are based on a "percentage" of total fee.