Independent Management Services

Providing Human Services to Families in Southern Minnesota

Housing Stabilization Services Referral Packet

INTRODUCTION: The Housing Stabilization Services (HSS) program provides housing related services to persons who are eligible and enrolled Medicaid beneficiaries to assist them in obtaining and maintaining stable housing. These individuals MUST also have a documented disability or disabling condition, need assistance due to that disability in obtaining and maintaining housing and be experiencing housing instability. Housing instability includes literal homelessness, at-risk of homelessness, currently transitioning, or has recently transitioned, from an institution or licensed or registered setting or at risk of institutionalization.

In this packet you will find:

- HSS Referral Form
- IMS Consent Form
- IMS Release of Information

Releases of Information should be included for ALL of the following (if applicable):
Department of Human Services for the county which you live in, Primary Care Provider/Clinic, Psychiatrist, Therapist, Probation Officer, Emergency Contact, Insurance Company, Case Manager, or any other professional or natural supports you feel may be beneficial to list or that you wish to have involved in your services.

Please complete the entire packet. Referrals may be sent via email to: info@imsofmn.com or Faxed to: 507-437-0977 Attention: Intake Coordinator.

Please feel free to contact our Intake Coordinator at 507-437-6389 or by email with any questions or concerns.

Housing Stabilization Services Referral Form

Date of Referral: _______________

Client Information

Name: ____ DOB: _________________________

Address: ____

Phone: ____________________________________ Email: ____________________________________

Does client have Medical Assistance: ☐ YES ☐ NO

Housing status: ☐ Homeless ☐ At-risk for homelessness ☐ Transitioning from an institution
☐ At-risk for institutionalization AND receives waivered services

Disabling condition (check all the apply):
☐ Developmental Disability ☐ Learning Disability ☐ Mental Illness
☐ Chemical Dependency ☐ Physical Illness, injury or impairment

Does client have any of the following (check all that apply):
☐ Targeted Case Manager ☐ Waiver Case Manager ☐ Senior Care Coordinator (MSHO/MSC+)

Referral Source Information

Name/Agency: ____

Relationship to client: ____

Phone: ____________________________________ Email: ____________________________________

Is client aware of referral being made: ☐ YES ☐ NO

Please list any known professional supports and/or any additional pertinent information:
____
____
____

Name: ________________

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Austin, MN 55912
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Welcome to Independent Management Services

-Thank you for entrusting us with your care-

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

We find it helpful to our patients to provide a brief overview of our practice, policies, and the services we provide, as well as a discussion of the therapy process. In your first meeting at Independent Management Services, staff will discuss the issues that led you to contact us and will gather additional information needed to begin the therapeutic relationship. We will review confidentiality, privacy practices and financial responsibility. At any time during our work together, please ask any questions or alert the staff to any concerns you may have.

INSURANCE/BILLING: Independent Management Services offers a full billing service for our Patients with insurance. If you have insurance, our billing service will send service claims to your insurance provider. Following adjudication of the claim by your insurance company, you are responsible for paying your portion (if any) of the fee, as will be shown on the Explanation of Benefits statement you should receive from your insurance provider. For any unpaid balance, you will receive a statement from Independent Management Services. Your payment is due, in full, within 30 days of the billing date, unless we have made other arrangements in advance.

APPOINTMENT SCHEDULING & ATTENDANCE: Appointments are scheduled by calling the clinic office. As with any other medical provider, mental health appointments do occasionally require some flexibility with scheduling. Your treatment provider reserves a block of time for you and your scheduled appointment. If you cannot attend your scheduled session, you must notify the clinic office and/or your treatment provider as soon as possible. Your provider will discuss any missed appointment with you; however, it is your responsibility to call your provider as soon as is reasonably possible. Contact our office at 507-437-6389 to change or cancel an appointment. Missed appointments need to be kept to a minimum if progress is to continue in treatment. Multiple cancelled appointments will be discussed and if we decide that the commitment to treatment is not possible, then treatment services can be placed on hold or your case closed. If this should occur, it cannot be guaranteed you will be scheduled with the same provider.

OFFICE RECEPTION AREA: While we provide services to children, we are not able to provide oversight of children in the reception area. If a child is left in the reception area and engages in disruptive or other behaviors that we deem inappropriate, your session will need to be interrupted so you can redirect your child and address their behaviors. Children under the age of 10 must have an adult present with them at all times in the reception area.

DIMENSIONS OF MENTAL HEALTH TREATMENT: Patients generally come to Independent Management Services because they are experiencing difficulties and desire to make some changes. Our focus is on each Patient's individual needs and goals. The treatment process requires commitment, flexibility and courage, since there may be some discomfort in treatment as we move towards change and reaching your goals. It is important to remember that new and sometimes unexpected insights can be gained through both positive and negative emotions/experiences. Together you and your provider will work through any difficulties and insights gained during the treatment process.

TERMINATION OF MENTAL HEALTH TREATMENT SERVICES: Termination is part of the normal process of treatment services. Like any other relationship, either person can decide to end it at any time, but ideally, it will be a mutual agreement. When you begin working with your provider, you will discuss your goals in therapy and decide how you both will know when those goals have been met. When these are achieved, you can expect to review progress, status, and expectations for your continued success apart from mental health treatment. There may be circumstances in which your provider determines that a referral to another professional is appropriate. In this event, you may expect your provider to provide you with referrals to other resources. This will not be a judgment of you or the provider, or of your work together, instead it will be a recommendation for a resource to better allow you to meet your goals.

PROFESSIONAL FEES: Fees vary depending upon whether the work is individual, couple, family, etc. Your provider will be happy to discuss your particular situation and our fees with you.

Payment options - We accept cash, check, MasterCard, Visa, and Discover. We also accept most insurance plans.

Payment for services is due in full at the time of service unless you have insurance (see Insurance/Billing below). If you

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do not have insurance, or prefer not to use your insurance, payment is due in full at the time of service unless other payment arrangements are made with our billing office.

Co-pays are the Patients responsibility in accordance with the contractual obligations and agreements of the insurance plan. Any co-insurance or deductible will be due within 30 days following notification by your insurance company to Therapy Connections of the co-insurance or deductible amount.

We understand that financial situations occur which can make paying a balance in full difficult. If you experience this type of difficulty, call our office as soon as possible so we can make the appropriate arrangements. If a bill remains unpaid after thirty (30) days, our office will call you to set up a payment schedule.

PATIENT RELATED RIGHTS

Please read the information below as it pertains to your rights as a patient of Independent Management Services.

- HIPAA Privacy Notice
- Independent Management Service Grievance Procedure
- Patient Bill of Rights

HIPAA PRIVACY NOTICE

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.

As part of providing services to you, we will collect information about your health care. We need this information to provide you with quality services and to comply with certain legal requirements. This notice applies to all of the records of your care generated at or located at Independent Management Services. The law requires us to:

a) Make sure that information that identifies you is kept private;

b) Give you this notice of our legal duties and privacy practices with respect to information about you; and

c) Follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Information about You:

Listed below are a number of reasons or ways in which information about you might be disclosed. In each category we will explain what we mean and give an example. NOT EVERY USE OR DISCLOSURE IN A CATEGORY WILL BE LISTED. The ways we might disclose information include:

A. **For Treatment:** We may disclose information about you to any personnel at Independent Management Services or outside of Independent Management Services who are involved in your care. For example, your direct care staff may need to share information about your medications with your psychiatrist, or with your case manager.

B. **For Payment:** We may use and disclose information about you so that services may be billed and payment may be collected from you, an insurance company, or a government health program. We may also tell your health plan about a service you may receive to obtain prior approval or to determine whether your health plan will cover the treatment.

C. **For Health Care Operations:** We may use information about you to run our program and to make sure you receive quality services, or to decide if we should change or modify our services.

D. **As Required By Law:** We will disclose information about you required by federal, state, or local law. For example, we may reveal information about you to the proper authorities to report suspected abuse or neglect.

E. **To Avoid a Serious Threat to Health or Safety:** We may use or disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

F. **Military and Veterans:** If you are a member of the armed forces, we may release information about you as required by military command authorities.

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G. **Workers' Compensation:** We may release information about you for workers' compensation or similar programs when required by law to do so. For example, if you are involved in a claim for workers' compensation benefits, we may release information requested about your health.

H. **Health Oversight Activities:** We may disclose information to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections and licensure.

I. **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning your services or someone who provided services to you, we may disclose information about you in response to a court or administrative order. We may disclose information about you in response to a subpoena, discovery request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

J. **Law Enforcement:** In certain situations, we may release information about you to law enforcement officials. For example, we might release information about you to identify or locate a missing person; about a death that may be the result of criminal conduct; or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description of location of the person believed to have committed the crime.

K. **Coroners, Medical Examiners and Funeral Directors:** We may release information to a coroner or medical examiner to identify a deceased person or determinate a cause of death. We may release information to funeral directors as necessary to help them carry out their duties.

L. **National Security and Intelligence, Protective Services for the President and Others:** We may release information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

M. **Correctional Programs:** If you are an inmate or in the custody of a law enforcement officer, we may release information about you to the correctional institution or law enforcement official, for example, to protect your health and safety or the health and safety of others.

N. **Civil Commitment:** In certain circumstances, your records may be released without your consent as part of a civil commitment proceeding.

O. **Marketing:** Generally, we will not use your information for marketing purposes without your consent.

P. **Psychotherapy Notes:** Private notes taken by a therapist in a therapy session generally will not be released without your authorization.

Your Rights Regarding Information About You:

You have the following rights:

1. **To Inspect and Copy your Service Records:** Usually this includes medical and billing records, but may exclude psychotherapy notes. To inspect and copy information in your record, you must submit your request in writing to the Program Director, Administrator or HIPAA Compliance Officer. We may charge a fee for the costs of copying, mailing or other costs related to your request.

   In very limited circumstances, we may deny your request. If we deny your request, you may ask that the denial be reviewed. Another licensed health care professional of Independent Management Services choice will review your request for review.

2. **To Amend Your Record:** If the information we have about you is incorrect or incomplete, you may make a written request to the HIPAA Compliance Officer to amend the information. You must include a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:
   a) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
   b) Is not part of the information kept in our file;
   c) Is not part of the information you would be permitted to inspect and copy; or
   d) We believe the information is accurate and complete.

   If you disagree with the denial, you may submit a statement of disagreement. If you request an amendment to your record,

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we will include your request in the record, whether the amendment is accepted or not.

3. **To Receive an Accounting of Disclosures:** We will keep a log of disclosures made on or after April 13, 2003, other than disclosures for treatment, billing or health care operations. You have the right to request the list of disclosures. You must submit a written request to the HIPAA Compliance Officer. The request may not cover more than a six-year period.
4. **To Request Restrictions:** You may request a restriction on the disclosure of information about you for treatment, payment or health care operations. Your request must be writing and made to the HIPAA Compliance Officer. Your request must tell us 1) what information you want to limit; 2)whether you want to limit our use, our disclosure or both; and 3) to whom you want the limit to apply. For example, you could ask that we not use or disclose information to a certain person about services you've received.
   We do not have to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
5. **To Request Alternative Ways to Communicate:** You may request that we communicate with you about your services in a certain way or at a certain location. For example, you can ask that we contact you only at work, or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and must be sent to the HIPAA Compliance Officer. We will accommodate all reasonable requests.
6. **To Receive a Paper Copy or Electronic Copy of this Notice:** You have the right to receive a paper copy or an electric copy of this notice. You may request either a paper or an electronic notice from the HIPAA Compliance Officer.
7. **To be Notified if there is a Breach:** If there is an unauthorized release of your information, we will notify you of this breach promptly and will offer suggestions on how to minimize damage that might result from the breach.

ADDITIONAL RIGHTS UNDER STATE LAW:

State piracy laws may provide additional privacy protections. Any such protections will be attached in a separate State addendum to this Notice.

CHANGES TO THIS NOTICE:

We may change this notice in the future. We can make the revised or changed notice effect for information we already have about you as well as any information we have in the future.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer.

ELECTRONIC ACCESS:

If your health records are stored electronically, you may make arrangements to access an electronic version of these records.

Internal Complaint Procedure:

Contact: Human Resources Department
101 21st St SE
Austin, MN 55912
Phone: 507-437-6389
Fax: 507-437-0977

Complaints may also be made directly to the government at:

Office for Civil Rights
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 515F HHH Bldg.
Washington, D.C. 20201

All complaints must be in writing. We will not retaliate against you for filing a complaint.

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Patient's Bill of Rights

Subject to certain limitation authorized by a parent, legal guardian, legal custodian, or a court of law concerning a minor or guardian of an incapacitated person or restrictions by the treating provider, each patient has the:

1. Right to reasonable access to care.
2. Right to informed consent.
3. Right to exercise all civil rights.
4. Right to respect the security, personal privacy, and confidentiality of information.
5. Right to confidential treatment of your personal and medical records and you may approve or refuse the release outside the facility.
6. Right to be treated with respect and be free from maltreatment.
7. Right to be informed of facility rules and regulations.
8. Right to fully participate in the development, care and evaluation of the services you receive from this company. We are here to assist you in obtaining and maintaining services that meet your unique needs and wants. We encourage you to let this company know what services you need and want upon evaluation, how we can modify the services to better meet your desired service outcomes.
9. Right to family involvement in your care.
10. Right to refuse or terminate treatment after being informed of potential consequences of that action. If you are not satisfied with your services, you may discuss your concerns and dissatisfaction with us at any time. All discussions regarding this right will be taken seriously by everyone you speak with. By refusing or terminating services, you may have to complete the application again and wait for openings for the program.
11. Right to transfer to another facility to receive additional assistance. Regardless of the situation that brings forth a change in service provider, this company will clearly inform the other service provider of necessary information regarding your services and care (with your permission). We will continue to provide you with services until you leave this company at which point we will consider services to be ceased (with your permission). You have the right to a smooth and seamless transfer that is coordinated, as much as possible, with your next service provider to ensure your care.
12. To know conditions and terms governing the provisions of services, including the admission criteria and policies and procedures related to service termination. If services terminate, you have the right to know why we are not able to continue to serve you.
13. Right to treatment consistent with acceptable professional standards of practice and right to file a grievance if not satisfied with the care received.
14. To receive services from a professional who is competent and trained and meets MN State Statute requirements to be employed in this position.
15. To know service charges and funding sources.
16. Right to refuse to participate in an experiment.
17. Right to use the phone and private mail.
18. Right to be free from discrimination based on age, race, color, creed, religion, national origin, gender, marital status, disability, sexual orientation, and status with regard to public assistance.
19. Right to be informed prior to a photograph or audio or video recording being made of the client. The client has the right to refuse to allow any recording or photograph of the client that is not for the purposes of identification or supervision by the license holder.

Patient Responsibilities

1. Responsible to provide accurate and complete information relating to his/her health.
2. Responsible for following the treatment plan recommended and asking questions if he/she does not understand.
3. Responsible for his/her actions if treatment is refused or does not follow instructions.

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4. Responsible for updating the facility or any demographic and insurance changes.
5. Responsible for financial obligations of his/her care or fulfilled promptly.
6. Responsible for maintaining confidentiality of his/her peers.
7. Responsible for being courteous and respectful of the property of other and of the facility.
8. Responsibility to follow facility rules and regulations.

I have read, understand, and agree to the Patient Bill of Rights and Responsibilities and I have received a copy.

My signature on this form indicates my consent to receive medically necessary services from Independent Management Services.

Grievance Procedures

Patients and/or their designated representatives may voice a grievance or recommend changes in police and/or services to staff and others of their choice without fear of restraint, interference, coercion, discrimination or reprisal or retaliation.

Patients shall review and discuss the grievance procedure described here during the orientation phase of their treatment.

The following procedures are designed to help patients deal with any problems or grievances that may arise during their treatment at Independent Management Services.

1. The patient shall present his or her recommendation of grievance to his or her counselor.
2. If the patient and the counselor cannot resolve the grievance or complaint, the grievance or complaint shall be presented to the counselor's Supervisor.
3. Upon presenting the grievance to the counselor's Supervisor, if the patient feels that the grievance or complaint has not been fully addressed, the grievance or complaint shall then be elevated to the Clinical Director;
4. After elevation to the Clinical Director, if the patient feels that the complaint or grievance has not been fully addressed, the complaint or grievance shall be elevated to the Chief Operations Officer, Executive Director and Chief Administrative Officer.
5. Staff and supervisors to whom the grievance or complaint is addressed shall investigate the complaint or grievance without retaliation to the patient; staff shall advise the patient in writing of the status of the grievance within three (3) days of receipt of the grievance, and will assist the patient in this and any subsequent action.
6. If the patient feels that the grievance or complaint has not been fully addressed after review from the Chief Operations Officer, Executive Director and Chief Administrative Officer, the patient may present his or her complaint or grievance to the following entities:

Office of the Ombudsman
For Mental Health and Development Disabilities
121 7th Place East
Suite 420
St. Paul, MN 55101-2117
Phone: (651) 757-1800 or 1-800-657-3506

Minnesota Department of Health
Office of Health Complaints
P. O. Box 64975
St. Paul, MN 55164-0975
Phone: (651) 201-5000

Signatures:

____
Recipient Signature

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Parent/Guardian Signature

IMS Employee Signature

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Release of Information

Client Name: ________________ **DOB:** _______ **Date:** ________

I, _________________ (DOB): _______, **authorize Independent Management Services to:**

Exchange Information With:	**Name:**	**Number:**
☐ County Case Manager		
☐ Psychologist		
☐ Psychiatrist		
☐ Physician/Clinic		
☐ Neuropsychologist		
☐ Day Program		
☐ Family		
☐ Guardian/Conservator		
☐ School		
☐ Insurance		
☐ Probation		
☐ Other 1:		
☐ Other 2:		
☐ Other 3:		
☐ Other 4:		
☐ Other 5:		
☐ Other 6:		

The following information to be Exchange:

☑ Discharge Summary
☑ History and Physical
☑ Consults
☑ Neuropsychological/Psychological testing
☑ Diagnosis
☑ Chemical Health Information
☑ Case Plan/Notes
☑ Medications/Dosage
☐ Other

Purpose for disclosure: Treatment and Continued Care

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items to Exchange can occur:

☑ Verbally ☑ In person conference ☑ Written questionnaire ☑ Mailed or faxed medical record / correspondence

I understand that:

* My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Independent Management Services's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
* I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Independent Management Services's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
* For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)
* Communications resulting from this authorization will reveal that I receive services at Independent Management Services.
* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient

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- * Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Independent Management Services to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
- * This authorization may be used by Independent Management Services owned or managed programs upon transfer of my care to them.

Recipient Signature ______________________ **Date:** __________

Parent/Guardian Signature ______________________ **Date:** __________

Staff Signature ______________________ **Date:** __________

**** Information to be disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**