Valley Mental Health

821 Saginaw St. S
Salem, OR 97302
TEL (503) 589-4046
FAX (503) 480-0484
www.valleymental.com

PATIENT COPIES OF FORMS

Attached:

1. Informed Consent for Treatment
2. Fee Agreement and Schedule
3. Individual Rights and Responsibilities
4. VMH No Show / Late Cancel Policy
5. HIPAA Notice of Privacy Practices
6. Grievance Procedure and Feedback Form
7. Voter Registration Information
8. Free Transportation Services
9. Oregon Advanced Healthcare Directive Information
10. Declaration for Mental Health Treatment

INFORMED CONSENT FOR TREATMENT

At Valley Mental Health, your treatment may be provided by a subcontracted therapist and/or at a satellite office. As such, any physician or therapist associated with Valley Mental Health may review your records in part or in whole. Otherwise, clinical records are kept under the strictest rules of confidentiality, which means that information about your treatment will not be released to any outside agency or individual without your written permission. Please be advised, however, that rules of confidentiality will be broken under certain circumstances as VMH employees and subcontractors are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse and evidence of past or current elder abuse. Additionally, confidentiality may be broken if the information we have could help save your life in a life-threatening emergency. If you have questions about confidentiality, please feel free to discuss them with your therapist.

Entering mental health treatment is a courageous step. You should know that sometimes symptoms become worse before they become better, though this should subside as the work of treatment progresses. Your therapist may ask you to participate in activities or ask you to do tasks outside the "therapy hour". While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about your treatment. You will be involved in the process of designing and implementing, and the periodic review, of your Treatment Plan. If you have any questions about the nature of your treatment, talk directly to your therapist as soon as the question arises.

FEE AGREEMENT

It has been explained that OHP members will not be billed for any services. Other insurance will be billed as appropriate.

NOTE: Clients with Medicaid funding will not be charged for services and will not be responsible to pay for missed appointments.

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FEE SCHEDULE

CPT Code	Psychiatrist (MD) Nurse Practitioner (PMHNP)	Licensed Therapist	Therapist (MA)	Qualified Mental Health Associate
90785	$30			
90791	$390	$267	$192	
90792	$390			
90832	$175	$160	125	
90833	$150			
90834	$245	$238	$175	
90836	$250			
90837	$320	$290	$210	
90838	$300			
90839	$290	$270	$210	
90840	$135	$125	$95	
90846	$280	$273	$210	
90847	$330	$320	$227	
90853	$105	$100	$80	
90882	$150	$135	$95	$90
90887	$175	$160	$120	
96127	$45			
99203	$227			
99204	$350			
99205	$435			
99212	$120			
99213	$175			
99214	$250			
99215	$345			
99348	$214			
99349	$275			
99350	$375			
99417	$45			
G0176	$55	$50	$40	$35
G0177	$49	$45	$36	$33
H0004	$75	$65	$50	
H0032		$248	$190	
H0034	$45			
H2010	$60			
H2011	$75	$67	$50	$47
H2014	50	45	$37	33
H2027				$35
H2032	$25	$20	$16	$13
Q3014	$35	$35	$35	$35
T1013		$110	$80	$75
T1016	$60	$53	$40	$37
T1023	$190	$167	$125	$120

Updated: August 2024

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Individual Rights and Responsibilities

As an individual receiving services from Valley Mental Health, you have the right to:

- Choose from available services and supports, those are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence.
- Be treated with dignity and respect.
- Have access to Peer Delivered Services.
- Participate in the development of a written Service Plan, receive services consistent with that plan, and participate in the periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan.
- Have all services explained, including expected outcomes and possible risks.
- Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.
- Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstance:
    - Under age 18 and lawfully married
    - Age 16 or older and legally emancipated by the court; or
    - Age 14 or older for outpatient services only. For purposes of informed consent, outpatient services does not include service provided in residential programs or in day or partial hospitalization programs.
- Inspect your Service Record in accordance with ORS 179.505.
- Refuse participation in experimentation.
- Receive medication specific to your diagnosed clinical needs.
- Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety.
- Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation.
- Have religious freedom.
- Be free from seclusion and restraint.
- Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule.
- Be informed of the policies and procedures, service agreements, and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information present.
- Have family and guardian involvement in service planning and delivery.
- Make a declaration for mental health treatment, when legally an adult.
- File grievances, including appealing decisions resulting from the grievance.
- Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules.
- Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
- Exercise all rights described in this rule without any form of reprisal or punishment.

Valley Mental Health must give you and, if appropriate, your guardian, a document that describes your rights as follows:

- Information given to you must be in written form or, upon request, in an alternative format or language appropriate to your needs.
- The rights, and how to exercise them, must be explained to you, and if appropriate, your guardian; and
- Your individual rights must be posted in writing in a common area.

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No Show/Late Cancellation Policy

Effective 05/01/2017

Please note: your appointment time is reserved just for you. We respect your time and we do not double book our patients. Therefore, we require **48 hours' notice** if you need to change or cancel your appointment so that the time may be offered to someone else in need. Valley Mental Health understands that sometimes missed appointments can mean that someone is not yet ready for treatment. If this is the case for you, our intake department and providers are happy to support you in coming back into services when the time is right.

For changes to a therapy appointment, please contact your therapist directly.
For changes to a medication or case management appointment, please call **(503) 589-4046.**

1. Appointments must be cancelled or rescheduled 48 hours before the appointment to allow scheduling for other individuals.

2. After the **FIRST UNEXCUSED MISSED APPOINTMENT,** a new appointment may be scheduled within 14 days or the first available time that works for your provider. **FOR MISSED MEDICATION APPOINTMENTS,** a limited amount of medication will be prescribed until the new appointment can be scheduled.

3. After the **SECOND UNEXCUSED MISSED APPOINTMENT,** a warning letter will be mailed out that reminds the individual that ALL services are at risk of being discontinued. Individuals can also be offered a referral to a general case manager to identify obstacles to accessing care that can be addressed, if needed.

4. After the **THIRD UNEXCUSED MISSED APPOINTMENT,** your provider and/or prescriber may choose to discontinue services and, if so, will mail you a Service Conclusion Letter. If **MEDICATION SERVICES** are discontinued, you will be prescribed enough medications for one month and referred to your Primary Care Provider or to PacificSource Community Solutions (CCO) for a new prescriber.

Unexcused missed appointments are defined as any "No Shows" or appointments cancelled outside the 48-hour time frame that have not been approved by the therapist, assigned prescriber, or case manager. When appropriate, Valley Mental Health reserves the right to request documentation for any missed appointment due to a health or safety concern.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the administrative office at:

Valley Mental Health
821 Saginaw St. S
Salem, OR 97302
Phone (503) 589-4046

WHO WILL FOLLOW THIS NOTICE?

This notice describes the privacy practices followed by us, and the office personnel who manage our practice at the above address.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the counseling and care services you have received through Valley Mental Health. Your health information may include information created and received by your therapist, it may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, counseling, evaluations, test results, prescriptions, diagnoses, treatments, procedures, and related billing activity and/or similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE AND OUR OFFICE PERSONNEL MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

For treatment, with your written consent we may release information to your primary care physician and /or other treating physicians, therapists, counselors, care givers, office staff or other personnel who are involved in taking care of you and your health.

> For example, your doctor may be treating you for a health condition and may need to know if you have issues or problems that could complicate your treatment. The doctor may use this information to decide what treatment is best for you. We may need to confer with your doctor or another clinician in the field of our practice to assist us in a choice of treatment that would be best for you.
>
> Different personnel may share information about you and disclose information to people who do not work in your therapist's office to coordinate your care, such as scheduling appointments and tests. Family members and other health care providers may be part of your medical care and may require information about you that we have.

For payment: we may use and disclose health information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party.

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For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

For Health Care Operations: We may use and disclose health information about you to make sure that you and our other clients receive quality care. For example, we may use your health information to evaluate the performance of the office personnel who are caring for you. We may also use health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for helping these plans and providers provide or improve care, reduce cost, coordinate, and manage health care and services, train staff and comply with the law.

Appointment Reminders: Office personnel may contact you by phone as a reminder that you have an appointment for counseling. *Please specify to office personnel what phone numbers they may use to remind you of appointments. Please notify us if you do not wish to be contacted for appointment reminders.*

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health 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.

Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health reasons to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

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Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement along with your written authorization to do so. We will give you an opportunity to object to such a disclosure and request you state this in writing. We may also disclose information to your family or friends if we can infer from circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to limited disclosure of information to your spouse when you bring your spouse with you to a counseling session and have not requested in writing that any form of disclosures cannot be made.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

We will need specific, written authorization from you to disclose certain types of specially protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to your therapist or our administrative office to set up an appointment to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

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Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment if your therapists keep the information.

To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to your therapist or Valley Mental Health, 821 Saginaw Street South, Salem, Or 97302.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- That your therapists did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions, and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to your therapist or Valley Mental Health, 821 Saginaw Street South, Salem, Or 97302.

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a hospitalization you had.

We are not required 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 or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to your therapist or to our administrative office at Valley Mental Health, 821 Saginaw St. S, Salem, OR 97302.

Right to Request Confidential Communications. You have the right to request that we communicate with you about matters in a certain way or at a certain location. For example, you can ask that we only contact you at work by phone or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL

COMMUNICATION to your therapist or office personnel of Valley Mental Health. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask your therapist or our office personnel to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective from information we already have about you as well as any information we receive in the future. We will post the current notice in the offices for Valley Mental Health clinicians with the effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with our administrative office, please contact our Complaints Representative at:

Valley Mental Health
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Phone: 503-589-4046

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LET US KNOW HOW WE CAN BETTER HELP YOU

Do you have a question, feedback, concern, or complaint about your services here?

You can:

- Talk with any staff person
- Fill out a Feedback Form (next page)
- File a Grievance with the Oregon Health Authority at **503-945-5763**

You can also contact your health plan directly. If you are covered by Oregon Health Plan, look on your OHP card to see which of these plans is listed:

PacificSource Community Solutions	Phone: 541-382-5920 (1-800-431-4135)
Division of Medical Assistance Programs	Phone: 1-800-273-0557

For legal help, call Disability Rights Oregon

Phone: 503-243-2081 or 1-800-452-1694

Please refer to the attached VMH Complaint/Grievance Process for guidance about how to file a complaint or grievance. Or call Oregon Health Authority at 503-945-5763.

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FEEDBACK FORM

DATE: _____

Name of Complainant (optional):	**Name of Client (optional)**
Contact phone number/address:	**Name of staff member receiving complaint:**

What happened? When did it happen? Who was involved? Who have you told about this?

What would you like to see happen?

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FEEDBACK FORM

Action taken (resolution and who was involved)

Forwarded to Program Manager?	☐ **Yes**	☐ **No**	**Date:** _____
Letter sent to client?	☐ **Yes**	☐ **No**	**Date:** _____
Reviewed by CAC?	☐ **Yes**	☐ **No**	**Date:** _____
Formal Grievance filed?	☐ **Yes**	☐ **No**	**Date:** _____

If yes, with what agency? _____

Additional Notes:

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Valley Mental Health Complaint/Grievance Process

If you feel our service can be improved or feel that your rights as a client have been disregarded, we urge you to first discuss those concerns with the therapist or staff member. If you do not feel that your concerns are adequately addressed, we encourage you to file a complaint by filling out a Feedback Form. A complaint is a verbal or written expression of dissatisfaction. There will be no retaliation for filing a complaint. We see your feedback as an opportunity to improve our services. If you need this information in an alternative format, please contact our office at 503-589-4046.

1. You may file a complaint verbally or in writing. If you express your complaint verbally, either your therapist or a staff member will explain the complaint process and provide you with a copy of the Feedback Form. If you need help with completing the Feedback Form, please let us know and we will make sure someone will help you.
2. Once VMH receives the complaint, the program manager will confirm the client's health care coverage to ensure compliance with the correct procedure.
3. The program manager will also review the complaint to ensure that it contains all the information needed to answer the complaint. If more information is needed, we will ask you to provide the information within 10 days or at a time which we agree.
4. We will contact you to resolve the complaint within 5 working days of receiving the Feedback Form. If we need more information or cannot resolve the concern, we will let you know why and when we hope to resolve the situation. An extension cannot be for more than 30 calendar days from the date we receive a complaint.
5. We will provide you with a written answer to the complaint. We will speak to each concern in your complaint.
6. **Expedited Grievances**: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.
7. **Retaliation:** A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages, or benefits, or basing service or a performance review on the action.
8. **Immunity**: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.
9. **Appeals:** Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:
    a. If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the Division as applicable.
    b. If requested, program staff must be available to assist the individual.
    c. The Division must provide a written response within ten working days of the receipt of the appeal; and
    d. If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the Chief Officer.
10. If Valley Mental Health cannot resolve your grievance, you may contact Pacific Source at 541-382-5920 (toll free at 1-800-431-4135) or the Oregon Health Authority Human Services Division at 503-945-5763.

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Voter Registration Information

As a new client of Valley Mental Health who is 17 years or older in age and a citizen of the United States of America, we would like to assist you in registering to vote.

A voter registration card may be completed in the following ways:

- Contact your local County Elections Office for a paper form
  - **Marion County:** 503-588-5041 or 1-800-655-5388
  - **Polk County:** 503-623-9217
- Complete voter registration online (English and Spanish) at the following link:
  - https://secure.sos.state.or.us/orestar/vr/register.do
- Ask for assistance from your new VMH provider to complete the registration process.

Free Transportation Services

ModivCare, or Non-Emergency Medical Transportation (NEMT) is a **free** ride service that helps you get to and from OHP covered appointments and services.

ModivCare's call center is open Monday through Friday from 6:00am – 7:00pm.

The phone number to call and reserve a ride is: 1-844-544-1397

How to get the most out of the free ride service:

- You MUST call 2 business days before your visit **unless it is an emergency.**
- Plan some extra time on the phone when you call to set up your first ride. Staff will ask you some questions about your needs. This is to make sure you get the right type of ride.

Do you prefer to ride the bus? Call ModivCare ask for a bus pass to help you get to and from your OHP covered appointments and services!

Do you have your own transportation? You can use the mileage reimbursement benefit! This is for travel to and from your OHP covered appointments and services. Request a form from your provider at your first appointment.

If you have any questions or concerns about this letter, please call PacificSource (CCO) Toll Free at 1-800-431-4135 or 541-382-5920. TTY users call 1-800-735-2900.

Si used necesita ayuda en entender esta informacion, por favor llame a linea gratis 1-800-431-4135 or 541-382-5920. Equipo teletranscriptor 1-800-735-2900 para la ayuda.

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Oregon Advanced Healthcare Directive

An advanced directive will help you describe who you want to make medical decisions on your behalf if you become unable to do so. It will also help you decide what kind of medical treatments you are willing to have if you cannot communicate about treatment options.

Please ask your healthcare provider for assistance if you have questions regarding this form.

A copy of an Oregon Advanced Healthcare Directive is available at
https://www.oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.pdf

You may also ask your VMH therapist or prescriber for a copy of the form.

Valley
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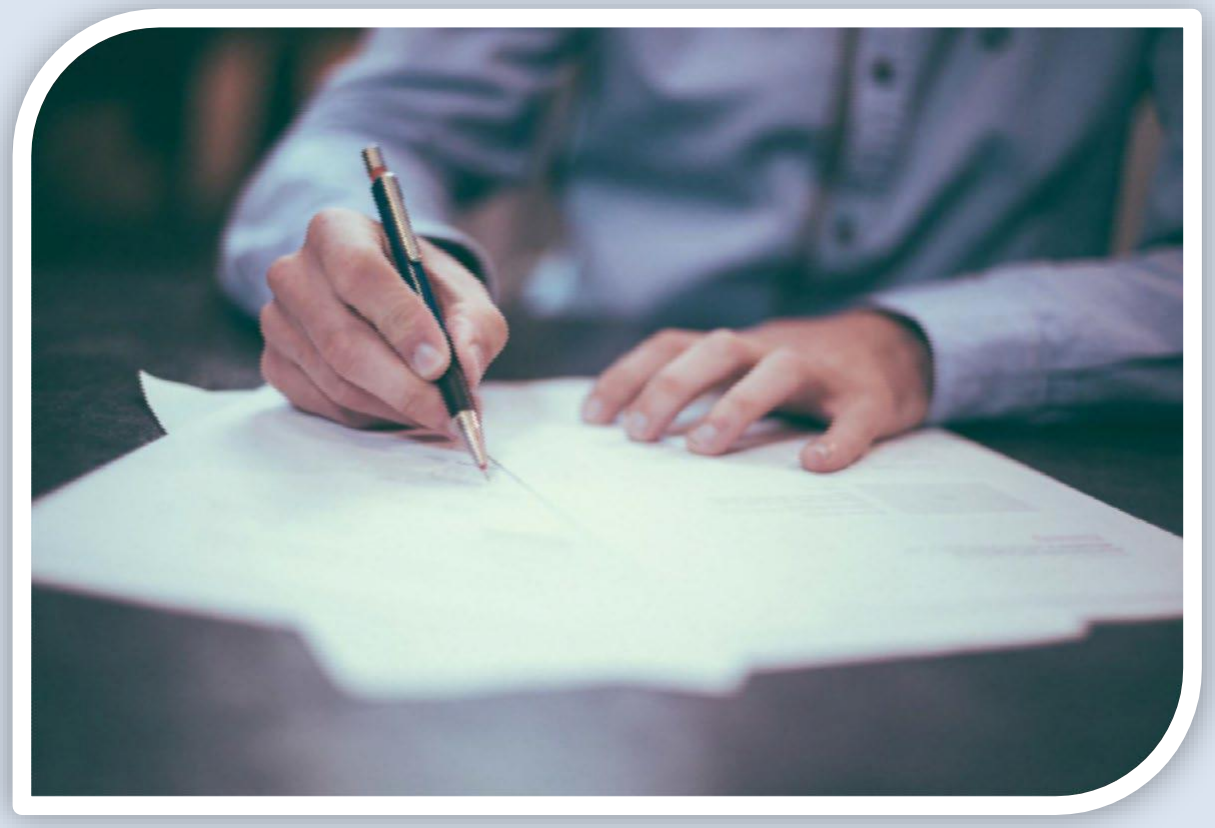
670 Hawthorne Ave SE,
Ste. 150
Salem, OR 97301
TEL (503) 589-4046

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



If you have a disability and need this document in an alternate format, please call 503-945-5772 (voice) or TTY 711.

Valley Mental Health

670 Hawthorne Ave SE,
Ste. 150
Salem, OR 97301
TEL (503) 589-4046

Contents

Answers to questions about 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*

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*

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 cannot 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 consent to 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 misdiagnosis 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-rundrop-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. When the witnesses sign the form they acknowledge that:

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.

I,_____, being an adult of sound mind, willfully and voluntarily make this declaration for mental healthtreatment.

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 thisdeclaration.

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 am naming that person here. I may also name an alternate representative to serve. Each person I appoint must accept my appointmentin 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 if I 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 care 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 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:

Oregon Health Authority

Health Systems Division
500 Summer Street NE, E-86
Salem, Oregon 97301
503-945-5772

NAMI-Oregon

4701 SE 24th Ave., Suite E
Portland, OR 97202
503-230-8009

Disability Rights Oregon

610 SW Broadway, Suite 200
Portland, OR 97205
503-243-2081

Here is a card you can fill out and carry with you:

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

821 Saginaw StSouth
Salem, OR97302
phone 503589-4046
fax 503480-0484
www.valleymental.com

Acknowledgments

Authored in 1994 by:
Patricia Backlar

Center for Ethics in Health Care Oregon Health Sciences University

Editorial Board:

Brett D. Asmann, M.A. Project Coordinator Mary

Alice Brown, Ph.D.

Roderick Calkins, Ph.D. Nellie

Fox-Edwards Gary Cornelius

Theodore Falk, J.D., Ph.D. Michael

Garland, D.Sc. Rel.

Rex Surface, M.S.W.

Robert C. Joondeph, J.D.
(Authored instructions)

Richard C. Lippincott, M.D.

Sandra Millius

Linda O'Mallia, M.C.S.W., B.C.D.

Garrett Smith, M.P.A.

Gary Smith, M.S.

Stanley Sturges, M.D.

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To the consumers of mental health services who reviewed and commented on the text.

Updated by:
Robert C. Joondeph, J.D., Oregon Advocacy Center Jan E.

Friedman, J.D., Oregon Advocacy Center

Bob Nikkel, Office of Mental Health and Addiction Services Jamie

Rockwell, Office of Mental Health and Addiction Services

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