Kinship House

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

FAX

To:	From:
Attn:	Pages: (including cover)
Fax:	Date:
Phone:	RE:

Please complete the attached intake paperwork and fax back the pages that require signatures. I will fill in the case number at the top. Please complete each section of the emergency contact sheet as well as a release of information for each contact listed. I'm only including one copy of our release so make as many copies as are necessary.

It is very important for me to have some background information for this client as we begin services. Please provide the following documents, as available, and any others you think may be helpful in understanding this child's environmental and developmental history:

- ☐ Current DHS Case Plan
- ☐ DHS Assessment Summary or other documentation of the circumstances surrounding the child's removal from parental care
- ☐ Psychological Evaluation of child
- ☐ Early Intervention Assessments and Documentation
- ☐ Previous mental health assessment and treatment records
- ☐ Visitation notes
- ☐ Pertinent medical history
- ☐ Individualized Education Plan
- ☐
- ☐

Thank you. Please feel free to contact me if you have any questions or to provide any additional information.

Kinship House

Intake Information

Client Name: _____ Date of Birth: _____ Case Number: _____

Welcome to Kinship House. Please review and complete the following, as indicated, prior to your initial appointment with your / your child's therapist:

- ☐ Kinship House brochure / description of services
- ☐ Kinship House Service Delivery Policies
- ☐ Client Rights and Responsibilities
- ☐ Informed Consent for Services*
- ☐ HIPAA Notice of Privacy Practices
- ☐ HIPAA Acknowledgement of Privacy Practices*
- ☐ Grievance Procedure
- ☐ Releases of Information*
- ☐ Child Medical / Developmental Questionnaire*
- ☐ Emergency Contact Information*
- ☐ Fee Disclosure and Payment Agreement*
- ☐ Copy of medical / OHP card
  - ☐ Please check here if you have mental health coverage other than OHP
- ☐ Developmental screening tool: ACORN, DECA, Achenbach, and / or Connors*

*Require completion / signature.

By signing below I indicate I have received, understand, and completed to the best of my ability the above-listed forms and information.

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

Kinship House

Agency Information

About Kinship House

Kinship House provides high-quality mental health services to children and their families. We specialize in working with children and families during all stages of foster care and adoption. We have been open since October 1996 as a small and easily accessible agency. Our clinicians are experts in their field, experienced, and effective. We are governed by a representative board; have an exceptional staff; and are supported through a diversity of donors, funding sources, and community groups. Kinship House is located in a home-like facility in Northeast Portland's Historic Irvington District from which we serve the region. Our warm house welcomes children into a cozy, supportive environment and offers a professional approach with outstanding results.

Programs

Counseling & Assessments

Counseling at Kinship House is available on an individual basis for both children and parents or as a family. Sessions often include time with the parents as well as one-on-one time with the child. Our clinicians structure each session according to the client's unique needs and current family dynamics.

Education

Education is a vital part of the Kinship House mission. We support our clients and community by providing ongoing educational opportunities for parents, caseworkers, educators, and others about the special needs of children, especially those in foster care and adoption.

Advocacy

Our clinicians have a deep understanding of the unique challenges facing children and families, especially those involved with foster care and adoption. Accordingly, Kinship House strongly advocates for decisions and treatment to be in the best interest of children. We participate in a broad spectrum of community collaborations and initiatives to advocate on behalf of children.

Access Services

Our intake process is simple and expedient. Call the Kinship House Intake Department at **(503) 724-6878**, email **intake@kinshiphouse.org** or fax an intake form found on our website to **(503) 460-3750**. (Please note: Email is not a secure form of communication and confidentiality cannot be guaranteed.)

For more information about Kinship House, please visit: **www.kinshiphouse.org.**

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

Counseling & Assessment Services

Counseling at Kinship House is designed to meet each child's unique needs, family dynamics, and history with particular sensitivity to cultural and racial issues. Our therapists identify the child's emotional and mental health needs and potential struggles. Clinicians integrate data received from other professional sources with information gathered through play, art, or conversational sessions. All assessments focus on understanding and recommending actions to support successful placements, effective parenting, and the special needs of each child.

Mental Health

- Individual Therapy for Children and Teens ages 0 - 18
- Individual Therapy for Adult Adoptees
- Family Therapy (for biological, foster, and/or adoptive families)
- Sibling Group Therapy
- Therapy for prospective adoptive parents

Child Welfare Assessments

- Sibling Interactions
- Parent-Child Interactions
- Permanency and Needs Assessments
- Parental Assessments

Other Services

- Adoption Preparation
- Transition Planning and Support Services (for placement in biological, foster, and/or adoptive home)
- Therapeutic Visitation
- Facilitation of Goodbye/Good Luck Visits
- Medication Evaluation & Management

Education

Kinship House Outreach Project

The Kinship House Outreach Project was launched in 2006. It includes trainings for parents and child welfare professionals as well as Child Welfare Assessments for children in foster care throughout Oregon. Training topics include:

- Preparing Children for Adoption
- How to Make a Life-Story Book
- How to Talk to Kids about Adoption
- Empowering Therapeutic Visitations
- Facilitation of Goodbye/Good Luck Visits
- Parenting Sexually Abused & Drug Abused Children
- Aspects of a Successful Transition
- Facilitation of Foster/Adoptive Parent Support Groups

Contact Kinship House at **(503) 460-2796** if you are interested in scheduling or attending an upcoming training.

Advocacy

Providing a Bridge

The Kinship House board, administrative team, and therapists are strong advocates for children and families. We join caseworkers, CASA's, attorneys, and judges to advocate for services and initiatives that support the mental health of children in need. In order to advocate for our clients' best interests, our clinical team is available for:

- Expert Witness Court Testimony
- Family/Team Decision Meetings
- Educational Meetings

These services are typically provided as part of our comprehensive mental health treatment. If you are interested in obtaining these services separately, please contact the Kinship House Intake Department at **(503) 724-6878**.

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

Kinship House

Service Delivery Policy Summary

I. Services Provided

A. Kinship House provides outpatient child mental health services including
   1. Individual and/or family mental health treatment
   2. Crisis services
   3. Medication management services
   4. Case management services as needed

II. Entry and Orientation

A. Prioritization of referrals
   1. Clients receive services at Kinship House without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age (except based on service eligibility criteria), familial status, marital status, source of income, or disability
   2. Clients receive services in the most timely manner available based on date of referral
   3. Clients presenting with more urgent needs are prioritized

B. Referrals
   1. Referrals are accepted from a number of different sources, including but not limited to parents (birth, foster, adoptive), guardians, other service providers, school personnel, and client self-referral
   2. When a referral is received, the information is reviewed by the intake department to ensure that all necessary information, including billing information, is included
   3. The case is assigned at the weekly clinical team meetings
   4. The clinician contacts the family and sets a mutually agreeable time for intake session at first available time, within 14 days of receipt of referral

C. Orientation
   1. A brief description of Kinship House services is provided by the Intake Department as needed
   2. The client and/or guardian receives intake packet and instructions for completion at initial assessment meeting or via mail prior to initial assessment
   3. The clinician assigned to the case reviews the intake paperwork with the client/guardian at the initial appointment and assures client/guardian understanding and completion of paperwork

III. Fee Agreements

A. Fee agreements are signed with clients as applicable
B. Fee agreements are completed as part of the intake packet
C. Medicaid clients are not billed for missed appointments per OAR 410.120.1280

IV. Assessment

A. Assessments are completed by the assigned clinician
B. Assessment is completed prior to development of the Individual Service and Support Plan (ISSP)
C. A full mental health assessment is conducted with each individual upon entry by the assigned clinician
D. The assessment is maintained in the ISR and contains the following
   1. Biopsychosocial information on the child and family
   2. Parent/child interaction and observation if the client is ages 0-5 (see section E below)
   3. Screening for the presence of substance use, problem gambling, and mental health conditions in client and family and referrals made if needed
   4. Screening for client neurodevelopmental history, medical/physical history, educational/vocational history, social history, legal history, environmental/trauma history, and screening for physical/psychological trauma symptoms
   5. Cultural and religious information
   6. Client and family strengths
   7. Mental Status Exam
   8. Screening for suicide potential
   9. Screening for homicide potential
   10. Risk factors and assessment of danger
   11. Clinical formulation
   12. DSM five-axis diagnosis
   13. Documentation of medical necessity

E. If the client is aged 0-5, diagnosis is informed by treatment guidelines included in the Health Services Commission prioritized list of paired conditions and treatments

F. Updates to assessment
    1. Assessments are updated as needed if new information becomes available
    2. Assessments are updated following guidelines established in the ISSP
    3. Assessments are updated annually by the assigned therapist and must be reviewed and signed by the LMP annually
G. Provisional assessment
    1. A provisional assessment can be completed if a full assessment cannot be completed at entry, such as in a crisis situation
    2. The provisional assessment must include sufficient biopsychosocial information to support a DSM diagnosis and medical necessity of services
    3. The provisional assessment must document medical appropriateness of services
    4. A full assessment must be completed as soon as possible and within a reasonable time frame

V. Service Planning

A. An Individual Service and Support Plan (ISSP) is developed for each client
B. Each ISSP contains the following
    1. Client identifying information
    2. Five-axis DSM diagnosis
    3. List of current medications
    4. Measurable or observable objectives
    5. Periodic update information
    6. Informed consent for ISSP signed by client/guardian
    7. Signature of client/guardian
    8. Signature of Kinship House clinician
    9. Signature of Kinship House Licensed Medical Provider (LMP) required annually
C. Each ISSP is developed collaboratively with the client/guardian, in developmentally and culturally appropriate language, and with the input of other family members or service providers as indicated
D. Clinicians will collaborate with family members and providers to provide services outlined in the ISSP
E. Each ISSP is reviewed with the client/guardian and updated at least every six months or as needed when circumstances change enough to warrant review
F. Provisional ISSP
    1. A provisional ISSP can be completed if a full ISSP cannot be completed at entry
    2. A provisional ISSP must include applicable crisis services, provisional diagnosis, medications (if known), a provisional goal, and appropriate signatures
    3. A complete ISSP must be completed as soon as possible based on level of services and supports to be provided, the completion of an assessment, and client/family engagement in treatment planning

VI. Coordination

A. Kinship House recognizes the value of coordinating services with other agencies and individuals in providing comprehensive, effective treatment for clients
B. Services are coordinated to the fullest extent possible with other providers and family members as indicated
C. Releases of information are obtained for all individuals and agencies with whom coordination is desired and/or required

VII. Documentation

A. An Individual Service Record (ISR) is created for each individual upon entry and contains
    1. Insurance enrollment information
    2. Copy of current Medical Card or computer print-off verifying enrollment
    3. Identifying information
    4. Informed consent for service
    5. Refusal and/or denial of services and supports
    6. A signed fee agreement, when applicable
    7. A mental health assessment or provisional assessment and updates to the assessment
    8. An Individual Services and Supports Plan (ISSP) or provisional ISSP
    9. Individual services notes
    10. Medical service records
    11. CPMS form
    12. Collateral contact information, when applicable and available
    13. Signed consents for release of information
    14. Developmental screening tools
    15. Service Conclusion Summary (if indicated)

VIII. Person-Directed Services

A. Kinship House seeks to involve the client, family members, and other important individuals in the client's life
B. Cultural Competency
    1. Kinship House is dedicated to continual cultural competency improvement and development
    2. Clients, family members, and other important individuals are involved to the fullest extent possible in treatment and service planning and delivery, and treatment is culturally specific and appropriate
    3. Treatment is enhanced by the inclusion of family and other important individuals who share the client's cultural background and values, and the therapist seeks to include culturally significant and appropriate supports to the fullest extent possible
C. Developmentally- and age-appropriate service planning and delivery
    1. Children receive treatment and are involved in treatment planning based on developmental age rather than chronological age, which is assessed at initial assessment appointment(s)
D. Family Involvement
    1. Kinship House recognizes family as anyone crucial to the development of a child, including parents, extended relatives, and close friends
    2. Family members are invited and encouraged to attend assessment and therapy sessions (within guidelines set by client/guardian and as is therapeutically indicated)
    3. Caregiver/child interaction is included as part of each assessment and treatment for young clients and informs treatment goals

IX. Service Conclusion, Transfer, and Continuity of Care

A. Service Conclusion
    1. Services are concluded when
        a. The client has met measurable treatment goals
        b. The clinician and client/guardian mutually agree that services are no longer required
        c. The client moves out of the service area
        d. The client requests service conclusion
        e. The client transfers to another service provider
        f. The client requires a higher level of care
        g. The client ceases to access service or engage in treatment
    2. Prior to service conclusion, the assigned therapist will provide referral information and coordinate referral / transfer services as needed, including medical care and medication management
    3. Clients/guardians are included in service conclusion planning whenever possible
    4. Planned and agreed-upon service conclusion is conducted in the most therapeutic manner possible
    5. Referral information and further treatment options are provided to the client / guardian and coordinated as needed
    6. The Service Conclusion Summary is completed by the clinician
    7. In the case of unplanned service conclusion, the clinician attempts to re-engage the client / guardian
    8. In the case of unplanned service conclusion, the case will be considered closed after three attempts at re-engagement have been made (at least one in writing)
    9. In planned service conclusion the date of service conclusion is considered the last date of contact with client / guardian
B. Transfer and Continuity of Care
    1. Clients are transferred to other service providers if a higher level of care is indicated or if client/family needs cannot be met by Kinship House

X. Trauma-Informed Services

A. Clients are assessed for symptoms and history of trauma in initial assessment sessions
A. Clinicians are skilled in recognizing trauma and receive ongoing education regarding trauma and trauma-informed services through weekly clinical team meetings and periodic outside trainings
B. Clinicians maintain current knowledge about trauma-informed treatment practices and utilize this knowledge in treatment planning and interventions with all clients
C. Clinicians provide psycho-education to clients and families regarding trauma as indicated
D. Clinicians recognize that most clients have experienced some form of trauma, and that trauma has often been misdiagnosed in past treatment
E. Clinicians are immediately responsive to the symptoms of trauma
F. Clinicians individualize treatment in response to ways in which trauma manifests itself in client and family

XI. Confidentiality

A. Kinship House carefully guards all confidential information about clients
   1. All open and closed client files are stored in locked filing cabinets when not in use
   2. Information is only released to designated individuals indicated on a signed Release of Information
   3. Computers are password protected
   4. Email is password protected

XII. Americans with Disability Act

A. Kinship House complies with the Americans with Disability Act and provides services to all eligible individuals and families, regardless of disability
B. Barriers have been removed to allow access to Kinship House facilities for those with disabilities, and a wheelchair ramp is in place
C. Reasonable and necessary accommodations will be made for those with disabilities to enable them to receive the same services as all other clients of Kinship House, including but not limited to physical accommodations and translation services for hearing or speech impaired.

XIII. Grievance and Appeals

A. Clients receive a written copy of the client grievance procedures upon service entry
B. The assigned clinician reviews the grievance procedure with the client/guardian to assure understanding. Clients / guardians are made aware that grievances may always be filed without fear of retribution
C. If a client / guardian is dissatisfied with services provided and feels rights have been violated, they must take the steps outlined in the Grievance Procedure to file an official grievance

XIV. Individual Rights

A. Clients/guardians are informed of their rights at program orientation/intake, at or before the initial assessment appointment
B. Client rights are posted in the general waiting area in the main building

XV. Quality Assessment and Performance Improvement

A. Quality Assurance/Utilization Management (QA/UM) Committee
   1. Meets at least quarterly
   2. Is organized by a Kinship House staff member who serves as the QA/QU Coordinator
   3. Includes the Kinship House Medical Director (LMP), a child psychiatrist, one or more QMHP from the staff, one DHS caseworker, one parent, and at least one youth will participate annually in the Kinship House Advisory Board
B. Performance Improvement Plan
   1. A Performance Improvement Plan is maintained by the Clinical Coordinator and QA/UM Coordinator
   2. The Plan is reviewed at least quarterly as part of the QA/UM Committee meeting

XVI. Crisis Prevention and Response and Incident Reporting

A. Kinship House maintains a 24-hour, 7 day per week crisis line, which is made available to all clients and families for mental health emergencies.
B. Clinicians and Kinship House staff monitor health and safety risks and are diligent in maintaining client safety to the fullest extent possible
C. The QA/QU Coordinator is responsible for ensuring agency compliance with Multnomah County and OAR guidelines on critical incidents, including corrective actions and required reporting to the proper authorities
D. A written incident report is completed for any incident occurring on Kinship House property or involving Kinship House staff or clients while conducting Kinship House activities
E. Follow-up responses are documented in the incidence report
F. Incident reports are submitted to and reviewed with the Clinical Coordinator within 24 hours
G. Upon becoming aware of an incident, the Clinical Coordinator notifies the Quality Management Coordinator within 24 hours, completes a written critical incident report within 30 days, and (for Verity clients) faxes the critical incident report to VERITY Quality Management

XVII. Policy Availability and Review

A. A summary of these Service Delivery Policies is provided to each client / guardian upon service entry
B. A summary of these Service Delivery Policies will be made available to clients in a language they can understand
C. These Service Delivery Policies will be reviewed and updated at least annually by the Board of Directors Program Committee or a designee

Kinship House

Client Rights and Responsibilities

YOU HAVE THE RIGHT TO:

- Be treated with respect, courtesy, and dignity
- Be given information about mental health needs and treatment and have this explained in a way that is understandable to you
- Participate in planning and decisions about treatment including information about your condition and covered/non-covered services to allow an informed decision about proposed treatment and participate in periodic review of treatment
- Participate in the development of a written ISSP, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written ISSP
- Choose from available services and supports consistent with your planned treatment that allow for the most independence
- Have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines
- Talk to provider and expect that what is said will be kept confidential except in certain circumstances permitted by law
- Give written informed consent or refusal of treatment prior to the start of treatment, except in some instances permitted by law
- Not participate in experimentation
- Have a clinical record maintained which documents conditions, services received, and referrals made
- Have access to your own clinical record, unless restricted by statute, and to request that the record be amended or corrected
- Have a copy of your clinical record transferred to another provider
- Get mental health care without a long delay
- Receive information about rights, responsibilities, benefits, risks, how to access services and what to do in an emergency
- Receive emergency mental health care 24 hours a day, 7 days a week
- Participate in choosing a mental health provider
- Receive necessary and reasonable services to diagnose the presenting condition
- Receive mental health care and medication management regardless of age, race, religion, origin, gender, or sexual orientation
- Receive medication specific to your clinical needs
- Have religious freedom
- Receive a notice of an appointment cancellation in a timely manner
- Receive prior notice of service conclusion or transfer, unless this poses a threat to health or safety
- Have someone help talk to your provider if interpretation is needed, or if you are hearing or speech impaired at no cost to you
- Receive Notice of Action if your treatment will be changed or denied and request review of this decision
- Make a Declaration of Mental Health/Advance Directive and have your wishes about mental health treatment be followed
- Change primary mental health provider or get a second opinion
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Be free from abuse or neglect and to report abuse or neglect or file grievances without retaliation
- Be informed of policies and procedures, service and fee agreements, and to have a representative assist with understanding any information presented
- Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule
- File grievances, including decisions resulting from the grievance
- Exercise all rights set forth in ORS 109.610 through 109.697 if you are a child, as defined by these rules
- Exercise all rights set forth in ORS 426.385 if you are committed to DHS
- Know how to file a grievance about your provider to Verity or about Verity and receive a timely response
- Refer yourself directly to a provider for Covered Services without first having to gain approval from another provider
- Have access to Covered Services and obtain covered Preventive Services, which at least equals access available to other persons served by provider
- Request a Department of Human Resources hearing, including an Expedited Hearing if you feel the problem is urgent or emergent and cannot wait for the normal hearing process

- Request Continuation of Benefits until a decision in a hearing is rendered, however, you may be required to repay any benefits continued if the issue is resolved in the favor of Verity
- Receive in writing, a 30-day notice in a readable format, when a service or benefit is cancelled reduced or changed.
- Appeal when a service has been denied if you are the person consenting to treatment
- Execute a statement of wishes for treatment, including the right to accept or refuse treatment

YOU HAVE THE RESPONSIBILITY TO:

- Help your provider get old mental health records or fill out new ones
- Honestly share concerns about mental health needs and ask questions about things that are not clear
- Help decide treatment plan and approve the plan before it starts
- Treat provider and staff with respect and courtesy
- Keep appointments and be on time. Call provider when late or can't keep the appointment.
- Tell provider if there are changes to address or phone number or emergency contact information
- Choose a mental health provider
- Bring DMAP Medical Care ID whenever care is needed
- Pay your monthly OHP premium on time if so required
- Use only selected provider for mental health needs; in an emergency, services from someone else may be needed
- If emergency mental health services are used when out of the area, you must let VERITY know within three days

By signing below I agree I have read and understand each of the Rights and Responsibilities outlined above. I understand that if I have any further questions I may discuss this with my clinician. Initial: _____

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

Kinship House

Informed Consent for Services

Client Name: _____ Date of Birth: _____ Case Number: _____

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. Below are outlined client and therapist responsibilities and guidelines for treatment.

Informed Consent to Treatment

According to OAR 309-032-0960 (36) "Informed consent to treatment" means that the information about a specific diagnosis and the risks or benefits of treatment options and the consequences of not receiving a specific treatment are understood by the child, if able, and the parent or guardian, if the client is a minor. The person consenting to treatment voluntarily agrees in writing, as required in OARS 430.210(d), to a prescribed treatment for the specific diagnosis, which will be discussed with you by your therapist or by the Kinship House Licensed Medical Practitioner (LMP).

Confidentiality

All information shared in the counseling relationship is confidential. Information about you will not be released to outside individuals, agencies or institutions without your (or in the case of a minor, the guardian's) written consent. There are three exceptions covered under law: 1) when abuse of a child or adult is disclosed; 2) if the client presents a physical danger to self or others; 3) by court order.

Kinship House therapists are Licensed Clinical Social Workers (LCSWs) or Licensed Professional Counselors (LPCs) or are in the pursuit of licensure. The therapists at Kinship House regularly access professional clinical supervision. This ensures better therapy for clients and provides therapists with continuing education and professional growth. Although individual cases may be discussed in a supervisory setting, identifying names or circumstances are used as little as possible. Audio and video taping of therapy sessions will be done at the discretion of the mental health therapist and only with your written permission. These audio and/or video tapes will be reviewed during clinical supervision. The supervisors and staff are obligated by federal law to protect the confidentiality of the client. As is the case of all clinical information there is the potential for these materials to be subpoenaed and reviewed in a court of law.

Emergencies

Kinship House offers after-hours crisis coverage. If your child presents a danger to self or others, and you believe this threat of harm requires an emergency assessment by a mental health professional, you may call Kinship House at 503.460.2796 weekdays between 9:00am and 5:00pm. After 5:00pm weekdays, or any time during weekends and holidays, you may call **503.913.4098**. If it is a life-threatening emergency, please call 911.

Grievances and Complaints

You have the right to file a grievance if you are dissatisfied with the services provided to you at Kinship House, and your clinician will discuss this process with you. If possible, please first discuss your grievance with the person it concerns. If your complaint is not resolved, you may then contact the clinical director, executive director, and then the board of directors. Grievances must be filed in writing. Please see the form "Grievance Policy" for more detailed information.

Rights and Responsibilities

As a client of Kinship House, you have many rights and responsibilities which your Kinship House therapist will discuss with you. Please see the form "Client Rights and Responsibilities" for more detailed information.

Advance Directive and Declaration of Mental Health Treatment

As a client of Kinship House, you have the right to make a statement of your preferences regarding mental health treatment. This statement will be honored, as clinically appropriate, if you become unable to understand and legally make decisions regarding your mental health treatment.

Service Options, Risks, and Benefits

Kinship House provides counseling and assessment services for children and their families. Assessment in therapy cases may take up to three sessions, and assessment is vital in planning interventions and best meeting the client's needs. Recommendations and treatment planning are done based on the comprehensive assessment conducted. Kinship House also provides medication management services provided by the Kinship House LMP. Any treatments, including

therapeutic treatments and medication, carry inherent risks which must be weighed with the expected benefits and outcomes. Risks are dependent upon the treatment provided and may include but are not limited to uncomfortable feelings such as sadness, guilt, anger or frustration, conflicts with others, or an increase in negative behaviors. Benefits may include but are not limited to improved mood and feelings, improved quality of relationships, and a decrease in negative behaviors.

Contacting Kinship House

All calls to your Kinship House therapist are confidential and will be returned as soon as possible. You can also reach your Kinship House therapist via email (typically your therapist's first and last initial @kinshiphouse.org). Email is not a secure form of communication and confidentiality cannot be guaranteed.

Appointments

Your Kinship House clinician will schedule appointments with you. If you need to reschedule or cancel an appointment, please provide at least 24-hour notice.

By signing below I agree to the following:

☐ I have reviewed and understand this Informed Consent for Services.

☐ I understand that my health information will be disclosed only on a need-to-know basis for purposes of coordinating my treatment by Kinship House staff and for obtaining payment, and that my health information will not be disclosed to anyone outside of Kinship House without my signed authorization, except as required by law.

☐ I understand that emergency mental health crisis services are available 24 hours a day by calling the Kinship House crisis line at 503.913.4098 or by dialing 911.

☐ My right to file complaints or grievances and the process for doing so has been explained to me.

☐ I state my desire to receive services at Kinship House as outlined in my ISSP. Should I become unable to understand or legally make decisions regarding my mental health treatment, I would like these decisions to be honored as clinically appropriate.

☐ My rights and responsibilities as a client of Kinship House have been explained to me.

☐ Kinship House proposed service options, including medications, have been explained to me in a manner I /my child comprehend.

☐ The risks and benefits of mental health treatment at Kinship House for me (or my child) have been explained to me and I understand and accept these risks and benefits (as required by OAR 309-032-1505(60)).

☐ I have signed this form prior to the start of services at Kinship House.

☐ I give permission for the client named below to receive treatment at Kinship House.

Client name: _____ Date of birth: _____

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

Kinship House

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on May 1, 2005 and remains in effect until we replace it.

1. Our Pledge Regarding Medical Information
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty
Law requires us to:

1. Keep your medical information private,
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information, and
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law,
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information
The following section describes different ways that we use and disclose medical information. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

For treatment: We may use medical information about you to provide you with medical treatment or services. We may also share medical information about you to your other health care providers to assist them in treating you, with your written consent.

For payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include you medical information.

For health care operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional uses and disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: In the case of an emergency, we may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according

to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We will limit our use and sharing to information that describes you in general, non-identifying terms and the dates of your health care.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may obtain the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $0.25 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency or exceptions required by law).
4. Request that we communicate with you about your medical information by different means or at different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

4. Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in this notice by writing to the following address:

KINSHIP HOUSE
Attn: Privacy Official
1823 NE 8th Avenue
Portland, OR 97212

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

5. Supplemental Use and Disclosure

The therapists at Kinship House access professional clinical supervision. This ensures better therapy for clients and provides therapists with continuing education and professional growth. Although individual cases may be discussed in a supervisory setting, identifying names or circumstances are used as little as possible. The supervisors and staff are obligated by federal law to protect the confidentiality of the client.

Kinship House

Acknowledgement of Privacy Practices

Client Name: _____ Date of Birth: _____ Case Number: _____

I have received the HIPAA Notice of Privacy Practices for Kinship House and I have been provided an opportunity to review it.

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

Kinship House

Grievance Procedure

Client Name: _____ Date of Birth: _____ Case Number: _____

As a client of Kinship House, you have the right to file a grievance, without fear of retribution, if you are dissatisfied with the services provided to you or feel your rights have been violated. The following steps must be followed to file an official grievance:

1. Clients are encouraged to first discuss concerns and any possible grievance with the Kinship House therapist or others involved. A facilitator or representative may be present at this discussion if requested by either party.

2. If a complaint or grievance cannot be resolved at this level, a grievance may be filed in writing with the Clinical Director. The grievance must include date, approximate time and description of the incident, and names of the individual(s) involved. The Clinical Director can assist with the filing of a grievance as needed and requested by the client / guardian.

3. The Clinical Director will review the grievance and provide written acknowledgement of receipt of the grievance within three business days. Receipt will include the date the grievance was received, a summary of the grievance, a summary of the planned investigation process, and a time line for review and follow-up.

4. The Clinical Director will investigate the grievance, gather facts, speak with all parties involved, and attempt to satisfactorily resolve the grievance. If resolved, the Clinical Director and client / guardian will sign and date a summary of the resolution.

5. If the grievance is not resolved to the client / guardian's satisfaction, the client may file the written grievance with the Executive Director as outlined in step 2 above.

6. The Executive Director will convene a meeting with the client / guardian and any other involved parties, as well as any other individual(s) designated by the client / guardian. This meeting will be conducted within 30 business days of when the Executive Director receives the written grievance. The Executive Director will review pertinent information and hear from the parties involved. The Executive Director will present a decision in writing regarding the grievance within three business days. A written summary of the decision will be given to all parties involved. The decision by the Executive Director is final at the agency level.

7. If the Executive Director is named in the grievance, the Chairperson of the Board of Directors will act in the role outlined in step 6 above.

8. If the client / guardian remain unsatisfied with the resolution, a complaint may be filed with an outside entity, including but not limited to the Department of Human Services and / or appropriate professional licensing or regulatory associations. The addresses for these entities will be provided upon request.

By signing below I indicate I have received and had a chance to review the Kinship House Grievance Procedure.

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

Kinship House

Authorization for Use / Disclosure of Protected Health Information

Client Name: _____ Date of Birth: _____ Case Number: _____

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Release from:

Person or Organization: _____ Mutual exchange? ☐ yes ☐ no

Address / Phone / Fax: _____

Release to:

Person or Organization: _____ Mutual exchange? ☐ yes ☐ no

Address / Phone / Fax: _____

The following items must be **initialed** to be included in the use and disclosure of protected health information/other medical record:

The information to be used or disclosed includes:

_____ Social, medical or psychological reports (not to include information related to HIV/AIDS)

_____ Medication(s) used in treatment

_____ Treatment goals and results

_____ Information about drug and/or alcohol abuse

_____ School records

_____ Police, court or probation records

_____ Other (specify):

This information disclosure is necessary for the following purpose(s):

_____ Diagnosis and evaluation

_____ Continuity and coordination of care

_____ Completion of historical information

_____ Evaluation of medication

_____ Custody/parent-child interaction

_____ Other (specify):

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to my Kinship House therapist. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signing unless otherwise specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used and disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of this health information I may contact the Kinship House Privacy Officer at 503-460-2796.

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

Kinship House

Child Medical / Developmental Questionnaire

Client Name: _____ Date of Birth: _____ Case Number: _____

Please complete the following:

	Yes	No	Unknown		Yes	No	Unknown
Prenatal/neonatal abnormalities	☐	☐	☐	Seizures	☐	☐	☐
Delayed developmental milestones	☐	☐	☐	Major injuries	☐	☐	☐
Low birth weight	☐	☐	☐	Surgeries	☐	☐	☐
Malnutrition	☐	☐	☐	Hospitalizations	☐	☐	☐
Inadequate diet	☐	☐	☐	Pregnancies	☐	☐	☐
Exposure to lead or other toxins	☐	☐	☐	Sleep problems	☐	☐	☐
Eating nonfoods	☐	☐	☐	Wets self	☐	☐	☐
Excessive dieting/fasting	☐	☐	☐	Soils self	☐	☐	☐
Fine motor problems	☐	☐	☐	Overactive	☐	☐	☐
Gross motor problems	☐	☐	☐	Lack of energy	☐	☐	☐
Speech/language problems	☐	☐	☐	Vision problems	☐	☐	☐
Allergies	☐	☐	☐	Hearing problems	☐	☐	☐
Asthma	☐	☐	☐	Recurrent infections	☐	☐	☐
Head/stomach aches	☐	☐	☐	Chronic medical condition	☐	☐	☐
Head injury/trauma	☐	☐	☐	Other	☐	☐	☐

If you marked yes for any items above, please explain:

Date of last physical exam: _____

Does the child take any medication? ☐ yes ☐ no If yes, complete below:

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Prescribing physician name: _____

Does the child take any over-the-counter medication: ☐ yes ☐ no If yes, complete below:

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Does the child have any allergies or adverse reactions to medication? ☐ yes ☐ no ☐ unknown

If yes, describe: _____

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org

Kinship House

Emergency Contact Information

Client Name: _____ Date of Birth: _____ Case Number: _____

Please complete the following. All sections are required.

Legal Guardian: _____ Email: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Primary Caregiver: _____ Email: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Kinship House Release of Information completed? ☐ yes ☐ no

Emergency Contact: _____ Email: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Kinship House Release of Information completed? ☐ yes ☐ no

Primary Care Physician: _____ Email: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Kinship House Release of Information completed? ☐ yes ☐ no

Emergency Medical Resource: _____ Email: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Kinship House Release of Information completed? ☐ yes ☐ no

Emergency Dental Resource: _____ Email: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Kinship House Release of Information completed? ☐ yes ☐ no

Other: _____ Email: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Kinship House Release of Information completed? ☐ yes ☐ no

Client/Guardian Signature: _____ Date: _____

If guardian, printed name: _____ Relation to client: _____

Kinship House signature: _____ Date: _____

1823 NE 8th Avenue • Portland, OR 97212
P: (503) 460-2796 • Fax: (503) 460-3750 • Intake: (503) 724-6878
www.kinshiphouse.org