KINGS VIEW

Message to Consumers:

Please be advised that this packet is intended to guide you during your over-the-phone screening and assessment with Kings View staff.

There is no need to fill this packet out as it will be for your reference only.

To enroll in services via phone, please call: (559) 582-4481.

Please note the days and time for phone screenings below:

Monday 8:00am – 2:00pm

Wednesday 8:00am – 2:00pm

Thursday 8:00am – 2:00pm

Friday 8:00am – 2:00pm

For an Online Version of the Consumer Packet please visit our website at:
https://www.kingsview.org/services/mental-health/

1393 BAILEY DRIVE
HANFORD, CA 93230
PHONE (559) 582-4481

KINGS COUNTY

Distribution of Mental Health Plan (MHP) Informing Materials

Name of Client: _____ **EHR #:** _____

DOB: _____ **Date:** _____

Beneficiary Preferred Language: _____

Were Materials given/offered in the beneficiary preferred language: _____

Material must be given/offered in preferred language. Where material is not available in preferred language, use on-site interpreter or your entities interpretation services such as Language Line to interpret.

Initial upon distribution of or offer of each		**Informing Materials Provided**
Staff Initial	**Client Initial**	
*The following materials are **given at intake to all individuals**.*		
		Notice of Privacy Practices - Tells you how Kings County Behavioral Health and its Providers/Contractors may use or disclose information about your physical and/or mental health. The county is required by federal law to give you this notice.
		Health Information Exchange Participation- Tells you how your health information may be shared with hospitals, behavioral health providers, county health programs, physicians, social workers, and other HIE participants who may provide health or behavioral health services to you.
		Beneficiary Rights - Provides you with information of your right to receive medically necessary specialty mental health services from the MHP.
		Consent to Treat - Outlines the expectations regarding the treatment you may receive. It also explains that the risks, benefits, and alternatives to treatment have been explained to you.
		Taglines and Auxiliary Aides - Assists you in identifying the language that you may need services provided in by way of either on-site bilingual or interpreter services, telephonic interpreter services via a language line, or through an auxiliary aid.
		Non- Discrimination Notice - Informs you that Kings County MHP follows the federal civil rights law, and provides information on how you can file a complaint if you believe you've been discriminated against.
		Grievance and Appeal Form and Procedure - Helps you file a complaint about your services if you need to at some point. The procedure tells you how to file the complaint.
*The following materials are **given at intake to all individuals accessing child/youth services**.*		
		Early & Periodic Screening Diagnosis Treatment (EPSDT) Mental Health Services - Explains the Medi-Cal EPSDT services for children and young adults and their caregivers or guardians.

		Therapeutic Behavioral Services (TBS) Information Brochure – Summarizes TBS services that are available to children/youth with serious emotional challenges who may need a supplemental service to their to their mental health services.
		Foster Child Mental Health Bill of Rights - Provides information to the foster child/youth of their rights to receive mental health services.
*The following materials are **offered to all individuals at intake**, and given upon request. A copy of each must also be maintained in the lobby for public use.*		
		Kings County Behavioral Health MHP "Guide to Medi-Cal Mental Health Services" - Contains information eligibility for specialty mental health services through Medi-Cal, as well as how to access those services, what services are available, what your rights and responsibilities are, and how to file a grievance, appeal, or file for a state fair hearing. *This document is over 50 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/*
		Medi-Cal Beneficiary Handbook – Kings County – Explains your Medi-Cal specialty mental health services benefits, can answer many of your questions related to services, and contains important phone numbers and information related to Kings County MHP. *This document is over 50 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/*
		MHP Provider List – Kings County – Contains a list of licensed, registered, and waivered clinical providers who are employed by or contracted by the MHP to provide mental health services through Medi-Cal for Kings County residents who meet medical necessity. *This document is over 20 pages and is available upon request. However, a copy is also available at all times in the lobby and on the MHP website: http://www.kcbh.org/*
*The following materials are **offered to all 18 years of age and older, at intake**, and given upon request.*		
		Advance Health Care Directive Brochure - Explains your right to make decisions about your medical treatment. It includes how to appoint a person who can make health care decisions for you when you are unable (Health Care Agent), and how to change your directive at any time.
		Do you already have an Advance Health Care Directive or a Durable Power of Attorney for Health Care? Yes No
		If yes, will you provide a copy for our medical record? Yes No

Staff Signature upon Completion:_____ **Date:**_____

Beneficiary Signature upon Completion: _____ **Date:** _____

Instructions:

1. Give client a copy
2. Scan original into the EHR under attachments (title "Informing Materials")
3. Once scanned, this may be shredded

Legend:
____ Screener Completes
____ Admissions Completes

INDEX CARD - ALL CAPS

Client #:

Sort Name:

Last, First Middle

Legal Name:

*Last Name: | *First Name:

Middle: | Suffix:

*DOB: | Soc Sec #:

CLIENT IDENTIFYING INFORMATION - use sentence case

Effective Date: | Admission Status: ❍ Admit ❍ Pre-Register

*(6) Referral Source: Circle One | Referral Phone:

(1) Self
(2) Family
(3) Friends
(4) Employer
(5) Other
(9) Psych Hospital
(11) Hospital
(13) Jail
(21) Homeless Program
(24) Convalescent Hospital / SNF
(25) DSS
(26) Probation
(27) Outside AOD
(28) Primary Care Provider
(29) School/College
(33) MHSA
(34) CALWORKS
(41) CPS
(42) Parole
(99) Unknown/Not Reported

*Birth Name (if different from above):

Last Name: | First Name:

Middle: | Suffix:

*Physical Address: | Apt. #:

*City/State/Zip: | *(21) County:

*Home Phone: | Work Phone: | Ext.

Cell Phone:

*Mailing Address: | Apt. #:

*City/State/Zip:

*Driver's License: ❍Yes ❍No | DL No.: | State:

*Social Security #: (If SSN not entered above) | (8) Reason SSN Not Provided: (*If SSN blank)

*(7) Gender: Circle One
(F) Female (M) Male (O) Other (T) Transgender

*Is DOB: ❍ Actual? ❍ Estimated?

Born in US: ❍ Yes ❍ No

Born in California: ❍ Yes ❍ No

Place of Birth: | *(21) County: | *(22) State: | (23) Country:

*Mother's First Name

*(9) Marital Status: Circle One
(D) Divorced/Annulled (M) Married (N) Never Married (P) Domestic Partner (S) Separated (W) Widowed (U) Unknown

*(10) Ethnicity: Circle One
(1) Not Hispanic
(2) Mexican / Mexican American
(3) Cuban
(4) Puerto Rican
(5) Other Hispanic / Latino
(7) Unknown / Not Reported

*(11) Race: Circle One

(3) Mien	(F) Filipino	(N) Native American	(V) Vietnamese
(4) Other Pacific Islander	(G) Guamanian	(O) non-White – Other	(W) White
(A) Asian – Other	(H) Hawaiian Native	(P) Laotian	(Y) Hmong
(B) Black / African American	(I) Cambodian	(Q) SE Asian – Other	(U) Unknown / Not Reported
(C) Chinese	(J) Japanese	(R) Samoan	
(D) Asian Indian	(K) Korean	(T) Eskimo / Alaskan Native	

*(12) Primary Language: Circle One

(1) American Sign	(C) Chinese Dialect	(K) Korean	(S) Spanish
(2) Other Sign	(D) Cambodian	(L) Lao	(T) Turkish
(3) Samoan	(E) English	(M) Mien	(V) Vietnamese
(4) Other Chinese	(F) French	(N) Thai	(W) Filipino Dialect
(5) Tagalog	(G) Cantonese	(O) Other non-English	(X) Hmong
(6) Mandarin	(H) Hebrew	(P) Polish	(Y) Ilocano
(A) Armenian	(I) Italian	(Q) Farsai	(Z) Portuguese
(B) Arabic	(J) Japanese	(R) Russian	(U) Unknown / Not Reported

*(13) Communication Method: Circle One

(C) Communication Device	(S) Sign Language	(V) Verbal
(H) Translator – Hmong	(T) Translator – Spanish	(X) Translator - Other

*(12) Language Preferred (Individual): Indicate Code (from prim lang above) _____

**(12) Language Preferred (Caretaker): Indicate Code (from prim lang above) _____

*Interpreter Needed? ❍ Yes ❍ No

*(14) Employment Status: Circle One

(1) Comp Job 35+ hours/week	(8) Full Time Student	(F) Not in labor Force
(2) Comp Job <20 hours/week/	(9) Job Training	(H) Resident / Inmate
(3) Comp Job 20-35 hours/week	(A) PT School / Job Training	(I) Non-Comp Job 35+ hours/week
(4) Homemaker	(B) Volunteer	(J) non-Comp Job < 35 hours/week
(5) Rehab 35+ hours/week	(C) Unemployed, seeking work	(K) Other
(6) Rehab < 20 hours/week	(D) Unemployed, not seeking work	(U) Unknown / Not Reported
(7) Rehab 20-35 hours per week	(E) Retired	

*(15) Living Arrangement: Circle One

(01) Family	(13) House or Apt w/ Supervision	(25) Temporary Assignment
(02) Alone	(14) Supported Housing	(26) Homeless – In transit
(03) Foster Home – Child	(15) Residential Treatment Center	(27) SNF / ICF / IMD for psych
(04) SRO – hotel, motel, rooming house	(16) Comm. Treatment Facility	(28) Medical Facility – Hospital
(05) GP Quarters – dorm, brks, mig camp	(17) Adult Residential / Social Rehab	(29) Correctional Facility – Adult
(06) Group Home	(18) State Hospital	(30) Correctional Facility – Minor
(07) CRTS L/T trn house	(19) VA Hospital	(31) Homeless – no county res
(08) Satellite Housing	(20) SNF / ICF / NH Physical Health	(32) Other Institution
(09)Alt Hospital 6 beds or less	(21) MH Rehab Center	(33) Friend / Other
(10) Alt Hospital 7 beds or more	(22) PHF / Inpatient Psychiatric	(34) Board & Care
(11)House or Apartment	(23) Sober Living	(99) Other
(12) House or Apt w/ Support	(24) Specialty Transitional	(98) Unknown / Not Reported

*Number of Children under age 18 the client cares for/responsible for 50% or more of the time?

*Number of Dependents age 18 or older the client cares for/responsible for 50% or more of the time?

*(16) Education (highest grade completed): | Special Education: ❍Yes ❍No

District of Residence:

*(18) Disability: Circle One

(D) Developmentally Disabled	(H) Hearing	(O) Other Disability (not AOD)	(V) Vision
(E) Mental Health	(M) Mobility	(S) Speech	(N) None

*Veteran: ❍ Yes ❍ No | Branch:

Alias(es)/Maiden Name			
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:
	Last Name:	First:	Middle:

EMERGENCY NOTIFICATION INFORMATION		
	*Name:	*(17) Relationship: See page 4
	Address:	Home Phone:
	City/State/Zip:	Work Phone:
	Employment Place:	
LEGAL INFORMATION		
	*(24) Legal Consent: See page 4	
	**Responsible Person:	**(17) Relationship: See page 4
	Address:	Phone:
	City/State/Zip:	
	Employment Phone:	Employment Place:
	Responsible Party SSN:	

MEDICAL INFORMATION - okay to skip			
	Personal Physician:	Phone:	FAX:
	Address:		
	City/State/Zip:		
	Pharmacy:	Phone:	FAX:
	Hospital Preference:		

ADVANCE DIRECTIVE INFORMATION
Advance Directive Given? ❍ Yes ❍ No

CLIENT CONTACT INFORMATION
May we leave message at home? ❍ Yes ❍ No
May we leave message at work? ❍ Yes ❍ No
May we leave message via emergency contact? ❍ Yes ❍ No
May we leave message on your cell? ❍ Yes ❍ No
May we contact you by mail? ❍ Yes ❍ No
NPP Given? ❍Yes ❍No Form Signed Date:
BHA – Consent Form: ❍Yes ❍No Form Signed Date: Obtained By (Agency Name): _____
If we cannot contact you by mail, then what is an alternative address or method of contact to send you clinical information such as letters and billing information? _____

Signature of Staff Obtaining Information: who filled out the form								
						❍Yes	❍No	❍N/A
*Staff ID	*Staff Name		*Date		*Time			
Signature of Staff Entering Information (If Different from Above):								
						❍Yes	❍No	❍N/A
*Staff ID	Staff Name*		*Date		*Time			
*Key: *=Required Field **=Required if the 'Legal Status' selection is Adult with Guardian or Minor with Guardian*								

(17) Relationship Types

ID	Description
A	Aunt/Uncle
B	Father
C	Child
D	Guardian
E	Spouse
F	Foster Parent
G	Grandparent
H	Cousin
I	Caretaker
J	Sibling
L	Nephew/Niece
M	Mother
N	Friend
O	Other Relation
P	Self
Q	Legal Representative
S	Stepparent
X	Domestic Partner
R	Unknown / Not Reported

(24) Legal Consent
(CSI – Conservatorship/Court Status)

ID	Description
9	Not Applicable
A	Temporary Conservatorship
B	Lanterman–Petris-Short
C	Murphy
D	Probate
E	PC 2974
F	Representative Payee w/out Conservatorship
G	Juvenile Crt0 Dependent of Crt
H	Juvenile Crt, Ward Status Off
I	Juvenile Crt, Ward Juv Off
0	Unknown / Not Reported

KINGS VIEW

PRESCRIPTION DRUGS:

Please list prescriptions taken in last six (6) months (Check here if NONE) ☐

Drug-RX No., Name, Strength	Directions

Have you ever taken someone else's prescription medicine? ☐ No
☐ Yes. If yes, give the name of the drug and reason it was taken
_____.

Have you ever taken any drug that made you sick? ☐ Yes ☐ No.
If yes, explain _____.

Have you ever had side effects or undesirable effects from drugs you have taken? ☐ Yes ☐ No
Specify _____.

NON-PRESCRIPTION DRUGS (Over The Counter):

Fill in the name of the drug(s) taken for following. Check the box which best describes frequency.

Problem	*Name of Drug*	Regular	Seldom	Never	Problem	*Name of Drug*	Regular	Seldom	Never
FOR COLDS & COUGHS					FOR INDIGESTION				
FOR ASTHMA					FOR SLEEP				
FOR CONSTIPATION					FOR SKIN PROBLEMS				
FOR DIARRHEA					FOR DIETING				
FOR HEADACHE/PAIN					FOR STAYING AWAKE				
FOR NERVOUSNESS/TENSION					VITAMINS/SUPPLEMENTS				
OTHER					HERBAL/HOMEOPATHIC				

ALLERGIES:

Are you allergic to:	No	Yes	*If yes, name the specific substance(s) and describe reaction*
ANY DRUG?			
ANY FOOD?			
ANYTHING ELSE?			

HAVE YOU EVER HAD ☐ HAY FEVER ☐ ASTHMA ☐ HIVES ☐ ECZEMA?
DOES ANY MEMBER OF YOUR FAMILY HAVE ALLERGIES? ☐ MOTHER ☐ FATHER ☐ SISTER ☐ BROTHER

DRINKING HABITS:

DO YOU DRINK	No	Yes	Regular	Seldom	HOW MUCH?
COFFEE					
TEA					
COKE/PEPSI					
BEER					
WINE					
LIQUOR					

ARE YOU ON A SPECIAL DIET?

☐ No ☐ Yes IF YES, DESCRIBE

SOCIAL/RECREATIONAL HABITS:

DO YOU, OR HAVE YOU EVER?	No	Yes	IF YES, IDENTIFY SPECIFIC SUBSTANCE, QUANTITY & FREQUENCY
SMOKED CIGARETTES			
Smoked Marijuana			
Taken Hallucinojens: PCP or LSD			
Taken Downers: Sleepers or Valium			
Taken Uppers: Amphetamines, cocaine, meth, crank			
Taken Narcotics: Heroin, Codeine, Oxycodone, Vicodin			
Do you have reactions to any medications?			

Signature of Consumer: _____ *Date* _____
(Parent or Guardian Signature if Consumer is a child or youth)

LAST NAME:	FIRST NAME:	CHART NO.

DRUG AND ALLERGY HISTORY

NOTICE OF PRIVACY PRACTICES

The County creates records of health care to provide quality care and comply with legal requirements. The County understands your health information is personal and private, and commits to safeguarding it to the extent reasonably possible. The law requires the County to keep your health information private and to provide you this notice of our legal duties and privacy practices. The law also requires the County to follow the terms of this notice. This notice outlines the limits on how the County will handle your health information. Under federal law, the County must provide a copy of this notice when you receive health care and related services from the County, or participate in certain health plans administered or operated by the County. The County reserves the right to change practices and make new provisions effective for all health information it maintains. You may request an updated copy of this notice at any time.

Use and Disclosure – General

Generally, except as otherwise specified below, the County may use and disclose the following health information, as allowed by state and federal law:

For treatment

The County uses and discloses health information to provide you health care and related services. For instance:

- Nurses, doctors, or other County employees may record your health information, and they may share such information with other County employees.

- The County may disclose health information to people outside the County involved in your care who provide treatment and related services.

- The County may use and disclose health information to contact you to remind you about appointments for treatment or health care-related services.

For payment

The County may bill you, insurance companies, or third parties. Information on or accompanying these bills may identify you, as well as diagnoses, assessments, procedures performed, and medical supplies used.

For health care operations

The County may use information in your health record to assess the care and outcomes in your case to improve our services, and in administrative processes such as purchasing medical devices, or for auditing financial data.

For health plan administration

As administrator of certain health plans, such as Medicare, Medi-Cal, and Exclusive Care, the County may disclose limited information to plan sponsors. The law only allows using such information for purposes such as plan eligibility and enrollment, benefits administration, and payment of health care expenses. The law specifically prohibits use for employment-related actions or decisions.

Use and Disclosure Requiring Your Authorization

On a limited basis, the County may use and disclose health information only with your permission, as required by state and federal law:

- From mental health records.

- From substance abuse treatment records.

Use and Disclosure Requiring an Opportunity for You to Agree or Object

In certain cases, the County may use and disclose health information only if it informs you in advance and provides an opportunity to agree or object, as required by state and federal law:

- The County may include your name, location in the facility, general condition, and religious affiliation in a facility directory while you are a patient so your family, friends and clergy can visit you and know how you are doing.

- To individuals assisting with your treatment or payment.
- To assist with disaster relief to notify your family about you.

NOTICE OF PRIVACY PRACTICES

If you have comments, questions or would like
additional information regarding this notice
or the privacy practices of

KINGS COUNTY BEHAVIORAL HEALTH,

Please contact:

Dr. Lisa Lewis, PhD, Director
460 Kings County Drive, Suite 101
Hanford, CA 93230
(559) 852-2376

Patients' Rights Advocate Line

1-866-701-5464
www.kcbh.org/patients-rights-advocacy

Use and Disclosure NOT Requiring Permission or an Opportunity for You to Agree or Object

In specific cases, the County may use and disclose the following health information without your permission and without providing you the opportunity to agree or object:

As required by law.

For public health activities, which may include the following:

- Preventing or controlling disease, injury or disability;
- Reporting births and deaths;
- Reporting abuse or neglect of children, elders and dependent adults;
- Reporting reactions to medications or problems with products;
- Notifying people of recalls of products they may use; or,
- Notifying a person exposed to or at risk to contract or spread a disease or condition.

For mandated reporting of abuse, neglect or domestic violence.

For health oversight activities necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

To the minimum extent necessary to comply with judicial and administrative proceedings when compelled by court order, or in response to a subpoena, discovery request or other lawful process as allowed by law.

To law enforcement

- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; or,
- In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description or location of a person who may have committed a crime.

To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.

For organ donation once you are deceased.

For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.

To avert serious threats to the health and safety of you or others.

Regarding military personnel for activities deemed necessary by appropriate military command authorities to assure proper execution of a military mission.

To determine your eligibility for or entitlement to veterans benefits.

To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.

To correctional institutions and other law enforcement custodial situations, inmates of correctional institutions or in custody of a law enforcement official.

To determine your eligibility for or enroll you in government health programs.

For Workers Compensation or similar programs, to the minimum extent necessary.
The County will not disclose your health information for marketing fundraising, or other reasons not listed above without your prior written permission, and you may withdraw that permission in writing at any time. If you do, the County will no longer use or disclose health information about you for the reasons you permitted. You understand the County is unable to retract disclosures already made with your permission, and must retain records of care already provided.

Rights and Responsibilities

With regard to health information, the County recognizes and commits to safeguard your:

Right to request restrictions on certain use and disclosure

You have the right to request restriction or limitation on the health information the County uses or discloses for treatment, payment or health care operations, though the law does not require the County to agree to your request. If the County agrees, it will comply except to provide emergency treatment. Requests must be in writing and state: the information you want to limit; whether to limit use, disclosure, or both; and, to whom limits apply. For instance, you may ask not to disclose to your spouse.

Right to confidential communications

You have the right to ask the County to communicate with you in a certain way, or at a certain location.

Right to inspect and copy records

You have the right to inspect and obtain copies of your health information. Requests must be in writing, and the County may charge you a fee for the costs of fulfilling your request. The County may deny requests to inspect or copy psychotherapy notes, mental health records, or materials for legal proceedings. You may ask for review of a denial by another health care professional chosen by the County. The County will comply with the results of that review.

Right to amend health records

If information the County has about you is incorrect or incomplete, you may ask to amend it. Requests must be in writing, and provide a reason supporting your request. The County may deny your request if it is not in writing, or does not include a reason supporting it. The County may deny requests if the information:

- Was not created by the County;
- Is not health information kept by or for the County;
- Is not information you are permitted to inspect and copy; or,
- Is accurate and complete.

Right to an accounting of certain disclosures

You have the right to ask for a listing of the last six years of disclosures of your health information since April 14, 2003, not pertaining to treatment, payment or health care operations. Requests must be in writing. The first list you request in a twelve-month period is free. The County may charge you the cost of providing or reproducing additional lists. When told the cost, you may withdraw or modify your request.

Right to obtain a paper copy of the notice of privacy practices upon request

Right to file complaints without Fear of retaliation

Under law, the County cannot penalize you for filing a complaint. If you believe the County violated your privacy rights, you may file a complaint with the department privacy officer, County privacy office, or with the U.S. Secretary of Health and Human Services.

Start Date: _____ End Date: _____Client: _____ ID#: _____ DOB: _____

Consent to Treat

Purpose

I would like services for myself or my child from _____(County) and/or its contracted providers. I understand this document contains information about services that may be provided to me or my child. I understand that I have the right to speak with a provider about the information in this document and ask questions in order to understand this information.

My Rights

I acknowledge I was informed of my/my child's rights as a client and that I was offered the consumer rights document, which contains my/my child's rights as a client.

Privacy Practices

I acknowledge I have been offered a copy of _____(County)'s Notice of Privacy Practices, which has information about how my/my child's private health information may be used and disclosed under the law. I understand that in certain circumstances information I share must be disclosed. For example, behavioral health providers are mandated to report if there is a reasonable suspicion of child, elder, or dependent-adult abuse or neglect; if there is a threat to my/my child's physical safety; or if there is a threat to the safety of others.

I understand that if my child is receiving services, in certain cases the provider of those services may not be able to share information with me about those services unless my child permits them to do so.

Services

I understand that the services that may be provided focus on mental health and substance use issues. I am aware my/my child's information and records may be shared between mental health and substance use programs and providers for the purpose of providing treatment, to the extent permitted by law.

Risks and Benefits of Services

I understand behavioral health services may have risks and benefits. I am aware that behavioral health services may involve discussing difficult aspects of my or my child's life and making changes to psychiatric medication I or my child may take and/or substance use treatment. I or my child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I or my child may also experience an increase in the symptoms as I or my child work through issues or as my or my child's medications are being changed and/or added to in the course of treatment.

I am also aware behavioral health services have been shown to have benefits. For example, psychotherapy and/or substance use treatment may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychiatric medication may alleviate symptoms of mental health issues.

I understand there are no certainties about what I or my child will experience as I or my child receive services and how successful services will be. I understand behavioral health services require an investment of time and effort from all involved and openness to what change and success may look like.

Services are Voluntary

I understand participation in behavioral health services is voluntary, except for certain situations where _____(County) is legally required to provide services even if it is involuntary, such as 5150 psychiatric holds or conservatorships.

I understand that even if a court orders me to participate in behavioral health services, I can still choose not to participate in services. I am aware that consequences that may arise due to my decision not to participate in court-ordered services are my responsibility. I understand that I may speak with an attorney, probation officer, and/or Child Welfare Services worker to make the best possible decision regarding participating in court-ordered services.

Eligibility for Services

Eligibility for behavioral health services is determined by a combination of laws, regulations, and local policies. I understand that if an assessment determines that I/my child is no longer eligible for behavioral health services, the reasons will be discussed with me and I will also be provided with a notice of adverse benefit determination (NOABD) that explains these reasons and information on the appeals process. I will then be given referrals to other service providers, as appropriate, that may meet my or my child's needs.

Service Providers

I understand that providers come from different educational and professional backgrounds and have a variety of experience levels and licensure and that providers only provide services that are allowed by law for their specific education, experience, profession, and licensure.

I understand that _____(County) may utilize some unlicensed professionals that are in the process of completing their requirements for clinical licensure but who are authorized by law to provide mental health services under the supervision of a licensed mental health professional. I understand I or my child may receive services from some of these individuals, who will clearly identify themselves, as well as their supervising provider/clinician. I understand I may call the supervising licensed clinician if I have any questions about this arrangement.

Availability of Providers and Crises/Emergencies

I understand providers are generally available during regular county business hours, which are _____, except during county holidays. I understand that some programs have different hours of availability.

For non-urgent matters after-hours, I understand I or my child can leave messages in the provider's confidential voicemail (if they have one available) or with _____(County)'s after-hours telephone service. For urgent or crisis situations, I or my child can contact: _____(County) Crisis Line at: _____.

For emergencies, I understand my family or I should call 911.

Change of Clinician/Provider

I understand I can request a change of mental health provider at any time by completing a Change of Provider form, which is available at all clinics. I understand requesting a change of provider does not guarantee a change, and there may be significant administrative or treatment issues that may not make the change possible. I understand a supervisor or manager will provide me the reason(s) the change is not possible.

Fees and Billing Medi-Cal, Medicare, and/or Insurance

I understand _____(County) will ask me to provide my financial information on annual basis and this information will be used to calculate service fees that I may be responsible for paying. For substance use treatment services for Drug Medi-Cal Beneficiaries, Drug Medi-Cal funding shall be accepted as payment in full.

I understand any private insurance will be billed by _____(County) before billing Medicare and/or Medi-Cal. I understand I may consult with my private insurance, Medicare social worker, and/or Medi-Cal eligibility worker if I have any questions about my or my child's coverage, deductibles, and co-pays.

Additional Documents for Medi-Cal Clients

I understand the Guide to Medi-Cal Mental Health Services handbook and/or the County Beneficiary Handbook for Substance Use Disorder Services contains details about behavioral health benefits for Medi-Cal beneficiaries.

Complaints and Grievances

I understand I may file a complaint or grievance if I am dissatisfied with the services I or my child receives from _____(County) and its contracted providers. I understand I or my child will not be subjected to any penalty for filing a complaint, grievance, or an appeal. I was offered a copy of the Problem Resolution document, which explains how I can file a complaint, grievance, or appeal.

Complaints to the Licensure Board

I understand that the California Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors, marriage and family therapists, licensed educational psychologists, and clinical social workers. I understand that I may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Informed Consent

By signing, I acknowledge that I understand the information contained in this document and I agree to my receipt, or my child's receipt, of behavioral health services in accordance with the terms described above.

Signature: _____ Date: _____

Printed Name: _____

Advance Health Care Directives

What is an Advance Directive?

An Advance Health Care Directive is a legal document that enables people to make their wishes known even when they are incapacitated and unable to communicate. You can use an Advance Directive to spell out your wishes regarding physical and mental health care.

In California, an Advance Directive is made up of two parts: (1) Appointment of an Agent for health care; and (2) Individual Health Care Instructions. Either part is legally binding by itself.

What is a healthcare Agent?

A Healthcare Agent is a person you appoint in your Advance Directive to make health care decisions for you should you lose the ability to make these decisions for yourself. You do not have to appoint an Agent in order to complete an Advance Directive.

What are Individual Health Care Instructions?

Individual Health Care Instructions are verbal or written directions about health care. These can cover both physical and mental health treatment. You can let your health care provider know what you want done and under what circumstances.

What are the benefits from completing an Advance Directive?

Completing an Advance Directive can improve communication between you and your doctor. Completing and filing an Advance Directive is a good way to open a discussion with your health care providers about treatment plans and the full range of choices in treatment.

Completing an Advance Directive creates an opportunity for you to discuss your wishes in detail with family and/or friends. This may help your family and/or your friends advocate more effectively for you if you are ever found to lack the capacity to make health care decisions for yourself.

An Advance Directive can empower you to make your treatment choices known in the event you need health care and are found to be incapable of making health care decisions.

An advance Directive may prevent forced treatment and may reduce the need for long hospital stays.

Who can fill out an Advance Directive?

Any person 18 years or older who has the "capacity" to make health care decisions may fill out an Advance Directive. "Capacity" in this situation means the person understands the nature and consequences of the proposed health care, including the possible risks and benefits, and is able to make and communicate decisions about that health care. Legally a person is assumed to be competent unless proven otherwise.

When does an Advance Directive go into effect?

An Advance Directive goes into effect when your primary physician decides that you lack the capacity to make health care decisions. The fact that you have been admitted to a mental health facility does not, in itself, mean that you lack capacity to make health care decisions.

The Advance Directive is no longer in effect as soon as you regain the capacity to make health care decisions.

Does a health care provider have to follow an Advance Directive?

In general, the law is clear that health care providers must follow your Individual Health Care Instructions, as well as the decisions made on your behalf by a Health Care Agent.

Who can help if an Advance Directive is ignored/not followed?

If a health care provider refuses to follow your Individual Health Care Instructions, or refuses to comply with the decisions of your Agent, contact the County's Patients' Rights Advocate at 1-866-701-5464 and/or Protection & Advocacy, Inc. at 1-800-776-5746. The County Patients' Rights Advocate and PAI can work with you and/or your Agent to make sure that the Advance Directive is followed.

Kings View Counseling Services for Kings County

Hanford Clinic	Avenal Clinic	Corcoran Clinic
1393 Bailey Drive	228 E. Kings St.	1002 Dairy Ave.
Hanford, CA 93230	Avenal, CA 93204	Corcoran, CA 93212
559-582-4481	559-386-2295	559-992-2833

ABOUT YOUR FEE

The amount of money you will be charged for our professional services is based on your ability to pay. We call this amount your yearly deductible, or your UMDAP amount. To figure the amount you will be charged, we use the California Department of Mental Health's schedule called "Uniform Method of Determining Ability to Pay" (UMDAP), which is required by all community mental health centers.

Your YEARLY DEDUCTIBLE (UMDAP) is: $ _____

This means the most you will be charged from _____ to _____ is $ _____.

You may only come for professional services for a short time, but you will be responsible for the charges for any services you receive up to your yearly deductible amount shown above. If your treatment ends before you have used up the deductible, you will only be responsible for the charges for services you received. You can take up to the full UMDAP year to pay your deductible provided you make a payment **every month.**

Based on your income, your MONTHLY PAYMENT will be: $ _____.

You are expected to pay at least this amount every month until your deductible has been paid for the year. If your financial information changes, please notify us. You may call 582-4481 if you have any questions about your bill.

I understand I am expected to pay the amount shown above each month and to notify Kings View if my financial information changes.

_____ _____ _____ _____
Signature of Client Date Agent for Mental Health Date

ABOUT YOUR FREEDOM OF CHOICE

Your acceptance and participation in our Mental Health Service is voluntary and shall not be required for access to other health care services.

In receiving our services, you retain a free choice of providers of other covered services of the Medi-Cal program; you are not limited to service providers of the Short – Doyle system (i.e., you may choose to receive services from any provider of choice, such as a private psychiatrist).

You have the right to request a change of a Mental Health provider, staff person, therapist and/or case manager. I have been informed and acknowledge receipt of a copy of this document, "About Your Freedom of Choice".

I have received a copy of the Confidentiality Statement. ☐ Yes ☐ No

_____ _____ _____ _____
Signature of Client Date Agent for Mental Health Date

KINGS COUNTY
BEHAVIORAL HEALTH

Lisa D. Lewis, PhD
Behavioral Health Director

Health Information Exchange Participation

Kings County Behavioral Health, and its contracted providers participate in health information exchanges (HIEs), including an HIE operated by the California Mental Health Services Authority (CalMHSA). Through HIEs, your health information may be shared with hospitals, behavioral health providers, county health programs, physicians, social workers, and other HIE participants who may provide health or behavioral health services to you. Some types of your health information, such as certain substance use disorder records, will not be shared with HIE participants unless you authorize such disclosures; other types of health information may be shared without your authorization. If you do not want us to share your health information with HIE participants via the CalMHSA HIE, you may "opt-out" of the HIE by contacting CalMHSA at OptOut@calmhsa.org. Opting out will prevent future sharing of your health information via the CalMHSA HIE, but HIE participants may still be able to access information about you from other sources.

Participación en el Intercambio de Información de Salud

Kings County Behavioral Health y sus proveedores de servicios participan en intercambios de información de salud (HIEs por sus siglas en Ingles). Esto incluye un HIE operado por la Autoridad de Servicios de Salud Mental de California (CalMHSA). A través de los HIEs, su información de salud puede ser compartida con hospitales, proveedores de salud conductual, programas de salud del condado, médicos, trabajadores sociales y otros participantes del HIE que puedan proporcionar servicios de salud o salud conductual. Algunos tipos de su información de salud, como ciertos registros de trastornos por uso de sustancias, no serán compartidos con los participantes del HIE a menos que usted lo autorice; otros tipos de información de salud pueden ser compartidos sin su autorización. Si no desea que compartamos su información de salud con los participantes del HIE a través del HIE de CalMHSA, puede "optar por no participar" en el HIE comunicandose a CalMHSA en OptOut@calmhsa.org. Optar por no participar evitará en un futuro el intercambio de su información de salud a través del HIE de CalMHSA, sin embargo los participantes del HIE aún podrán acceder a su información por otras fuentes.

MENTAL HEALTH PATIENTS' RIGHTS

MOSAIC FOREST — Alice Washington, 2004

Mental health patients have the same legal rights guaranteed to everyone by the Constitution and laws of the United States and California.

YOU HAVE THE RIGHT:

- To dignity, privacy and humane care
- To be free from harm including unnecessary or excessive physical restraint, medication, isolation, abuse and neglect
- To receive information about your treatment and to participate in planning your treatment
- To consent or refuse to consent to treatment, unless there is a legally- defined emergency or a legal determination of incapacity
- To client-centered services designed to meet your individual goals, diverse needs, concerns, strengths, motivations and disabilities
- To treatment services which increase your ability to be more independent
- To prompt medical care and treatment
- To services and information in a language you can understand and that is sensitive to cultural diversity and special needs
- To keep and use your own personal possessions including toilet articles
- To have access to individual storage space for your private use
- To keep and spend a reasonable sum of your own money for small purchases
- To have reasonable access to telephones—both to make and to receive confidential calls or have such calls made for you
- To have access to letter-writing material and stamps—to mail and to receive unopened correspondence
- To social interaction, participation in community activities, physical exercise and recreational opportunities
- To see visitors every day
- To wear your own clothes
- To see and receive the services of a patient-advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services
- To religious freedom and practice
- To participate in appropriate programs of publicly supported education
- To be free from hazardous procedures
- And all other rights as provided by law or regulation

FOR MORE INFORMATION, CONTACT YOUR

LOCAL COUNTY PATIENTS' RIGHTS ADVOCATE:

Kings County Patient Rights Advocate
BHPRA@co.kings.ca.us
(559) 852-2423

California Office of Patients' Rights
1831 K Street, Sacramento, CA 95811-4114
(916) 504-5810, http://www.disabilityrightsca.org/

Department of Health Care Services
Mental Health Services Division Ombudsman
(800) 896-4042 or Email: mhombudsman@dhcs.ca.gov

KINGS COUNTY behavioral health

LANGUAGE TAGLINES

English Tagline

ATTENTION: If you need help in your language call 559-852-2444 (TTY: 7-1-1). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 559-852-2444(TTY: 7-1-1). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجتإلى المساعدة بلغتك، فاتصل بـ 559-852-2444 (TTY: 7-1-1). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 559-852-2444 (TTY: 7-1-1). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 559-852-2444 (TTY: 7-1-1): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 559-852-2444 (TTY: 7-1-1): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 559-852-2444 (TTY: 7-1-1)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 559-852-2444 (TTY: 7-1-1)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 559-852-2444 (TTY: 7-1-1)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 559-852-2444 (TTY: 7-1-1)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 559-852-2444 (TTY: 7-1-1) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 559-852-2444 (TTY: 7-1-1) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 559-852-2444 (TTY: 7-1-1) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 559-852-2444 (TTY: 7-1-1) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nge Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 559-852-2444 (TTY: 7-1-1). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 559-852-2444 (TTY: 7-1-1). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は 559-852-2444 (TTY: 7-1-1)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 559-852-2444 (TTY: 7-1-1)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 559-852-2444 (TTY: 7-1-1) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 559-852-2444 (TTY: 7-1-1) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 559-852-2444 (TTY: 7-1-1). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສຳລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ໃຫ້ໂທຫາເບີ 559-852-2444 (TTY: 7-1-1). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 559-852-2444 (TTY: 7-1-1). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 559-852-2444 (TTY: 7-1-1). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 559-852-2444 (TTY: [1-xxx-xxx-xxxx]). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ [1-xxx-xxx-xxxx] (TTY: [1 .
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 559-852-2444 (линия TTY: 7-1-1). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 559-852-2444 (линия TTY: 7-1-1). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al 559-852-2444 (TTY: 7-1-1). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 559-852-2444 (TTY: 7-1-1). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 559-852-2444 (TTY: 7-1-1). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 559-852-2444 (TTY: 7-1-1). Libre ang mga serbisyong ito.

แทกไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต
้องการความชวยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 559-852-2444 (TTY:
7-1-1) นอกจากนี้ ยังพร้อมให้ความชวยเหลือและบริการต่าง
ๆ สาหรับบุคคลที่มีความพิการ เชน่ เอกสารต่าง ๆ
ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์
ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศพท์ไปที่หมายเลข 559-852-2444 (TTY: 7-1-1) ไม่มีค่าใช
้จ่ายสาหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 559-852-2444 (TTY: 7-1-1). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 559-852-2444 (TTY: 7-1-1). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 559-852-2444(TTY: 7-1-1). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 559-852-2444(TTY: 7-1-1). Các dịch vụ này đều miễn phí.

NONDISCRIMINATION NOTICE

Discrimination is against the law. Kings County Behavioral Health follows State and Federal civil rights laws. Kings County Behavioral Health does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Kings County Behavioral Health provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio or accessible electronic formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact *Kings County Behavioral Health* between *Monday-Friday from 8am-5pm* by calling *559-852-2444.* Or, if you cannot hear or speak well, please call *7-1-1*. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

HOW TO FILE A GRIEVANCE

If you believe that *Kings County Behavioral Health* has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with *the Patients Rights Advocate*. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact *Patients Rights Advocate* between *Monday- Friday from 8am-5pm* by calling *559-852-2444.* Or, if you cannot hear or speak well, please call *7-1-1*.
- In writing: Fill out a complaint form or write a letter and send it to:

  460 Kings County Dr. Ste 101. Hanford, Ca 93230

- In person: Visit your doctor's office or *Kings County Behavioral Health* and say you want to file a grievance.
- Electronically: Visit *Kings County Behavioral Health's* website at *KCBH.ORG.*

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California State Relay)**.
- In writing: Fill out a complaint form or send a letter to:

  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at:
  https://www.dhcs.ca.gov/discrimination-grievance-procedures

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex , you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

GRIEVANCE/COMPLAINT PROCESS

Grievance means the expression of dissatisfaction about any matter other than a **Notice of Adverse Benefits Determination (NOABD).** Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights regardless of whether remedial action is requested. All Mental Health Beneficiary's have the right to file a grievance or a complaint about any aspect of their mental health treatment. A beneficiary may file a grievance or complaint *in-person*, *by telephone*, *in writing*, *fax* or *online.* Self-addressed envelopes are also available, addressed to the Patients' Rights Advocate. You may use a representative you authorize (family member, patients' right's advocate, or significant support person) to assist on your behalf.

Standard Resolution of a Grievance: 90 Days

Patients' Right's Advocate

460 Kings County Drive suite 101, Hanford, CA. 93230.

Office: 1-559-852-2423 Fax: 1-559-584-6037

Website: http://www.kcbh.org/patients-rights-advocacy.html (temp loc)

For assistance with your grievance, you may contact the Patient Right's Advocate at

1-866 -701-5464

APPEAL PROCESS

All mental health consumers have the right to file an appeal after receiving a **Notice of Adverse Benefit Determination (NOABD)**, which states you do not qualify for Specialty Mental Health Services. NOABD also includes when previously approved services are reduce or terminated. An appeal can be requested verbally; however, a written appeal form must be completed and returned to the Patients' Right's Advocate. Appeal forms are available in the waiting room of the clinic. Self-addressed envelopes are also available, addresses to the Quality Assurance Clinician.

Standard Resolution of Appeal: 30 days.

EXPEDITED APPEAL

These apply in instances where a provider indicates or the MHP determines that the standard timeframe for appeals may seriously jeopardize the beneficiary's life or health or ability to sustain, maintain, or regain maximum functioning. An expedited appeal may be requested verbally without a need for written request,

In these instances, you have the same rights as the standard appeal process. For question, call the Quality Assurance Clinician at 1(559) 852-2297.

Standard Resolution of Expedited Appeals: if approved, 72 hours. Filing an Appeal, contact:

Quality Assurance Clinician

In-Person or by mail:

460 Kings County Drive Suite 101, Hanford, CA. 93230.

Phone: 1-559-852-2297

STATE FAIR HEARING

If you are dissatisfied with the outcome of an appeal, you have the option of requesting a State Fair Hearing. To do so contact the State Haring Division, State Department of Social Services; 744 P Street, Mail Station 19-37; Sacramento, CA 95814; 1(800)-952-5253 or 1(800) 952-8349 TDD/TDY

You have 120 days after the postmark date of a decision denying your Appeal to request a State Fair Hearing.

Please note you must exhaust the County's Grievance/Complaint Process prior to filing for a State Hearing.

Grievance, Appeal, and Expedited forms are available in the waiting room of each mental health clinic or online. Self-addressed envelopes are also available.

Burns Depression Checklist *

(Revised)

Instructions: Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.

	0—Not at All	1—Somewhat	2--Moderately	3—A Lot	4—Extremely
Thoughts and Feelings					
1. Feeling sad or down in the dumps					
2. Feeling unhappy or blue					
3. Crying spells or tearfulness					
4. Feeling discouraged					
5. Feeling hopeless					
6. Low self-esteem					
7. Feeling worthless or inadequate					
8. Guilt or shame					
9. Criticizing yourself or blaming yourself					
10. Difficulty making decisions					
Activities and Personal Relationships					
11. Loss of interest in family, friends, or colleagues					
12. Loneliness					
13. Spending less time with family or friends					
14. Loss of motivation					
15. Loss of interests in work or other activities					
16. Avoiding work or other activities					
17. Loss of pleasure or satisfaction in life					
Physical Symptoms					
18. Feeling Tired					
19. Difficulty sleeping or sleeping too much					
20. Decreased or increased appetite					
21. Loss of interest in sex					
22. Worrying about your health					
Suicidal Urges					
23. Do you have any suicidal thoughts?					
24. Would you like to end your life?					
25. Do you have a plan for harming yourself?					
Please Total Your Score on Items 1 to 25 here →					

Burns Anxiety Checklist *

(Revised)

Instructions: Put a check to indicate how much you have Experienced each symptom during the past week, including today. Please answer all 25 items.

	0—Not at All	1—Somewhat	2--Moderately	3—A Lot	4—Extremely
Anxious Thoughts and Feelings					
1. Feeling anxious					
2. Feeling nervous					
3. Feeling frightened					
4. Feeling scared					
5. Worrying about things					
6. Feeling that you can't stop worrying					
7. Feeling tense, agitated, or on edge					
8. Feeling stressed					
9. Feeling uptight					
10. Thoughts that something frightening will happen					
11. Feeling alarmed or in danger					
12. Feeling insecure					
Anxious Physical Symptoms					
13. Feeling dizzy, lightheaded, or off balance					
14. Rubbery or "jelly" legs					
15. Feeling like you are choking					
16. A lump in the throat					
17. Feeling short of breath or difficulty breathing					
18. Skipping, racing, or pounding of the heart					
19. Pain or tightness in the chest					
20. Restlessness or jumpiness					
21. Tight, tense muscles					
22. Trembling or shaking					
23. Numbness or tingling					
24. Butterflies or discomfort in the stomach					
25. Sweating or hot flashes					
Please Total Your Score on Items 1 to 25 here →					

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it ***happened to you*** personally, (b) you ***witnessed it*** happen to someone else, (c) you ***learned about it*** happening to someone close to you, (d) you're ***not sure*** if it fits, or (e) it ***doesn't apply*** to you.

Be sure to consider your ***entire life*** (growing up as well as adulthood) as you go through the list of events.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Not Sure*	*Doesn't apply*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

KINGS VIEW

Treatment Agreement

OUR GOALS:

- To provide quality mental health services to people who live in Kings County
- To teach you new skills for a healthy life.

TREATMENT: Kings View provides many mental health services. Our main services are skills groups or therapy groups. First you will have an in-depth interview with a therapist. Then we will connect you to the service(s) that will help you to make changes. If we are unable to serve you, then we will refer you to the right provider.

OFFICE HOURS: Our main office, at 1393 Bailey Drive in Hanford, is open from 8:00 AM until 5:00 PM. If you need to talk with your provider, you may call (559) 582-4481 during business hours. If you have a mental health crisis, please call our after-hours line, (559) 582-4484 or 1-800-655-2553 and talk with a crisis worker. The after-hours line is only for a mental health crisis. The crisis worker is unable to look up or reschedule an appointment, so please call during business hours for that kind of information. If you have a life-threatening emergency, please call 911.

TREATMENT PARTICIPATION: It may help you to meet your goals when the important people in your life participate. You decide who will be involved. You and your provider agree on goals to work on for change to happen. It is very important that you commit to your treatment by doing the following:

1. **Attend all appointments on time.** Appointments may be canceled by telling your therapist, doctor, or case manager at least 24 hours before the scheduled session. Remember that poor attendance and tardiness will keep you from meeting your goals. Missing appointments again and again will result in closing your case.

2. **Work together on treatment goals.** Full participation in your treatment is very important. “Full participation” means being on time for each session, finishing homework, and working with your therapist, doctor, or case manager to meet your goals.

3. **Keep a current financial account.** You are responsible for making the payments you agreed to when we opened your case. Accounts that are “overdue” may stop you from getting the treatment you need. If your income or financial health changes, please let your provider know as soon as possible. If you are having a hard time keeping up with payments, you may ask for a “financial adjustment.”

4. **Expect Kings View Counseling Services for Kings County to:**
    - Treat you with respect and dignity.
    - Protect your privacy. But remember that everyone who works at Kings View are “mandated reporters.” That means we must tell someone if we believe a child or elderly person or an adult who has special needs is being harmed. We may have to tell others about you in crisis or emergency situations, to keep you safe. We may have to tell others about you if you make a dangerous threat, to keep others safe.
    - Provide you with mental health services or referrals that will help you reach your goals.
    - Assign a therapist, doctor, or case manager to help you reach your goals.

KINGS VIEW

Treatment Agreement Acknowledgment

I, _____, am committed to my / my child's treatment.

My signature below signifies that I accept and agree with the conditions of the Treatment Agreement and verifies that I have received a copy of the Treatment Agreement.

Client Signature: _____ Date: _____

Parent /
Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Last Name	Client First Name	Case Number

KINGS COUNTY
BEHAVIORAL HEALTH

Lisa D. Lewis, PhD
Behavioral Health Director

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, and professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

AVISO DE QUEJAS

La Junta de Ciencias del Comportamiento (BBS por sus siglas en Inglés) recibe y responde a las quejas sobre los servicios prestados dentro del alcance de la práctica de (terapeutas matrimoniales y familiares, psicólogos educativos con licencia, trabajadores sociales clínicos y consejeros clínicos profesionales). Usted puede comunicarse con la junta en línea en www.bbs.ca.gov o llamando al (916) 574-7830.

My information/ Mi información:

_ _____ _____

*(Provider name, Title) (License or Registration #)/ (***Nombre del proveedor, título**) (**Licencia o número de registro)**

Clinical Supervisor (if applicable)/ Supervisor clínico (si aplica):

_ _____

*(Name, Title) (License #) (**Nombre, título) (Número de licencia**)*

For more information on how to file a Medi-Cal grievance, contact Kings County Patient's Rights Advocate at (559)852-2424.

Para obtener más información sobre cómo presentar una queja de Medi-Cal, comuníquese con el Condado de Kings Defensor de los Derechos de los Pacientes al (559)852-2424.

By signing below, I acknowledge reciept of this information. Al firmar a continuación, reconozco haber recibido esta información.

Signature/
Firma_____Date/Fetcha_____

KINGS COUNTY
BEHAVIORAL HEALTH

Lisa D. Lewis, PhD
Behavioral Health Director

NOTICE TO CLIENTS

The _ _____ of the _ _____
(Name of office or unit) *(Name of agency)*
receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at Kings County Behavioral Health.
To file a complaint, contact
__ _____.
(Telephone number, email address, internet website, or mailing address of agency)

AVISO DE QUEJAS

El/ La _ _____ del/ de la __ _____
(Nombre de oficina o unidad) ***(Nombre de la agencia)***

recibe y responde a las quejas sobre la práctica de psicoterapia de cualquier interno o consejero no registrado proveyendo servicios al departamento de Salud Mental de Kings. Para presentar una queja, puede comunicarse
_ _____.
(Número telefónico, correo electrónico, domicilio, sitio de internet , o dirección postal de la agencia)

My information/ Mi información:
_____
(Provider name, Title) / **Nombre del proveedor, título**

Clinical Supervisor/ **Supervisor clínico:**
_____ _____
*(Name, Title) (License #) / **Nombre, título, número de licencia***

For more information on how to file a Medi-Cal grievance, contact Kings County Patient's Rights Advocate at (559) 852-2424.
Para obtener más información sobre como presentar una queja de Medi-Cal, puede comunicarse con el Defensor de los Derechos del Paciente del condado de Kings al (559)852-2424.

By signing below, I acknowledge reciept of this information. Al firmar a continuación, reconozco haber recibido esta información.

Signature/
Firma_____Date/Fetcha_____

KINGS VIEW

Process, Benefits, and Risks of Psychotherapy

Participating in psychotherapy can result in a number of benefits, including a reduction in feelings of distress and problematic behaviors, greater personal awareness and insight, increased skills for managing stress, and resolution of specific problems. However, sharing personal history or ongoing life challenges may at times create discomfort and may even lead to increased anxiety and depression for a period of time before symptoms improve.

By signing below, I am acknowledging that I have been informed about the process, benefits, and risks of psychotherapy provided by Kings View Behavioral Health Systems, Kings County.

_____ _____

Consumer signature Date

KINGS VIEW
Kings View - Kings County
1393 Bailey Drive • Hanford, CA 93230 • 559) 582-4481 • Fax (559) 582-6547

Internal Use
☐ File
☐ Request
☐ Send

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. CLIENT INFORMATION

First Name	Middle Initial	Last Name	Birth Date (mm-dd-yyyy)	Medical Record #

2. FROM / TO INFORMATION

I authorize Kings View to:
☐ Disclose to and ☐ exchange my protected health information with:
☐ Request from and ☐ exchange my protected health information with:
☐ Use my protected health information:

Name & Job Title	Name of Agency / Entity			
Street Address / PO Box	City	State	Zip	Telephone (optional)
Name & Job Title	Name of Agency / Entity			
Street Address / PO Box	City	State	Zip	Telephone (optional)

3. INFORMATION TO BE DISCLOSED / REQUESTED / USED

☑ Check all that apply

☐ **Behavioral Health / Recovery Services** Client Initials _____

☐ All my program records (justify) _____	☐ Medical / Physical Health Information
☐ Appointment Information	☐ Treatment Plan / Treatment Team Progress Notes
☐ Attendance / Compliance / Program Status	☐ Transfer / Discharge Summary
☐ Financial / Billing / Insurance	☐ School Records
☐ Screening / Assessment / Diagnosis	☐ Probation / Court / DSS Reports
☐ Medical: Orders / Progress Notes / Medications / Lab Reports / Physical	☐ Hospitalization Records
	☐ Personal Information / Photo
☐ Referrals / Linkage / Care Coordination	☐ Other _____ _____

Time Period: ☐ NA ☐ Last 12 months Dates: From: _____ To: _____

NOTE: Records may include substance use disorder information and HIV test results. These records **WILL NOT** be disclosed unless specifically requested below.

☐ **Substance Use Disorder Records** Client initials _____	☐ **HIV Test Results** Client initials _____

4. PURPOSE

☐ Client / Legal Representative Request ☐ Treatment ☐ Other _____

5. DELIVERY OF PHI

☐ Pick Up ☐ Mail ☐ Fax ☐ Verbal ☐ Secure Email ☐ Electronic/CD/USB ☐ Other _____

6. EXPIRATION

If not revoked earlier, this authorization expires one (1) year from the date of signature OR other date or event (specify) _____

7. ADVISEMENTS

- I may inspect and/or obtain a copy of the information being disclosed or used.
- My signing this form is voluntary – my refusal to sign it will not generally affect services I receive from Kings View.
- A photocopy of this form is as valid as the original.
- I am entitled to a copy of this form.
- I understand the minimum necessary will be disclosed or used for my SUD information.
- I may revoke this authorization for any reason at any time, either verbally or in writing, by notifying Medical Records at the Kings View program processing this authorization. My revocation takes effect upon receipt by Kings View except to the extent others have already acted in reliance upon this authorization.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law.

8. CLIENT OR LEGAL REPRESENTATIVE SIGNATURE

By signing below, I acknowledge I have reviewed and fully understand and agree to this authorization form.	
➢ Signature Client or Legal Representative	Date (mm-dd-yyyy)
Printed Name If Legal Representative	Relationship To Client

9. FORM COMPLETED BY First & Last Name: _____

10. REVOCATION

➢ Signature of Client / Legal Representative Revoking This Authorization	Effective Date (mm-dd-yyyy)
➢ Signature of Employee Revoking Authorization At Client's Request	Date Requested (mm-dd-yyyy)

Kings County Behavioral Health

Mental Health Provider Directory

July 2024

As a Kings County Medi-Cal beneficiary, if you think you or a family member needs Mental Health services, call the Access Line at 1-800-655-2553 (toll-free). Note that all the below Providers can accommodate persons with physical disabilities and serve Kings County Medi-Cal beneficiaries. Services may be delivered by an individual provider, or a team of providers, who is working under the direction of licensed practitioners operating within their scope of practice. Only licensed, waivered, or registered mental health providers are listed on the Plan's Provider Directory.

If you require this document in an alternate format (example: Braille, Large Print, Audiotape, CD-ROM), you may request an alternate format, at no cost to the beneficiary, by calling the Access Line at 1-800-655-2553 (toll-free).

Provider Site	Service Type	Populations Served	Cultural Capacity	Non-English Language(s)	Hours of Operations	Disability Access
Kings View Counseling Services 1393 Bailey Dr Hanford, California 93230 http://www.kingsview.org (559-582-4481)	Outpatient Psychiatry, Therapy, and Rehabilitation Services in Individual, Family, and Group Modes	Adults	Multicultural Staff	Spanish	Mon-Fri 8 a.m. to 5 p.m.	Yes
Is provider accepting new clients: Yes						

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Ahmed	Zaheer	Psychiatrist	C 127721	1134330368	No	English	Psychiatry
Aldave	Briana	Licensed Professional Clinical Counselor	LPCC 15098	1174292270	Yes	English, Spanish	Quality Assurance
Areias	Cassondra	Licensed Marriage and Family Therapist	LMFT 106721	1841683729	Yes	English	Clinical Supervisor- Adult Services
Baker	Kimberly	Associate Clinical Social Worker	ASW 105792	1124788377	Yes	English	Clinician- Access & Crisis
Cardenas	Maria Veronica	Associate Marriage and Family Therapist	LMFT 145846	1922337658	Yes	English, Spanish	Clinician- Adult
Carrico	Tracy	Licensed Marriage and Family Therapist	LMFT 42980	1760608889	Yes	English	Clinician- After Hours Crisis
Contreras	Analieze	Associate Clinical Social Worker	ASW 118661	1326757501	Yes	English, Spanish	Clinician- Crisis

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Gacad	Leslie	Nurse Practitioner	95023818	1487350682	Yes	English	Psychiatry
Garivay	Denivie	Associate Marriage and Family Therapist	AMFT 133462	1962075861	Yes	English	Clinician- Adult
Gascon	Natalia	Associate Clinical Social Worker	ASW 109358	1801518089	Yes	English	Clinician- Adult
Gonzalez	Sandra	Licensed Marriage and Family Therapist	LMFT 104755	1962829879	Yes	English, Spanish	Clinician Supervisor- Adult Services
Grant-Miller	Sheila	Associate Clinical Social Worker	ASW 115649	1992244743	Yes	English	Clinician- Crisis Per Diem
Hall	Stefani	Licensed Psychiatric Technician	LPT 34655	1548751753	Yes	English	Nursing Services – Case Manager
Hipp-Renteria	Amanda	Licensed Marriage and Family Therapist	LMFT 130916	1093279549	Yes	English	Clinician- Per Diem Crisis

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Krumdick	Kameron	Associate Marriage and Family Therapist	AMFT 145402	1730878570	No	English	Clinician -Adult
Langley	Michael	Associate Professional Clinical Counselor	APCC 13990	1487346433	No	English	Clinician- Crisis
Licon	Anna	Licensed Psychiatric Technician	LPT 36367	1811244528	Yes	English, Spanish	Supervisor- Nursing
Lynn	Nora	Licensed Marriage and Family Therapist	LMFT 49807	1265616320	Yes	English	Assistant Regional Director
Mejia	Natalie	Associate Marriage and Family Therapist	AMFT 125890	1326506965	Yes	English, Spanish	Clinician- Adult
Miller	Janice	Licensed Marriage and Family Therapist	LMFT 125158	1699299891	Yes	English, Spanish	Clinician- Adult
Munguia	Isabel	Associate Marriage and Family Therapist	AMFT 125602	1972047439	Yes	English, Spanish	Clinician- Adult

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Onsurez	Susan	Associate Professional Clinical Counselor	APCC 13096	1730863341	Yes	English	Clinician-Adult
Orosco-Avalos	Ivett	Associate Marriage and Family Therapist	AMFT 138522	1568014074	Yes	English, Spanish	Intake Clinician-Access
Randell	Jessica	Doctor of Osteopathy	20A15435	1285020594	No	English	Psychiatry
Raya	Ramiro	Associate Marriage and Family Therapist	AMFT 11215	1912039959	Yes	English, Spanish	Clinician – Juvenile Probation
Reis	Selena	Licensed Psychiatric Technician	LPT 33084	1962128637	Yes	English	Nursing Services
Rogers	Lisa	Licensed Marriage and Family Therapist	LMFT 99767	1467794206	Yes	English	Regional Director
Rolfsema	David	Licensed Clinical Social Worker	LCSW 16614	1013136175	Yes	English	Clinician Access & Crisis - Per Diem

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Schenley	Agnes	Licensed Marriage and Family Therapist	LMFT 41233	1760513766	Yes	English	Clinician- After Hours Crisis
Shahbazian	Randy	Psychiatrist	A 85058	1629253836	No	English	Psychiatry
Smith	Anisha	Doctor of Osteopathy	20A9398	1245351568	Yes	English	Psychiatry
Smith	Marie Janelle	Licensed Psychiatric Technician	LPT 37637	1619593498	Yes	English, Spanish	Nursing Services
Taylor	Thomas	Licensed Clinical Social Worker	LCSW 17355	1891910527	Yes	English	Clinician- Adult
Truta	Mircea	Psychiatrist	A75064	1033230537	No	English	Psychiatry
Valero	Marissa	Licensed Marriage and Family Therapist	LMFT 106108	1194069799	Yes	English, Spanish	Clinician- Per Diem Crisis

Provider Last Name	Provider First Name	Licensure	License Number	National Provider Identification Number	Completed Cultural Competency	Language Capacity	Specialty
Vazquez	Bethany	Associate Clinical Social Worker	ASW 113374	1285393199	Yes	English	Clinician - Crisis
Vidad	Noelika	Licensed Psychiatric Technician	LPT 40813	1821847369	Yes	English	Nursing Services
Wallace	Lilly	Associate Clinical Social Worker	ASW 279278	1164201711	Yes	English	Clinician- Access
Zepeda	Lisa	Licensed Marriage and Family Therapist	LMFT 92541	1104121854	Yes	English	Program Manager- Adult Services

NOTICE TO PATIENTS

OPEN PAYMENTS DATABASE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospital be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I acknowledge that I have received a written notice of the Open Payments Database.

_____ _____

Consumer Signature Date

Chart number: _____

Kings View will not discriminate in the provision of health care services to an individual:

- Because the individual is unable to pay for the health care services;
- Because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); or
- Based upon the individual's race, color, sex, age, national origin, disability, religion, gender identity or sexual orientation.

Notice to patients

This practice serves all patients regardless of ability to pay. Discounts/sliding fee schedule for essential services are offered based on family size and income. For more information, ask at the front desk or visit our website. Thank you.

Aviso Para Pacientes

Este establecimiento de salud atiende a todos los pacientes independientemente de su capacidad de pago. Se ofrecen descuentos/escala móvil de honorarios para servicios esenciales según el tamaño de la familia y los ingresos. Para obtener más información, pregunte en la recepción o visite nuestro sitio web. Gracias.