SCOTT COUNTY HEALTH and HUMAN SERVICES DIVISION

GOVERNMENT CENTER WEST * 200 FOURTH AVENUE WEST * SHAKOPEE, MN 55379-1220

*(952) 445-7751 *Fax: (952) 444-9802 * https://www.scottcountymn.gov/ *

PAM SELVIG
Director

Dear Applicant,

You have received this letter to further process your request for chemical dependency assistance from Scott County Health and Human Services. Please provide the information requested in this letter so that we can determine the level of services you are eligible for. **Follow the check boxes to make sure you have provided all information.**

First, you will need to:

- ☐ **Complete fully and sign the Behavioral Health Fund Application**
- ☐ **Provide a copy of your insurance card if you have one**

Additionally, you will be required to provide the following documentation:

INCOME: *(SKIP THIS SECTION IF YOU ARE UNEMPLOYED)*

☐ Copies of your employment check stubs for one month **OR** have your employer complete and sign the Employment Verification Form to be sent directly to the address at the bottom of the page.

☐ Copies of your spouse's employment check stubs for one month **OR** have the employer complete the Employment Verification Form to be sent directly to the address at the bottom of the page.

☐ Statements from any additional income/benefits received: Social Security, UnemploymenW*HHUDO$VVLVWDFHLHDVK HHILWVKLOGVXSSRUW3HVLRV$XLWLHV$OLPR5HWLUHPHW5HW(WF

☐ Self Employment Only S ubmit quarterly tax statement or an income summary statement

☐ 3URYLGHSURRIRIFRXUWRUGHUHGSDLGFKLOGVXSSRUWDOLPR

PROOF OF RESIDENCY: *(Complete of the following)*

☐ Complete Authorization for Release of Information about Residency/Shelter Expense Form (on page 4). **Completed AND Signed.** This is needed for Scott County to verify your housing arrangement.

☐ Copies of **current** utility bill with your name and address on it

☐ Proof of current housing payment/lot rents with your name and address on it

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NOTE: Read your Rights and Responsibilities enclosed in the back of the packet. If you or the responsible relative, or policyholder does not comply with the provisions of the application process, you will be deemed to be ineligible for chemical dependency treatment funds. False reporting of information can leave you or the responsible relative to pay for the full cost of chemical dependency treatment services provided to you.

Mailing/Email information for the Chemical Dependency Unit:
CD UNIT
GOVERNMENT CENTER WEST
200 FOURTH AVENUE WEST
SHAKOPEE, MN 55379-1220

Email: scottcountycd@co.scott.mn.us Fax: 952-444-8358

If you have any questions regarding this application process, please call (952) 496-8358.

Scott County Behavioral Health Fund

(Must be completed in full in order for Scott County to process your application)

NAME (Last, First, Mi)	**DATE OF BIRTH:**	**SOCIAL SECURITY NUMBER:**	**GENDER** ☐Female ☐ Male
PHONE:	**MARITAL STATUS:** ☐Single ☐Married ☐ Separated ☐Divorced ☐Widowed		
ADDRESS:	**CITY**	**STATE**	**ZIP CODE**
EMAIL:			
How would you like to contacted regarding the Behavioral Health Fund? ☐ Phone Call ☐Mail ☐ Email			
RACE: ☐ Asian ☐Black or African American ☐Hispanic Heritage ☐ Pacific Island/Native Hawaiian ☐ Caucasian ☐ American Indian/Alaska Native – Tribe:_____			
Are you a Scott County Resident: ☐Yes ☐No **Current living situation:** ☐ Own ☐ Rent ☐Other – describe:			
What is your preferred spoken language? _____ **Do you need an interpreter? ☐Yes ☐No** **What is your preferred written language?**_____			

Do you currently have insurance? ☐ Yes ☐No *For assistance to apply call (952)496-8686 or go to www.mnsure.org*

If you have any public medical assistance/prepaid health insurance plans *(for example:U-Care, Health Partners, Blue Plus, Medica, Hennepin Health)* **you are not eligible** for the Behavioral Health Fund. Please contact the number on the back of your insurance card for covered providers

Check if you have any of the following insurance types:

☐ Private/Commercial ☐ Medicare ☐ Minnesota Care ***(Attach copies of insurance card front and back)***

Household Size: ***Adult Applicants (older than 18)***

Who do you live with? ***Do not include unmarried partners or their children unless legally adopted***

Spouse: ☐Yes ☐No

If yes, list spouses name:_____.

Children(under the age of 18): ☐Yes ☐No

If yes, how many children in the house under 18 years old _____.

Household Size: ***Minor Applicants (under the age of 18)***

(If the applicant is under 18, list parents and siblings under 18 years old)

Applicant under 18 years old: ☐Yes ☐No

Parent(s)Name:_____. Phone Number:_____.

Parent(s)Name:_____. Phone Number:_____.

Children(under the age of 18): ☐Yes ☐ No

If yes, how many children in the house under 18 years old _____.

*****Applicants 18 and older → Complete the income information below with your income and your spouse's only*****
*****Applicants Ages 14 to 18 → Complete the income information below with your Parent's income and your income, if you are receiving any****

Kind of income: (proof/statements are required for all received/paid income)	**Person(s) receiving**	**Monthly Gross Amount Received**
Wage or Salary: Person 1 *(Applicant)*		
Wage or Salary: Person 2 (*Spouse)*		
General Assistance (ie. Cash Benefits)		
Workers' Compensation		
Unemployment Benefits		
Social Security Income		
Veteran Benefits (VA) (do not include if receiving disabled veteran benefits)		
Retirement Benefits		
Pensions and Annuities		

Child Support Received		
Alimony Received		
Net Self-employment income		
Net Farm income		
Other income such as: Dividends/interest, rental income, royalties, etc.		
Paid:	**(-)**	**Court Ordered Paid Monthly**
Court Ordered PAID Child Support (proof required)		
Court Ordered PAID Alimony (proof required)		
		Total:

By checking the box(es) and providing us with the contact information above, you are authorizing us to contact you with private information via any of the ways you have authorized.

APPLICANT SIGNATURE (explain if unable to sign)	Date:
APPLICANT'S AUTHORIZED REPRESENTATIVE (if applicable)	Date:
AGENCY REPRESENTATIVE	Date:

SCOTT COUNTY COMMUNITY SERVICES DIVISION

HUMAN SERVICES · GOVERNMENT CENTER WEST
200 FOURTH AVENUE WEST · SHAKOPEE, MN 55379-1220
(952)445-7751 · Fax (952)444-9802 · http://www.co.scott.mn.us

EMPLOYMENT VERIFICATION FORM

Employer Name/Address/Phone/FAX:

_____

_____

_____

Phone_____FAX_____

Date:_____

Worker:_____

Case Number:_____

Employee Name:_____

Social Security Number:_____

I hereby grant permission to the above employer to complete the information requested below. Please return to Scott County Human Services within 10 days. Thank you for your cooperation.

_____ _____

(Client Signature) ***(Date)***

EMPLOYER COMPLETE THE FOLLOWING:

Pay periods: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Twice/month

Days worked per week:_____Hours per day:_____Hourly rate: $_____

Health insurance available? Y / N Dental insurance? Y / N Approx. start date: _____

Individual cost to employee for health insurance: $_____ Dental: $_____

Family cost to employee for health insurance: $_____ Dental: $_____

Start date:_____/_____/_____ Date of first paycheck:_____/_____/_____

Gross pay: $_____ YTD total: $_____ Hours on check: _____

Termination/Leave Date:_____/_____/_____ Date of last paycheck:_____/_____/_____

Reason for termination/leave:_____

Gross pay: $_____ YTD total: $_____ Hours on check: _____

Last date of health/dental insurance coverage:_____/_____/_____COBRA? Y / N Cost? $_____

Please list all pay dates, along with gross pay/hours for the following months:_____

Pay Date	Gross Pay	Hours	Pay Date	Gross Pay	Hours	Pay Date	Gross Pay	Hours
/ /	$		/ /	$		/ /	$	
/ /	$		/ /	$		/ /	$	
/ /	$		/ /	$		/ /	$	
/ /	$		/ /	$		/ /	$	

_____ _____

(Employer's Signature) *(Date)*

_____ _____

(Title) *(Phone Number)*

CD#003 9-07-2007

Authorization for Release of Information about Residence and Shelter Expenses

To be returned to Scott County: Fax 952-444-9802

Date:

To: *Please list a person who can confirm your residence*

Name of Landlord/ Owner/ Friend/ Family member:		
Phone Number of Landlord/Owner/Friend/Family:		
Applicant's Address: :	State:	Zip Code:
City:	Email Address:	

This form is a signed authorization to release information to the human services agency shown below. Thank you for you cooperation.

Scott County Human Services
Government Center West
200 Fourth Avenue West
Shakopee, MN 55379-1220

Authorization for Release of Information

Giving Permission: I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.
Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent.
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it.
- I may stop authorization with a written notice at any time, but this written notice will not affect the information the agency already has requested.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed onto others by Scott County, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it, unless the law allows for a longer period.

Client Signature	Date
Signature of spouse/guardian/authorized representative	Date

SCOTT COUNTY HEALTH AND HUMAN SERVICES DIVISION

GOVERNMENTCENTERWEST•200 FOURTHAVENUEWEST•SHAKOPEE, MN 55379-1220

(952) 445-7751 • FAX (952) 444-9802 • WWW.SCOTTCOUNTYMN.GOV

ACKNOWLEDGEMENT OF RECEIPT OF:
HIPAA PRIVACY NOTICE, TENNESSEN WARNING AND YOUR APPEAL RIGHTS

You may refuse to sign this acknowledgement

I have received a copy of the following documents:

Initial

_____ Health and Human Services HIPAA Privacy Notice (HIPAA 001)

_____ Notice of Privacy Practices – Tennessen (DHS 3979)

_____ Your Appeal Rights (DHS 1941)

I understand the content of the forms presented or have been given information where to go for help reading the forms and having my questions answered.

_____

(Please print your name)

_____ _____

(Signature) (Date)

**********Agency use below line**********

I have given the above named person(s) the forms listed.

OR

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Appeal Rights but acknowledgement could not be obtained for the following reasons:

_____Individual refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented obtaining acknowledgement
_____other (please specify)_____

_____ _____

(HHS Employee Signature) (Date)

Gen 0032
7/20/16

SCOTT COUNTY HEALTH AND HUMAN SERVICES
CLIENT CONSENT TO RELEASE INFORMATION

I voluntarily give my permission to the following people or agencies to disclose information, including health information, about me and/or my children. I understand that information about me is private. It cannot be shared with anyone without my permission unless the law says it can.

From/To	From/To
Rule 31	Scott County Health and Human Services
Licensed Chemical Dependency	Government Center West
Treatment Center	200 Fourth Avenue West
	Shakopee, MN 55379-1220

The information is regarding the following people:

Name	Birthdate
Name	Birthdate
Name	Birthdate
Name	Birthdate

The type of information to be used or disclosed Documents and written (including written, verbal, fax and e-mail communication) is as follows: (Be as specific as possible about data to be released)
Chemical dependency assessment, Treatment updates, Progress reports, Discharge Summary and Aftercare Summary

This protected information is being used or disclosed for the following purposes: (Be as specific as possible.) To complete assessment and arrange services, case management, funding purposes

- I understand that I may refuse to give my permission to share this information. If I refuse, Imay not receive the service I am requesting.
- I understand that I may cancel this authorization at any time before the information is given out. I must cancel in writing. The written notice should be sent to: Scott County Chemical Dependency Unit
  (staff name)
- I understand that once the above information is disclosed, it may be re-disclosed by the person receiving the information and federal privacy regulations may not protect the information.

This authorization will expire one year after the date I signed it or:

(Name the date or event on which this authorization expires.)

Signature of client or legal representative	Date
Signature of client or legal representative	Date

If signed by legal representative, relationship toclient

Notice to other parties: Minnesota State Statute 13.04 allows our clients to see private information kept in their files. If the client wants to see the information you are sending us, we must allow them to do so.

Distribution of copies: Copy to accompany use or disclosure; copy to client; original to file

HIPAA #038-GC
Rev. 05/22/12

(Tear off here)

Your responsibilities

NOTE: If you sign this application as an *Authorized Representative* of a person who is requesting or receiving assistance, you are agreeing to assume all of the following responsibilities on behalf of that person.

- **You must report changes which may affect your services to the county agency** after the change has occurred.

  Applicants - Report these changes to your worker when the change happens.

  This includes the following for everyone in your household:

  - **Household** - When a person dies, moves in or out of your home, or temporarily leaves; pregnancy; birth of a child
  - **Income** - Receipt or change in child support, Social Security, Veterans Benefits, Unemployment Insurance, inheritance, insurance benefits and other payments
  - **Employment** - Start or stop a job or business; change in hours, earnings or expenses
  - **Property** - Purchase, sale or transfer of a house, car or other items of value
  - **Address**
  - **Housing costs/rent subsidy**
  - **Filing a lawsuit**
  - **Health insurance**
  - **Drug felony conviction**
  - **Marriage or divorce**
  - **School attendance**
  - **Absent parent custody or visits**

- **The county, state or federal agency may check any of the information you give.** To get some information we must have your signed consent. If you don't allow the county to confirm your information, you might not get services.
- If **you give us information you know is untrue or we get information you did not report,** we may investigate you for fraud.
- **Contact your worker** if you have questions or are unsure about any reporting rules.

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a "Notice of Privacy Practices" information sheet. Please read it carefully. This sheet explains:
  - Why we are asking you to give us your private information
  - How we may use and share private information about you
  - Why we ask for your Social Security number
  - Your rights about your private information. You can:
    - Ask about how we can use information and with whom we will share this information
    - Ask to get this information in another format
    - Ask to see your information
    - Ask whom we have given your information to
    - File a privacy complaint.
  - How we must legally protect your private information
  - Whom you can contact if you think your private information has been mishandled.

  For more information about your data privacy rights or a copy of the Notice of Privacy Practices (DHS-3979), ask your worker. You can also get a copy of this notice at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG.

- **You have the right to apply for** any of the agency's applicable social services.
- **You have the right to know why, if we have not processed. your application promptly.**
- **You have the right to information about services.**
- **Appeal rights.** You have the right to appeal if the county denies, reduces, suspends or terminates social services or if you or your authorized representative do not agree with the services identified in your service plan. To start an appeal, send a very short letter saying you want to appeal to:

Write:
Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941

Call:
Metro: (651) 431-3600 (Voice)
Outstate: (800) 657-3510
TTY: (800) 627-3529
Fax: (651) 431-7523

The Appeals Office will hold a hearing and allow both you and/or your authorized representative and the county to explain their positions. Shortly after the hearing the Appeals Office will issue a written decision, outlining the facts in your case and determining if the county has acted correctly.

- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age, or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997
St. Paul, MN 55164-0997
(651) 431-3040 (Voice)
(866) 786-3945 (TTY)

Minnesota Department of Human Rights
190 East 5th Street, Suite 700
St. Paul, MN 55101
(800) 657-3704 (Voice)
(651) 296-1283 (TTY)

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 886-2359 (Voice)
(312) 353-5693 (TTY)

Scott County

Chemical Health Services

Behavioral Health Fund Application

Important: Tennessen Notice must be signed and dated prior to completion of the eligibility application!

YOUR PRIVACY RIGHTS

(Tennessen Notice)

Information about your rights under the Minnesota Data Practices Act

The Minnesota Government Data Practices Act, Minn. Statute Chapter 13, (hereinafter "Data Practices Act) seeks to protect the privacy of the individuals about whom government agencies, their subdivisions, and agencies under contract with them collect data. The Minnesota Government Data Practices Act also facilitates the release of information that is public. The information on this sheet applies to your current and future contacts with this agency, whether the contact is in person, by mail or by phone.

The Data Practices Act requires that whenever we ask you to provide us with private or confidential information about yourself that you be told:

- The purpose and intended use of the data within this agency;
- The legal requirements, if any, of providing the information;
- The consequences of providing or refusing to provide the information requested; and
- The identity of other persons or agencies authorized by statute to receive the information.

PURPOSES

The purposes of the information we collect from you are listed below. Because this list of purposes covers a variety of programs, some of the purposes listed may not apply to you. Details about the purposes of the information we collect from you are often listed on the forms you are asked to complete. Depending upon the program you are in, the data we collect from you may be used for the following purposes:

- To comply with any court ordered treatment
- Determine your eligibility for assistance or services provided by this agency
- Provide effective care and treatment of medical/social/psychological problems
- Establish the amount of financial aid for which you are eligible
- Enable us to collect federal, state or county funds for assistance and services for you or your family
- Determine your ability to pay for medical treatment or other assistance and services provided to you or to other persons for whom you are responsible
- Collect reimbursement from other agencies or individuals for services or assistance we give you
- Obtain school assistance authorized by law
- Investigate complaints or reports of abuse, maltreatment, neglect, fraud or misconduct
- Investigate facility complaints
- Ascertain applicant's eligibility for adoption services
- Conduct program and financial audits
- Determine whether you or your children need protective services

During the time we will be involved with you, we will be asking you for information about your physical health, your mental and emotional health, your chemical use, your living situation and employment, your finances, and/or your relationships. We will only ask for information that we are authorized by law to have and that will help us provide you with appropriate services.

CONSEQUENCES OF PROVIDING OR NOT PROVIDING INFORMATION

In most cases you are not legally required to provide the information requested. If you are legally required to supply the information requested, you will be informed of the law that requires it. If you do not provide the information requested, we may not be able to determine your eligibility for the services or assistance you request. In some cases giving you the assistance or services will be delayed or otherwise hindered if you refuse to provide the information. Providing the requested information will facilitate receiving the services available to you.

MINORS

If you are a minor, you have the right to request that private data about you be kept from your parents. You must make this request in writing. You must explain why you wish this data to be withheld and what you expect the consequences of sharing the data with your parents would be. If the agency agrees that withholding the information from your parents is in your best interests, the data will not be shown to your parents.

SHARING INFORMATION

There are other agencies that we are allowed by law to share information with if they need it for investigations, for background studies, for licensing actions, or to help you or help us to help you. Information will only be shared with those entities or organizations and anyone under contract with these entities or organizations once it is determined they need the information to perform their jobs. These may include:

- Services providers under contract with Scott County to provide Rule 25 chemical dependency assessment services
- Service providers under contract with Scott County to provide Rule 31 chemical dependency treatment services
- US Department of Health and Human Services
- Social Security Administration
- Minnesota Department of Human Services
- Minnesota Department of Health
- Local and State Law Enforcement
- Coroner or Medical Examiner
- County Attorney or Attorney General
- Internal Revenue Service
- Multidisciplinary Case Consultation Teams
- Minnesota Department of Revenue
- Other County Welfare or Human Services Agencies
- Court Officials
- Ombudsman for Mental Health & Mental Retardation.
- Local Early Childhood Intervention Contacts
- Applicable school districts and service providers
- The Immigration and Naturalization Service
- Managed care organizations about your health care or benefits
- Insurance companies to check healthcare benefits for you or your family members
- Employees or volunteers of any welfare agency who need the information to do their jobs
- Community Mental Health boards, state hospitals, state nursing homes, and/or entities under contract to one of these facilities, to the extent of the contract.
- Scott County Public Health, Community Corrections, Employment and Economic Assistance, and the Social Services Depart.
- Any other government agency that is authorized to have the information under state or federal law and has a need to know about the information
- Other: _____

OTHER RIGHTS

- You have the right to know what information is maintained about you.
- You have the right to view all public and private information about you maintained by this agency. This includes the right for you to authorize other persons or agencies to view it.
- You have the right to have data to which you have access explained to you.
- You have the right to request copies of the information to which you have access. You may, however, be required to pay for the cost of those copies.
- You have the right to challenge the accuracy or completeness of any private information in your records. If you want to challenge any information, write to the responsible authority of the agency that has your records. You may also talk to the person at this agency who works with you.
- You have the right to insert your own explanation of anything you object to in your records.

I acknowledge I have received this Notice that explains my privacy rights. If I have any questions or concerns, I can contact Scott County Social Services at 952-445-7751.

SCOTT COUNTY HEALTH CARE COMPONENTS
NOTICE OF PRIVACY PRACTICES

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

Under the Minnesota Government Data Practices Act and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to privacy regarding your Protected Health Information (PHI). These laws protect your right to privacy regarding your PHI, however these laws also allow Scott County to use and disclose information with others if required by law. Under HIPAA, we are required to keep your PHI private and give you a notice of our legal duties and privacy practices to protect your protected health information. We will limit the use and disclosure of PHI to the minimum necessary to provide services and benefits to you or to accomplish the intended purpose of the use, disclosure, or request. Protected Health Information is health information about you which can be used to identify you and relates to your past, present, or future physical or mental health condition(s), related health care services, and payment. Scott County is required to abide by the terms of the notice currently in effect.

However, we reserve the right to change the privacy practices described in this notice, in accordance with law. Changes to our privacy practices apply to all health information we maintain as well as any information we receive in the future. If Scott County changes its privacy practices, we will post the new notice at each Scott County site and facility and provide it as required by law. You may ask for a copy of the current notice anytime. This Notice describes the privacy practices pertaining to the use and disclosure of PHI that apply to the covered health care components of Scott County.

This Notice will be interpreted for you in other languages, if requested.

Scott County may use and disclose your Protected Health Information without your Authorization:

1. **For Treatment**. Scott County may use or disclose your health information with health care providers such as doctors, nurses, therapists and social workers who are involved in your health care. For example, information may be shared with our staff or providers outside our system to create or carry out a plan for your treatment.
2. **For Payment**. Scott County may use or disclose your health information to obtain payment for or to pay for the health services you receive. For example, Scott County may provide PHI in order to bill payers for health care provided to you.
3. **For Health Care Operations**. Scott County may use or disclose your health information about you in order to manage its programs and activities. For example, Scott County may use your PHI to review the quality of the services you receive, to train employees, or to call you by name in the waiting area when Scott County staff is ready to meet with you.
4. **For Appointments and other Health Information**. Unless you have instructed us not to, Scott County may send you reminders for medical care or checkups. Scott County may send you the information about health services that may be of interest to you.
5. **For Health Oversight Activities**. Scott County may use or disclose your health information to staff at Scott County or to authorities outside Scott County for the purpose of inspection or investigation of health care providers.
6. **For Public Health Activities**. Scott County may use or disclose health information about you for public health activities required or permitted by law. This may include using your medical record to report certain diseases, birth or death information, or information related to child abuse or neglect.
7. **For Judicial and Administrative Proceedings**. We may disclose health information about you in response to a court order or as otherwise authorized by law. For example, a court order or law may require Scott County staff to share PHI with the court and attorneys in a family court proceeding.
8. **For Law Enforcement**. We may disclose your health information to law enforcement when required by federal or state law. For example, a law may require Scott County staff to disclose PHI to law enforcement in legal proceedings or medical emergencies.
9. **For Abuse Reports and Investigations**. If Scott County suspects abuse, neglect, or domestic violence, we may disclose health information about you as required or permitted by law.
10. **For Government Programs**. Scott County may use and disclose PHI for public benefits under other gov. programs as authorized by law.
11. **For Reports to Coroner, Medical Examiners, and Funeral Directors**. Scott County may disclose your PHI to coroners, medical examiners, and funeral directors as authorized by law. For example, we may disclose PHI to a coroner or medical examiner to identify an individual or to determine the cause of death.
12. **For Research**. Scott County may use and disclose your PHI for research purposes as authorized by law.
13. **For Health and Safety Concerns**. Scott County may disclose your PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.
14. **For Workers Compensation**. Scott County may disclose your PHI as authorized by law to Workers' Compensation or similar programs.
15. **For Specialized Government Functions**. Scott County may disclose your PHI to government agencies with special functions, such as veteran's activities, National Security and Intelligence activities, Protection Services to the President, and correctional institutions and other law enforcement custodial situations as authorized by law.
16. **For Individuals Involved in Your Care or Payment for Your Care**. Scott County may disclose your PHI to family or other persons you identify as directly involved in your health care. You may object to the sharing of this information.
17. **Inmates**. Scott County may disclose PHI as authorized by law to a correctional institution having legal custody of you in order for the institution to give you health care; for the health and safety of you or others; or for the safety and security of the institution.
18. **When Requested by Law**. Scott County may use or disclose PHI when required by federal or state law.
19. **Parental Access**. Minnesota law requires Scott County to disclose PHI to parents, guardians, and persons acting in a similar legal status in most situations. We will act consistent with Minnesota law.

Other than the uses and disclosures described above, Scott County will not use or disclose your PHI without your written authorization, unless otherwise authorized by law. You have the following Privacy Rights regarding your PHI:

1. **You have the right to inspect and obtain copies of your records**, unless the records are psychotherapy notes, or the information has been compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. You must make the request in writing. You will be charged a fee for copying costs.
2. **You have the right to request that we amend the health information we maintain in your medical or billing record**. Your request must be in writing and we may deny your request in certain circumstances.
3. **You have the right to a List of Disclosures**. You have the right to ask for a list of disclosures of your PHI made by Scott County in the six year period prior to the date of your disclosure request. You must make the request in writing. This list will not include the disclosures made for treatment, payment or health care operations. This list will not include information made directly to you or your family. In addition, the list will not include information that was sent pursuant to your authorization or as otherwise authorized by law. If you request a list more than once during a year, we may charge you a fee for each subsequent request.
4. **You have the right to request limits on the uses or disclosures of PHI**. a) You have the right to ask that Scott County limit how your PHI is used or disclosed. You must make the request in writing and tell Scott County what information you want to limit and to whom you want the limits to apply. Scott County is not required to agree to the restriction, except as otherwise authorized by law and as stated in section b below. You may make a request at any time, either verbally or in writing that the restrictions
you have requested be terminated. Verbal requests will be documented by Scott County. b) Scott County must comply with your request to restrict the disclosure of your PHI if: the disclosure is to a health plan for purposes of carrying out payment or health care operations and the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.
5. **You have the right to revoke your authorization to release PHI**. If you sign an authorization requesting Scott County to use or disclose your PHI, you may revoke that authorization at any time by notifying Scott County in writing. This revocation will not apply to any PHI that was disclosed prior to the County's receipt of your written notification.
6. **You have the right to choose how Scott County communicates with you**. You have the right to ask that Scott County share information with you in a certain way or in a certain place. For example, you may ask Scott County to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.
7. **You have the right to file a complaint**. You have the right to file a complaint if you do not agree with how Scott County has used or disclosed PHI about you.
8. **You have the right to receive a paper copy of this notice at any time**. **You may contact Scott County to review, correct, or limit your Protected Health Information (PHI).** You may contact the Scott County Privacy Officer at the address listed at the end of this notice to:
1. Ask to look at or copy your records.
2. Ask to limit how information about you is used or disclosed.
3. Ask to cancel your authorization.
4. Ask to correct or change your records.
5. Ask for a list of the times Scott County disclosed protected health information about you.

Scott County may deny your request to look at, copy or change your records. If Scott County denies your request, we will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with Scott County or with the U.S. Department of Health and Human Services, Office for Civil Rights.

How to file a complaint or report a problem.
If you want to file a complaint or to report a problem with how Scott County has used or disclosed information about you, you may complain to the Scott County HIPAA Privacy Official at the address listed below or to the Office of Civil Rights, Medical Privacy Complaint Division, U.S. Department of Health and Human Services.

Your benefits will not be affected by any complaints you make. Scott County cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.
If you have any questions about this notice or need more information, please contact the Scott County Privacy Officer.

Privacy Officer
Scott County Health and Human Services
Scott County Government Center, West
200 Fourth Avenue West
Shakopee, Minnesota 55379-1220
Telephone: (952) 445-7751 Email: hsprivacy@co.scott.mn.us

You can also contact the State of Minnesota at the addresses below:

Department of Human Rights
State Office Building
St. Paul, MN. 55155
(800) 657-3704

Division of Licensing
Department of Human Services Building
444 Lafayette Road N.
St. Paul, MN. 55155

You may also send a written complaint to:

Medical Privacy Complaint Division
Office of Civil Rights, Region V
U.S. Dept of Health & Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

Secretary US Dept Health & Human Services
200 Independence Ave. SW
Washington, DC 20201
240-453-2800

Scott County Health and Human Services - HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

A. WE HAVE A LEGAL DUTY TO PROTECT YOUR HEALTH INFORMATION.

We have Protected Health Information (PHI) about you. This information identifies you and includes information about your past, present or future health; health care you are receiving; or payment for that care. This Notice describes the types of uses and disclosures that we may make and gives you some examples. This notice gives you information about our legal duties and privacy practices concerning PHI:

- We will use or disclose the least amount of PHI we need to accomplish the intended purpose of the use or disclosure.
- We will notify you about how we protect PHI about you.
- We will explain how, when and why we use and/or disclose PHI about you.
- We can only use and/or disclose PHI as we describe in this Notice.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice. If we do change this Notice, we will:

- Post the revised notice in our offices;
- Make copies of the revised notice available upon request (either at our offices or through the contact person listed in this Notice); and
- Post the revised notice on our website. www.scottcountymn.gov

B PHI MAY BE USED:

1. We may use and disclose your PHI to provide your health care treatment.

We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This means we may communicate with other health care providers about your treatment, care coordination, and the management of your health care. Examples are:

- When you need a prescription, lab work, an x-ray, or other health care services
- When we refer you to another health care provider
- When we talk with another agency that has a contract with Scott County Human Services to provide health care services to you

2. We may use and disclose PHI to obtain payment for our services.

We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. Before you receive services, we may share information about these services with your health plan(s) and their agents, which provide your coverage. Examples include:

- To see if you are eligible to receive services.
- To get payment for the help we give you.
- To prove that you really need the help given to you.
- Approval to send you to the hospital.
- To collect any money you owe us.

3. We may use and disclose your PHI for our health care operations.

We may use and disclose PHI in order to perform our business activities. We call these activities "health care operations". These "health care operations" allow us to improve the quality of care we

provide and reduce health care costs. Examples of how we may use or disclose PHI for "health care operations" includes:

- Telling you about other treatment or benefits that may help you.
- Calling to remind you about your appointments with us.
- Checking to make sure that your health care providers are qualified and have a good record.
- Helping other organizations evaluate, certify, or license their health care providers or facilities.
- Helping people who check on our qualifications, skills and performance.
- Planning for our organization's future operations.
- Resolving complaints within our organization.
- Complying with this Notice and with applicable laws.

4. Uses or disclosures that may be made without your authorization or opportunity to object.

We may use and/or disclose PHI about you without your permission in some situations. In these situations, you will not be asked to give your consent and you will not have an opportunity to agree or object. Those situations include:

- **Required by law**. We may use or disclosure your PHI if the federal, state or local laws require us to do so. We may disclose your PHI if judicial or administrative proceedings require us to do so.

- **Public health activities**. We may disclose PHI about you if you have been exposed to a communicable disease. We also may disclose PHI if you may be at risk of contracting or spreading a disease or condition.

- **Abuse and neglect.** We may make disclosures to government authorities concerning abuse, neglect or domestic violence.

- **Oversight activities**. We may disclose PHI about you to a state or federal health agency, which is authorized by law to oversee our operations.

- **Law enforcement**. We may disclose PHI about you in order to comply with laws. We may disclose PHI if you have certain types of wounds or other physical injuries; if you are a victim of a crime; to identify you; or in other situations where we are required by law to do so.

- **Coroners and Funeral Directors**. We may disclose PHI about you to a coroner or medical examiner to identify you, determine your cause of death or for other reasons as required by law. We may also disclose PHI to a funeral director as required by law.

- **Threat to health or safety**. We may disclose PHI about you to prevent a threat to the health or safety of a person or the public.

- **Specialized government functions**. We may disclose PHI about you because of military and veterans' activities or national security and intelligence activities as required by law.

- **Correctional institutions and in other law enforcement custodial situations**. We may disclose PHI about you to a prison, jail or other institution having lawful custody of you.

- **Legal proceedings**. We may disclose your PHI if we are court-ordered to do so. We may also disclose your information in response to a subpoena, discovery request or for another lawful purpose.

ANY OTHER USE OR DISCLOSURE OF YOUR PHI REQUIRES YOUR WRITTEN AUTHORIZATION

We will ask for your written consent before we use or disclose PHI about you in other situations not listed above. If you sign a written consent allowing us to disclose PHI about you, you can later cancel that

consent if you do so in writing. If you cancel your consent in writing, we will not disclose PHI about you after we receive that cancellation. Any disclosures that were being processed before we received your cancellation may still be disclosed.

C. YOUR RIGHTS

You have the following rights regarding your PHI:

1. The right to request restrictions

You have the right to request that we limit how we use and disclose your PHI. You must make the request in writing and tell Scott County what information you want to limit and to whom you want the limits to apply. You can later request that the restrictions be terminated. You can do this in writing or verbally.

We will consider your request, but are not legally bound to agree to the restriction. If we do agree to these restrictions, we agree to abide by them except in emergency situations. We cannot agree to limit uses or disclosures that are required by law.

If you refuse to allow us to use and disclose certain information you may not be able to receive assistance or services.

2. The right to confidential communications.

You have the right to request how and where we contact you about PHI. You do not have to explain the basis for your request.

For example, you may request that we contact you at work or use a special phone number or email address. Your request must be in writing. We will accommodate your request as long as it is reasonably easy to do so. We may accommodate this request as long as you provide information on how your payment, if any, will be made.

3. The right to access your PHI.

You have the right to request to see and/or receive a copy of your PHI for as long as we keep your information. Your request to view or copy this data must be in writing.

You may see your medical and billing records and any other records we use to make decisions about you and your services. We will respond to your request in 5 days. There may be a charge for copying and handling costs. You have a right to choose what parts of your information you want copied and to have prior information on the cost of copying.

- Under federal law, you may not inspect or copy the following records: (1) information compiled for use in a civil, criminal or administrative proceeding for child protection and mental health pre-petition screenings (In some situations, the information is not available until after the investigation is closed, such as welfare fraud.); and (2) PHI that is subject to law that prohibits access to PHI.

We may deny your request for access to this information. If we do, we will give you written reasons for the denial and explain your rights to have the denial reviewed.

4. The right to amend your PHI.

If you believe that there is a mistake or missing information in our records of your PHI, you may request, in writing, that we amend the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. We will make that denial in writing. The denial letter will state the reasons for denial and explain your rights to have your request and the denial added to your PHI. If we approve your request for amendment, we will change the information, inform you about the change, and tell others who need to know about the change.

5. The right to a list of disclosures.

If we make disclosures of your PHI, you have a right to get a list of those disclosures. You may ask, in writing, what information was disclosed and why it was released. We will not advise you or your family of disclosures involving treatment, payment or health care operations. We also will not advise you of disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14, 2003. We will respond to your written request for such a list within 60 days of receiving it. You can request a list of disclosures going back as far as six years. There will be no charge to you for one such list each year. There may be a charge for more frequent requests.

6. The right to have a copy of this Notice.

You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services, and then we will provide the Notice to you as soon as possible).

D. YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES.

If you think we have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below.

Privacy Officer
Scott County Health and Human Services
Scott County Government Center West,
200 Fourth Avenue West
Shakopee, Minnesota 55379-1220
(952) 445-7751
hsprivacy@co.scott.mn.us

You may also send a written complaint to the Department of Health and Human Services. Send your complaint to:

Medical Privacy Complaint Division
Office of Civil Rights, Region V
U.S. Department of Health and Human Services 233 North Michigan Avenue, Suite 240 Chicago, Illinois 60601

Voice: (312) 886-2359
FAX: (312)886-1807
TDD: (312)353-5693

If you file a complaint, we will not take any action against you or change our treatment of you in any way.

E. EFFECTIVE DATE OF THIS NOTICE

This Notice of Privacy Practices is effective on April 14, 2003. This notice will be changed and sent out again whenever there is a material change to Scott County's policies and procedures.

This institution is an equal opportunity provider