Venice Family Clinic

CASE MANAGEMENT INTAKE

Intake Date_____

Client Name: _____ **DOB:** _____ **Age**: _____
Last First MI

Referred By: _____ _____ _____
Person or Agency Name Phone #

SSN:_____-____-_____ Sex: _____ Birthplace: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Residence: _____ City: _____ State: _____ Zip: _____

Mailing: _____ City: _____ State: _____ Zip: _____

OK to receive mail from Common Ground? Yes No Comments? _____

_____

Names of people we can talk to: _____

EMERGENCY CONTACT: _____

Address: City: State: Zip:

_____ _____ _____ _____

Home phone: Message? Yes No Other phone:

_____ _____

Relationship: _____

Children? # Living in your household? #

_____ _____

Why are you seeking case management services? _____

_____

Are you currently enrolled in any other services? _____

_____ _____

Client Signature **Date**

_____ _____

Case Manager's Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ **D.O.B.** _____

MR# _____ **SSN:**_____

I,_____, authorize the release of HIV test results in compliance with the terms of the Confidentiality of Medical Information Act, Civil Code Section 56 et. Seq., and Health and Safety Code Section 199.2l(g).

In addition, authorization is given to release and share information from my medical records about my physical, mental, financial condition and personal information with no limitation placed on the date of illness, history of illness, the diagnosis, therapeutic information or patient information. Information received will be used for purposes of verification of diagnosis and provision of support services.

Authorization to release HIV status and medical information is given to:

Person/Agency:_____

Address:_____

City/State/Zip: _____

Phone: _____

Information released to: **VENICE FAMILY CLINIC/COMMON GROUND**

This authorization shall remain valid for five (5) years unless otherwise specified:

I understand that the receiving person/agency is not permitted to release or disclose information to another person or agency without obtaining an additional "Authorization to Release Information". A photocopy of this form is as valid as the original. I understand that this authorization may be revoked at any time, except to the extent that action has already been taken in reliance thereupon. I understand that I have a right to receive a copy of this signed authorization.

(Copy requested? No Yes Copy received? No Yes by:_____(staff initials)

Signature of Client:_____Date: _____

Agency Representative:_____Date: _____

Authorization to Release Information

Name: _____ DOB:_____/____/_____ SSN:_____-_____-_____

I have read the accompanying attachment and authorize the staff and/or volunteers of the agencies listed, and others I choose to add to this form:

AADAP Syringe Exchange
BAART Programs
BHS Treatment Center
Bienestar Syringe Exchange
California Department of Motor Vehicles
CA Department of Social Services
California Hospital Medical Center
Cedars Sinai Medical Center
Centinela Hospital Medical Center
Childrens Hospital Los Angeles CHOISS
CLARE Foundation
Common Ground Syringe Exchange
CRI Help Inc.
Edelman Westside Mental Health
Gateway Hospital & Mental Health Ctr
Good Samaritan Hospital
Health Advocates
Homestead Hospice & Shelter
Housing Authority of the City of L.A.
Kaiser Permanente
LAHSA
LAC/Department of Public Social Services
LAC/Harbor-UCLA Medical Center
LAC/King-Drew Medical Center LAC
Transit Operators Association LAC/
USC Medical Center
Los Angeles Gay & Lesbian Center
Miracles Detox
Northeast Valley Health Corporation
OPCC
Olive View Medical Center
PATH
PAWS Los Angeles
Phoenix House
Positive Steps
Program for Tortured Victims
Salvation Army
SAMHSA
Santa Monica/UCLA Medical Center
Social Security Administration
St. John's Hospital and Health Center
St. Joseph Center
Sober Living Network
Southern CA Hopsital EMS Dept.
SPY
St. Mary's CARE Program
Step up on Second
Substance Abuse Foundation
Tarzana Treatment Centers
UCLA Medical Center
Venice Family Clinic
Valley Community Clinic
Warm Springs Rehabilitation Center
Watts Health Foundation

to release, receive and share information from my records regarding personal information, services I have received, results of my HIV test or status, substance use and or treatment information and my physical, financial and/or mental condition(s), for the express purpose of receiving or gaining access to services related to my current or future needs.

I have indicated that information not to be exchanged with and agency listed above by drawing a line through the name of the agency and placing my initials next to the line. I understand that the receiving agency is not permitted to release or disclose information to another person or agency without obtaining an additional "Authorization to Release Information".

This consent is valid for five (5) years from the date it is signed and may be revoked at any time by signing the revocation line below, at the agency named above. I understand that I may add other specific agencies or persons to this form by listing them and signing below.

_____ _____/_____/_____
SIGNATURE (CLIENT) **DATE**

_____ _____/_____/_____
AGENCY REPRESENTATIVE (VFC/Common Ground) **DATE**

Authorization to Release Information

(Continuation)

I wish to add the following specific agencies or persons to this release:

	Agency/Person	Signature (client)	Date	Date Cancelled
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

I wish to cancel this release of information:

_____ _____/_____/_____

SIGNATURE **DATE**

Venice Family Clinic

CONSENT FOR HARM REDUCTION CASE MANAGEMENT SERVICES

Common Ground provides comprehensive services to person's experiencing homelessness, including case management,treatment advocacy, and mental health. To adequately assure provision of Case Management Services, your case manager will assess your circumstances and develop an Individual Service Plan (ISP) with you, refer you to appropriate services and contact you on a regular basis to monitor your progress. The case manager will appropriately advise you regarding issues, advocate for you when you cannot do it for yourself and refer you to services that will attempt to meet your needs. In order to do this, information may be shared between Common Ground program's in order to provide services most effectively. All information received by Common Ground is held in the strictest confidence, and no information may be disclosed without your written permission to programs outside of Common Ground. Written records regarding your service activities (i.e., progress notes, service plan, etc.) and other relevant documentation (i.e., personal identification, diagnosis, etc.) are required and kept confidential.

The following are exceptions to the above statements, as required by law:

1. If you threaten to harm yourself or another person, or threaten to damage property, Common Ground staff must take whatever action is deemed necessary under the circumstances to ensure your safety and the safety of others, including notification of appropriate persons/legal authorities.

2. In any instances where Common Ground staff should receive a report of child, disabled adult, or elder abuse, neglect or exploitation, past or present,or evidence of domestic violence, staff is mandated by law to investigate further and, under certain circumstances, report such incidences to the appropriate authorities.

3. There may be situations in which written records are subpoenaed by a court of law and used as testimony in legal proceedings.

4. Certain data about clients may be reported to our funding sources. Currently, data is submitted to DHSP (Division of HIV and STD Programs). The information sent to our funding sources does not include the client's name, address, social security number, or any other information that may identify the client.

I have read the above statements and understand their content and ramifications. I agree to these limits of confidentiality and will not hold Common Ground staff liable for breach of confidentiality under any of the conditions stated above. I agree to receive Harm Reduction Case Management Services.

Print Name: Client/Legal Guardian	Print: Staff Name
Signature Date	Staff Signature Date

Venice Family Clinic

Patient's Rights and Responsibilities

We at Venice Family Clinic/ Common Ground believe in providing equal access to all who request and are eligible for the services we offer. As a patient of the Venice Family Clinic, you have the right to expect to be treated in the following manner:

1. The right to courteous and considerate treatment by all clinic staff.
2. The right to appropriate privacy.
3. The right to confidentiality of information about your medical and health conditions and personal problems.
4. The right to know and understand your medical problems, treatment plan, effects on daily living and expected outcome.
5. The right to participate in decisions regarding your health care including giving informed consent for procedures after being informed of the risks and options.
6. The right to refuse medical treatment including treatment that is experimental.
7. The right to receive information about any fees, payment policies, how to make an appointment, provisions for after hours, emergency services, and how to make suggestions or express grievances to the Venice Family Clinic.
8. The right to change physicians if other qualified physicians are available.
9. The right to expect that brochures and advertisements will give accurate information about the capabilities of the Venice Family Clinic.
10. The right to elect to serve on the Venice Family Clinic's patient advisory board.
11. The right to receive services without regard to age, color, gender, national origin, physical or mental disability, race, religion, or sexual orientation.

As a patient of the Venice Family Clinic you have the following responsibilities:

1. The responsibility to work with staff and volunteers in creating a safe environment on the Venice Family Clinic premises. This includes:
    - maintaining appropriate behavior while on the premises
    - treating staff and fellow patients with respect and courtesy
    - refraining from verbal abuse directed towards staff, volunteers or patients
    - abstaining from the use of tobacco, illicit drugs or alcohol on the premises
    - refraining from eating or drinking while on the premises
    - not having or using weapons of any kind on the premises
    - abiding by the prohibition on threats of violence or actual physical violence
    - refraining from any sexual behavior while on clinic property
    - supervising your children at all time when you are here in the clinic. Children must not be left unattended or alone while you are seeing the doctor.
2. The responsibility to be truthful and honest in dealing with clinic staff providing correct information to determine eligibility for services, and to the best of your ability, accurately stating your situation, circumstances and use of other medical and social services.
3. The responsibility to attend appointments in the timeframe set by the doctor and understanding that it is necessary to have a medical visit at least every 12 weeks so that your doctor can monitor your medical condition(s) and appropriately prescribe medications.

Patient's Rights and Responsibilities
(Continuation)

4. The responsibility to complete the medical visit by providing blood, receiving immunizations, and making a follow up appointment when indicated. Understanding that if you are unable to complete your visit, you will be asked to call the call center for a follow up appointment and make arrangements to get your blood drawn and receive my immunizations.

Patient/Chart Responsibilities

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Communicate to your provider/case manager whenever you do not understand information given.
3. Follow the treatment plan you have agreed to and and/or accept the consequences of failing the recommended course or of using other treatments.
4. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
5. Keep your provider/case manager informed about how to reach you confidentially by phone, mail or other means.
6. Follow the agency's rules and regulations concerning patient/client care and conduct.
7. Be considerate of your providers and fellow clients /patients and treat them with the respect you yourself expect.
8. Maintain the confidentiality of everyone else receiving care or services at the agency by never mentioning to anyone who you see here or casually speaking to other clients not already known to you if you see them somewhere else.

I have read and understand my rights and responsibilities as a patient of Venice Family Clinic/ Common Ground. I understand that Venice Family Clinic/ Common Ground reserve the right to terminate or suspend services if I do not fulfill my responsibilities as a patient.

_____ _____
Patient Signature Printed Name

_____ Copy Given _____
Date Staff Initials

Venice Family Clinic

GRIEVANCE PROCEDURE

Any patient of the Venice Family Clinic may file a grievance if he/she has a concern regarding any issue involving the services provided by or through the Venice Family Clinic. Any grievance regarding any concern of a patient will immediately be referred to the Project Director for resolution. The Project Director receives grievances through the following means:

Direct written communication.
Direct verbal communication.

The Project Director is Arron Barba. The Project Director may be contacted by writing or phoning at:

Venice Family Clinic
604 Rose Ave.
Venice, CA. 90291
310-664-7611

Written and verbal grievances can be initiated by the patient, his or her significant other or any other service provider involved in the patient's care.

Unless grievances require immediate resolution, they will be discussed at the monthly Quality Management (QM) meeting. At the QM meeting the action for resolution will be determined and the Project Director will communicate the result back to the patient no later than two days after the monthly QM meeting.

If the situation requires immediate attention, the Project Director will obtain necessary information from the Case Manager to gain better insight into the situation at hand. In urgent situations which need resolution immediately, the Project Director will communicate with the patient within two days of the complaint.

If the patient is not satisfied with the solution provided by the Project Director, the patient may appeal this decision to the Administrator of the Venice Family Clinic, Ms. Anita Zamora. This must be done in written form and may be sent by mail or by fax. The administrator of the Venice Family Clinic can be reached at the above address as well. The Administrator will communicate his/her response to the patient in writing within 5 working days of receipt of the written grievance.

PATIENT SIGNATURE_____

Patient Name: _____

My signature above indicates that I have received a copy of the Grievance Policy above. DATE: _____