VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Plan Member Information Packet

Office Only	Client ID:

VCBH operates Ventura County's behavioral health plan. We need the information below to enroll you as a member in that plan.

Plan Member Information

Legal First Name	Legal Middle Name	Legal Last Name	Suffix
Preferred Name, *if different*			Pronouns
Date of Birth	Sex assigned at birth ☐ Male ☐ Female		I identify as ☐ Male ☐ Female ☐ Other: _____

Contact Information

Home Street Address		
City	State	Zip Code

Mailing Address, *if different*		
City	State	Zip Code

Phone	**Email**
I prefer to speak:	**I prefer to read materials written in**:

The below sections are optional.
This information helps us make sure that you get the best care possible.

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Decline to State

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to State

Are you a US military veteran?
- ☐ Yes
- ☐ No
- ☐ Decline to State

Emergency Contact Information
Please let us know if there is anyone we can contact in case of emergency.

Name	Phone	Relationship to Plan Member
Name	Phone	Relationship to Plan Member
Name	Phone	Relationship to Plan Member

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Parent or Legally Authorized Representative Information

(We will need to see proof of identity and your authority to act on behalf of the plan member.)

Legal First Name	Legal Middle Name	Legal Last Name	Suffix

Preferred Name, *if different*	Pronouns *(optional)*

Relationship to Plan Member

- ☐ Parent
- ☐ Court Appointed Guardian
- ☐ Court Appointed Conservator

Contact Information, *if different than plan member*

Residential Street Address

City	State	Zip Code

Mailing Street Address, *if different*

City	State	Zip Code

Phone	**Email**

I prefer to speak:	**I prefer to read materials written in**:

Additional Parent or Legally Authorized Representative Information

(We will need to see proof of identity and your authority to act on behalf of the plan member.)

Legal First Name	Legal Middle Name	Legal Last Name	Suffix

Preferred Name, *if different*	Pronouns *(optional)*

Relationship to Plan Member

- ☐ Parent
- ☐ Court Appointed Guardian
- ☐ Court Appointed Conservator

Contact Information, *if different than plan member*

Residential Street Address

City	State	Zip Code

Mailing Street Address, *if different*

City	State	Zip Code

Phone	**Email**

I prefer to speak:	**I prefer to read materials written in**:

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Insurance Information

(*We will need to see your insurance card(s).*)

Medi-Cal	Identification Number	Issue Date	
Medicare	Identification Number	Part A Effective Date	Part B Effective Date

Other Insurance (1)

Insurance Company Name	Is Prior Authorization Required for Mental Health Services? ☐ Yes ☐ No ☐ Don't Know	
	Is this Worker's Comp? ☐ Yes ☐ No	
Mailing Address		
Group Number	Policyholder Number	Effective Date
Policyholder Name		Relationship to VCBH plan member

Other Insurance (2)

Insurance Company Name	Is Prior Authorization Required for Mental Health Services? ☐ Yes ☐ No ☐ Don't Know	
	Is this Worker's Comp? ☐ Yes ☐ No	
Mailing Address		
Group Number	Policyholder Number	Effective Date
Policyholder Name		Relationship to VCBH plan member

Self-Pay

☐ I will pay for services myself.

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Uniform Method of Determining Ability to Pay (UMDAP)

(Recommended for all VCBH plan members.)

Responsible Person's Information

Responsible Person's Name	
Relationship to VCBH Plan Member	
Billing Address	
Number of Dependents	

Responsible Person's Monthly Income

Employment Income	$	Social Security Insurance (SSI)	$
Unemployment Income	$	VA Benefits	$
State Disability Insurance (SDI)	$	Other	$
Social Security Assistance (SSA)	$	**Total**	**$** 0.00

Other Monthly Income

Spouse / Partner Income	$	Other	$

Responsible Person's Assets		Responsible Person's Monthly Expenses	
Savings	$	Court Ordered	$
Bank Balances	$	Childcare	$
Market Value of Stocks	$	Dependent Care	$
Market Value of Bonds	$	Medical Expenses	$
Market Value of Mutual Funds	$	Retirement	$
Market Value of Other Assets	$		

Name	Date of Birth	Gender	Plan Member	Head of Household	Family Member in Household	Family Member Out of Household	Extended Family Member
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Office Use Only: UMDAP

Start Date:	End Date:	UMDAP:	$

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Agreement to Pay

I agree to pay for all services provided by VCBH. The amount I pay will be based on the information above. The information I have provided in this form is correct. If the information changes, I will report the changes to VCBH.

If I lose insurance at any time during treatment then I will pay VCBH's regular charges or my Uniform Method of Determining Ability to Pay (UMDAP) amount, whichever is less. What I pay will be based on my ability to pay. Proof of income will be required.

If I have a "share of cost" to pay before Medi-Cal Coverage starts, I agree to pay that "share of cost" today or according to a payment plan.

Responsible Person's Signature	**Date**	**Relationship to Plan Member**

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Authorization for Email and Voicemail Messages

If you want them, we can send information to you by email and voice messages. Examples are reminders of your appointments and information about health education programs.

If you want these types of messages, please initial below. **This is your choice.** What you decide will not affect the care you get from us. Many plan members like these messages.

These messages will not include clinical or treatment details.

Cost. Receiving emails and voice messages from us is free.

Risks. Sending and receiving email and voice messages may risk the privacy and security of Protected Health Information ("PHI") about you. *Examples of PHI are* your name, where you get treatment, your insurance coverage. Things you should consider:

- Our email and voice messages to you will not be encrypted.
- If you share your phone, email, or your phone is lost or stolen, someone other than you may be able to access PHI about you.

_____ **I authorize VCBH to send me** (check the one(s) you want)**:** ☐ **email** ☐ **voice messages**

- This authorization will continue as long as I receive treatment from VCBH, unless I tell VCBH that I have changed my choice.
- I will contact my care provider or treatment team if my phone number or email address changes or if I change my choice about the types of messages I want.

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Data Sharing, Health Information Exchanges, and Third-Party Health Apps

Health Information Exchange - Ventura County Behavioral Health (VCBH) participates in an health information exchange (HIE), operated by the California Mental Health Services Authority (CalMHSA). Through HIEs, hospitals, behavioral health providers, county health programs, physicians, social workers, and other HIE participants who may provide health or behavioral health services to you can access information about your care at VCBH. Some types of information, such as certain substance use disorder records, will not be shared with HIE participants unless you signed a separate authorization for such disclosures.

You can "opt-out" of sharing your health information via the CalMHSA HIE at any time by contacting your care provider or sending an opt-out form to OptOut@calmhsa.org. You can find the CalMHSA HIE opt-out form here: https://www.calmhsa.org/interoperability-optout/.

Opting out will prevent future sharing of your VCBH health information via the HIE, but HIE participants may still be able to access information about you that has already been shared or from other sources.

You can contact your care provider or treatment team any time for assistance with opting out.

Third Party Health Information Applications (Apps)
The VCBH electronic health record is "interoperable" with some third party health information APPs. Educational materials about interoperability and third party apps are available online at https://vchca.org/behavioral-health/client-resources/

Please ask your care provider if you want to receive the materials in a different format or language at no cost to you.

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Notice of Privacy Practices

One Joint Notice of Privacy Practices ("Notice") covers all services provided to you by the Ventura County Health Care Agency (VCHCA) and the members of its medical staff. It applies to the medical record of all services provided to you in VCHCA's clinically integrated care setting, which includes the Ventura County Medical Center, Santa Paula Hospital, clinics and physician offices, and those sites affiliated with Public Health and Behavioral Health, regardless of whether specific services are provided by VCHCA's workforce or by independent members of our medical staff.

We are required by law to maintain the privacy of protected health information and to provide you with the Notice of our legal duties and privacy practices with respect to protected health information. "Protected health information" is information, including demographic information, that may identify you and that relates to your past, present, or future physical or behavioral health or condition and related health care services. We are further required by law to notify you of any breach of unsecured protected health information that affects you.

We may use and disclose your protected health information to carry out treatment, payment or health care operations and other uses and disclosures authorized or required by law. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. The Notice also describes your rights to access and control your protected health information. Further, the Notice informs you of your rights to complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

We are required to abide by the terms of the Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time of the change.

To see the entire text of the notice, visit https://vchca.org/behavioral-health/client-resources/

Authorization

I authorize Ventura County Behavioral Health (VCBH) to use and disclose Protected Health Information - including information about substance abuse treatment I receive at VCBH - to my treating providers, health plans, third-party payers, and people helping to operate VCBH.

Signature	Date	Relationship to Plan Member

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Medi-Cal Beneficiary Handbook

Medi-Cal Beneficiaries: Your Beneficiary Handbook explains your rights, available services, and how to file a grievance or appeal. It is available to you online at https://vchca.org/behavioral-health/client-resources/.

Please contact your care provider if you want to receive the handbook in a different format or language at no cost to you.

Plan Member Rights and Responsibilities

Your Rights

Everyone receiving services from Ventura County Behavioral Health has these rights.

1. The right to privacy as stated in State and Federal regulations.
2. The right to be treated with respect by staff, volunteers, board members, and others.
3. The right to be informed of everything about recommended treatment. This includes the choice of no treatment, the risks of the treatment, and the expected results.
4. The right to treatment by qualified staff.
5. The right to receive evidence-based, individualized, outcome-driven treatment for as long as authorized.
6. The right to get treatment for co-occurring behavioral health conditions at the same time, if medically appropriate.
7. The right to ethical care as required by law.
8. The right to be free from verbal, emotional, physical abuse, and inappropriate sexual behavior.
9. The right to know how to file a complaint or appeal a discharge.
10. The right to be free from discrimination based on ethnicity, religion, age, sex, color, sexual preference, or disability.
11. The right to access personal health records, except in a few limited circumstances as permitted by law.
12. The right to ask about financial aid and get help in finding this information.
13. The right to attend religious services or activities inside or outside the facility and to have visits from a spiritual advisor, if these do not interfere with the treatment, program or facility requirements.

Your Responsibilities

Everyone receiving services from Ventura County Behavioral Health (VCBH) has these responsibilities.

1. Treat all providers and staff with courtesy and respect.
2. Be on time for visits or call the provider's office at least 24 hours before the visit to cancel or reschedule.
3. Give correct and current information to providers and VCBH.
4. Work with the treatment team to develop and agree on goals, do your best to understand your behavioral health problems, and follow the treatment plans and instructions from the treatment team.
5. Call 988 or the VCBH Crisis Line at 1-866-998-2243 for immediate behavioral health help. Call 911 for medical or safety emergencies.
6. Submit any grievances or appeals to VCBH by calling 1-888-567-2122.

Please ask your care provider if you want to get a copy of these rights and responsibilities or to receive them in a different format or language at no cost to you.

Signature	Date	Relationship to Plan Member