

Medication Name Date Filled	Dose	Frequency	Prescribing Physician	Related Diagnosis or Condition

EDUCATION:

Elementary School - Name: _____

Address: _____

Phone: _____ Fax: _____

High School - Name: _____

Address: _____

Phone: _____ Fax: _____

Dates Attended: _____ Graduated: Yes No G.E.D.: Yes No

VOCATIONAL TRAINING IN ADDITION TO ABOVE EDUCATION: Yes No

EMPLOYMENT HISTORY: Yes No

Name of Employer/Address/Phone	Job(s) performed	Years of employment

PLEASE SUBMIT COPIES OF:

Birth certificate	Medicaid card
Social Security card	Medicare Card
Photo ID or recent Photo	Guardianship papers

SUBMIT REFERRAL TO: SSA Office- Intake Department
35947 State Route 172
Lisbon, Ohio 44432

~~~~~  
**FOR CCBDD USE ONLY**

\_\_\_\_\_  
**Superintendent's Signature**

\_\_\_\_\_  
**Date**

**Columbiana County Board of Developmental Disabilities  
35947 State Route 172  
Lisbon, Ohio 44432  
PHONE: (330) 424-0404  
FAX: (330) 424-1184**

**CONSENT TO TEST**

I: \_\_\_\_\_  
Parent/Guardian Name

Give my consent for an SSA representing Columbiana County Board of Developmental Disabilities to administer the Children's Ohio Eligibility Determination Instrument (C/OEDI) ages 6-16 or Ohio Eligibility Determination Instrument (OEDI) ages 16 or older to:

\_\_\_\_\_  
Individual's Name

To determine eligibility for Developmental Disabilities services and /or assistance where needed.

I understand that I may invite informants of my choice who could offer information or explanation that may be helpful to the tester in making a determination.

I have read this Authorization or it has been explained to me.

I have received a copy of the Columbiana County Board of Developmental Disabilities Notice of Privacy Practices – Effective April 14, 2003

I was offered an opportunity to register to vote.

*\*In compliance with policies and procedures of confidentiality pursuant to Rule 3301-52-02 of the Administrative Code and 34 CFR Regulation 99.3.\**

\_\_\_\_\_  
Signature of Client or Guardian Date

\_\_\_\_\_  
Signature of Guardian: Date

\_\_\_\_\_  
Witness Signature Date



Ohio Department of Job and Family Services/Columbiana County Board of Developmental Disabilities  
**VOTER REGISTRATION  
NOTICE OF RIGHTS AND DECLINATION**

County Department of Job and Family Services: **COLUMBIANA**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**If you are not registered to vote where you live now, would you like to apply to register to vote here today?**

- YES, I want to register to vote or update my voter registration today
- No, I do not want to register to vote today
- I am currently registered to vote and my registration information is current and accurate
- I am not eligible to vote due to court determination of incompetency, I am underage or I am not a citizen

**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

*Applying to register or declining to register will not affect the amount of assistance that you will be provided by this agency.*

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

|                  |                                                                                |
|------------------|--------------------------------------------------------------------------------|
| Signature: _____ | Name of CCBDD individual assisting you today:<br><b>Patricia E. Homan, SSA</b> |
|------------------|--------------------------------------------------------------------------------|

(This portion to be retained by agency)

----- ✂ -----  
(This portion to be given to applicant/recipient)

Date: \_\_\_\_\_

If you have not received any verification of your voter registration from the county board of elections in which you reside within 21 days from the date you registered, you may inquire about the status of your registration by contacting your county board of elections. ( 7989 Dickey Drive Suite 3, Lisbon, Ohio 44432-8394-----330-424-1448)

If you think that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or political preference, you may file a complaint with the prosecuting attorney of your county or with the Secretary of State:

**Ohio Secretary of State  
180 East Broad Street  
Columbus, Ohio 43125  
(616) 466-2585  
Toll Free: (877) 868-3874**

|                                                                                           |
|-------------------------------------------------------------------------------------------|
| <b>County Prosecutor: Robert Herron</b>                                                   |
| <b>Address of County Prosecutor:<br/>105 South Market Street, Lisbon, Ohio 44432-1295</b> |
| <b>Phone Number of County Prosecutor: 330-424-6677</b>                                    |





# Notice of Privacy Practices

## Columbiana County Board of Developmental Disabilities

### FOR YOUR PROTECTION

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. It also describes our practices about Robert Bycroft School records.

### YOUR RECORDS ARE PRIVATE

We understand that information we collect about you or your child and records of the services and supports we provide, are personal. Keeping these records private is one of our most important responsibilities. The Board must follow many laws to protect your privacy. For the Robert Bycroft School records, we follow the federal FERPA laws. For adult services, and certain services for children, we follow the federal HIPAA laws. In addition, we follow many laws specific to Ohio Department of Developmental Disabilities Boards. For this notice, we will use the term "records" to mean the paper or electronic records we maintain about you.

Your records may be used and disclosed by the employees and volunteers at the Board who serve you, as well as persons or agencies who work for us and sign strict confidentiality contracts.

Our organization includes [Robert Bycroft School] [Adult Senior Center] [EDI Central] [EDI South] [Beaver Creek Candle Co.] [SSA Department] [Transportation Department] [CCBDD Administration] [Service Coordination] [Adult Services] [Residential] [Early Intervention].

At Robert Bycroft School, for example, records may be shared with "school officials" who have a "legitimate educational interest" in your child. "Educational interest" means any matter related to your child's instruction, developmental or behavioral support, dietary, health or safety. "School officials" include teachers, paraprofessionals, aides, bus drivers and administrators at Columbiana County Board of Developmental Disabilities.

### WHO USES AND DISCLOSES MY RECORDS?

In general, we use and disclose your information:

- For teaching, behavioral and medical support, transportation and school administration. For example, a school administrator will review progress data created by teachers.
- To provide the full range of services we provide: early intervention, habilitation, supported employment, and other services. For example, your service and support administrator will review your records to create an individual service plan, which may be shared with you, your guardian, and other individuals involved with providing services and supports to you.
- To get payment for services provided,
- For other operations to operate and manage the board: these include improving quality of care, training staff, managing costs, and conducting other business duties. For example, a quality assurance reviewer may audit your records to determine whether appropriate services were provided, and
- To remind you or a guardian of an appointment for services.

There are limited situations when we are permitted or required to disclose your records, or parts of them, without your signed permission. These situations include:

- Record transfers to other schools your child enrolls in,
- Reports to public health authorities to prevent or control disease or other public health activities,
- To protect victims of abuse, neglect, or domestic violence,
- For oversight including investigations, audits, accreditation and inspections, such as are conducted by the Ohio Department of Developmental Disabilities and federal agencies,
- When a court order, subpoena or other legal process compels us to release information,
- Reports to law enforcement agencies when reporting suspected crimes, when responding to an emergency, or in other situations when we are legally required to cooperate,
- In connection with an emergency, or to reduce or prevent serious threat to public health and safety,
- To coroners, medical examiners and funeral directors,
- To victims of alleged violence or sex offenses,
- For workers' compensation programs,
- For specialized government functions including national security, protecting the president, operating government benefit programs, and caring for prisoners,
- In connection with "whistleblowing" by an employee of the Board.

### COULD MY RECORDS BE RELEASED WITHOUT MY PERMISSION?

All other uses not described above require that we obtain your signed permission.

WHAT IF MY RECORDS NEED TO GO SOMEWHERE ELSE

For any purpose not described above, we will release your information only with your explicit written authorization. Federal law requires that we notify you that any healthcare provider must obtain your explicit permission to release your information for any of the following:

1. Psychotherapy Notes will only be released with your signed authorization;
2. For marketing purposes;
3. To sell information about you.

It has never been the board's practice to release information for marketing purposes or to sell your information. Your written authorization tells us what, where, why and to whom the information must be sent. Your signed authorization is good until the expiration date you specify. You can cancel your permission at any time by letting us know in writing.

You have legal rights concerning your privacy, access to your records, and the accuracy of your records. You have the following rights:

1. To see your records, or to get a copy, including an electronic copy;
2. To request a correction to your records if you believe they are incorrect;
3. To receive all communications at a confidential address or phone number;
4. To receive an "accounting of disclosures", that is, a list of any place we sent your record without your authorization;
5. To request additional limits on how we use or disclose your information, although we are not obliged to honor these requests except that if you choose to personally pay for services delivered, we will not bill Medicaid.
6. You may receive a paper copy of this notice.

WHAT ARE MY RIGHTS REGARDING PRIVACY, ACCESS TO MY RECORDS, AND THE ACCURACY OF MY RECORDS?

To exercise any of these rights, or if you have any questions or complaints regarding our privacy practices, call, deliver, mail or email your request to:

HIPAA Compliancy Officer  
Columbiana County Board of DD  
7675 State Route 45  
Lisbon, OH 44432  
(330) 424-7788  
[ccbdd@spii.net](mailto:ccbdd@spii.net)

Ask any employee if you need help in putting your request in writing.

OUR DUTIES

We are obligated by law to maintain the privacy of your information and to provide this notice. In the event of a breach, that is, an improper disclosure of your information, we are required to notify you. We are required by law to abide by the terms of this notice. From time to time we may make changes to our policies, and if and when we do, your records will be protected by our new, changed policies. Our current notice will always be available on our website.

QUESTIONS OR COMPLAINTS?

If you have any questions or complaints about our privacy practices, please contact us:

Attn: HIPAA Compliancy Officer  
Columbiana County Board of DD  
7675 State Route 45  
Lisbon, OH 44432  
(330) 424-7788

We will never retaliate against you for filing a complaint. Further, if you are not satisfied with the results, you may also complain to the federal government:

**For School issues:**

Family Policy Compliance Office  
U.S. Department of Education  
400 Maryland Avenue, SW  
Washington, D.C. 20202

**For any other issues:**

Secretary of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201  
[www.hhs.gov/ocr/privacy/hipaa/complaints/index.html](http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html)

**Columbiana County Board of Developmental Disabilities (CCBDD) – Authorization Form**

Columbiana County Board of DD  
7675 State Route 45  
Lisbon, OH 44432  
330-424-7788

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name of Individual Served \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize CCBDD to:

Release to: \_\_\_\_\_ Obtain from: \_\_\_\_\_

The following information:

- Assessment and diagnosis (MFE)
- Treatment and progress
- Social History
- Psychological Test results
- Other \_\_\_\_\_

The following information:

- Assessment and diagnosis (MFE) (F.E.D.)
- Treatment and progress
- Most current IP (ISP, IEP, IHP)
- Psychological Test results
- Results of recent physical examination
- Other Include medications list with frequency, dose, purpose; list diagnoses

The purpose of this disclosure is

- Coordination of care
- Requested by Individual Receiving Services, or guardian/parent
- Other \_\_\_\_\_

- 1) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
- 2) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
- 3) The CCBDD does not require that I sign this authorization in order to receive services.

Expiration Date:

- 90 days from date signed
- other date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by someone other than the Individual being served:

Print Name: \_\_\_\_\_

- Authority to sign:  Parent or Guardian  
 Appointed by Individual as HIPAA Personal Representative  
 Other \_\_\_\_\_

For staff use (complete the following steps and indicate by a check. Name of Staff Person \_\_\_\_\_)

- Copy of signed authorization given to Individual / Parent / Guardian
- Copy of records released given to individual / Parent / Guardian (if requested)
- Disclosure logged on Disclosure Log
- Revocation received on \_\_\_\_\_ and acted upon.



**Columbiana County Board of Developmental Disabilities (CCBDD) – Authorization Form**

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- \_\_\_ Treatment and progress
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- \_\_\_ Psychological Test results
- \_\_\_ Other \_\_\_\_\_

The following information:

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- \_\_\_ Psychological Test results
- Results of recent physical examination
- Other Include medications list with frequency, dose, purpose; list diagnoses

The purpose of this disclosure is

- \_\_\_ Coordination of care
- \_\_\_ Requested by Individual Receiving Services, or guardian/parent
- \_\_\_ Other \_\_\_\_\_

- 4) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
- 5) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
- 6) The CCBDD does not require that I sign this authorization in order to receive services.

Expiration Date:

- \_\_\_ 90 days from date signed
- \_\_\_ other date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by someone other than the Individual being served:

Print Name \_\_\_\_\_

- Authority to sign: \_\_\_ Parent or Guardian
- \_\_\_ Appointed by Individual as HIPAA Personal Representative
- \_\_\_ Other \_\_\_\_\_

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- 8) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
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Treatment and progress

Treatment and progress

Social History

Most current IP (ISP, IEP, IHP)

Psychological Test results

Psychological Test results

Other \_\_\_\_\_

Results of recent physical examination

Other \_\_\_\_\_

The purpose of this disclosure is

Coordination of care

Requested by Individual Receiving Services, or guardian/parent

Other Eligibility determination for DD services

- 10) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
- 11) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
- 12) The CCBDD does not require that I sign this authorization in order to receive services.

Expiration Date:

90 days from date signed

other date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

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Appointed by Individual as HIPAA Personal Representative

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other date: \_\_\_\_\_

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