

# *Center for Family Development*



*Serving the community since 1991*

## **Recovery Program Orientation Packet**

# INDIVIDUAL'S COPY

CENTER FOR FAMILY DEVELOPMENT  
1258 HIGH STREET  
EUGENE, OREGON 97401

## Consent for Services

### Entry & Assessment

- As part of my request for services with Center for Family Development (CFD), I authorize clinical staff to complete an assessment and provide services and supports.
- My request for services from CFD is voluntary and I may discontinue services at any time.
- I may ask questions at any time.

### Treatment for Adolescents

- If I am an adolescent age 14 or older, I have the right to access services without consent from my parent/guardian.
- My parent/guardian will be involved before the end of services unless they refuse or there are clear clinical reasons not to involve them, which will be documented in my record.

### Service Planning

- I will be involved in the creation of my Service Plan and will continue to be involved in changes made throughout the duration of services with CFD.

### Risks & Benefits

- There may be periods during therapy that may result in emotional discomfort, changes in relationships and temporary worsening of symptoms. The goal and intended benefit of services and supports is the resolution of the presenting problem.

### Supervision

- My therapist is supervised by a Clinical Supervisor.
- I may access my therapist's immediate supervisor upon my request should I experience concerns or wish to express a grievance.
- My therapist and their supervisor will keep my information confidential.

### Therapeutic Privilege

- I am the holder of privilege within the therapeutic setting. Information that is discussed during services is confidential and no information about my case can be released to anyone outside CFD without written authorization from me, except as stated below.

### Mandatory Reporting

- If, during services, I reveal to my therapist past or threatened abuse of a person who is in a protected category, whether that person is myself or another individual, my therapist must disclose and report such information as required by Oregon law. Individuals in the protected categories are children, elderly persons, developmentally disabled persons, and persons receiving mental health services covered by Oregon Health Plan or other public funding.
- If I threaten to harm myself or others, CFD is required to intervene, which may include a report to the appropriate agency and/or authority.
- In the event of threatened harm to any individual, my therapist may warn the intended victim(s) by the most efficient means available.

### Release of Information

- CFD may communicate with other physical and behavioral health providers involved in my care. This communication may include the sharing of physical and mental health charts. The purpose of this communication is to provide me with quality, integrated healthcare and to ensure all of my health needs are being addressed by those involved in my care.
- In cases of medical emergency, CFD may access emergency medical treatment on my behalf. Information may be released to the attending emergency workers but will be limited to only information that is necessary to resolve the situation. Any information shared will be documented in my record.
- In cases of psychiatric hospitalization, information about mental health status prior to hospitalization and information judged to be helpful in service conclusion planning may be released. Any information shared will be documented in my record.
- If a child abuse investigation is being conducted, CFD is required under Oregon law to permit the investigating agency to inspect and copy records of the child involved in the investigation without the consent of the child or the parent/guardian of the child.
- If I have concerns about my information being released, I may submit a "Request for Restriction on Use/Disclosure of Clinical Information."

### Legal Proceedings and Release of Records

- If I am involved in or anticipate being involved in legal or court proceedings, I will notify my therapist as soon as possible to help them understand how, if at all, their involvement in these proceedings might affect our work together.
- If information regarding my therapy becomes an issue in a court proceeding, the Judge may decide to order my confidential information be disclosed.
- My therapist or other CFD staff will not volunteer confidential information within a court proceeding without my written permission.
- Should a Judge order a disclosure of information regarding my therapy services, CFD staff will obey such an order.

### Access to Records

- I have the right to view and request copies of my record by written request, unless CFD determines access to my records would likely be harmful to my well-being, in which case a copy may be denied.
- If I request copies of my record, I may be asked to pay for copy costs and staff time. I will not be denied access to my record because of inability to pay.

### Psychological Evaluation

- An assessment and services and supports are not a substitute for a psychological evaluation. CFD does not conduct psychological evaluations.
- My therapist is available to discuss the difference between an assessment, a psychological evaluation and services and supports.

### Third Party Payer

- If I am covered by a third-party payer, I authorize billing to my health plan and payment of benefits directly to CFD.
- If I am covered by Oregon Health Plan, I am not required to pay for services provided to me.
- My information may be reviewed by my health plan, including the Oregon Health Authority or the local coordinated care organization, for funding authorization of services, quality improvement, utilization management and site review purposes.

### Information Provided at Intake

- I received a copy of the following information at intake: Consent for Services, Statement of Individual Rights, Notice of Privacy Practices, Grievance Procedure, Voter Registration Information, Tobacco Cessation Information, CFD Program-Specific Information, No Show/Late Show Policies, and Declaration for Mental Health Treatment.

### Scheduling and Cancellations

- I agree to keep scheduled appointments with my therapist.
- I will provide at least 24 hours advance notice if I need to cancel an appointment.
- I understand if I miss multiple appointments, services may discontinue.

CFD provides services to all individuals who are eligible regardless of race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, marital status, disability, or other factors prohibited by law or regulation, except when program eligibility is restricted to children, adults, or older adults, familial status, marital status, source of income, and disability.

My signature affirms that I have read and understand this form and have had the opportunity to ask questions.

## Statement of Individual Rights

In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

- A. Choose from services and supports that are consistent with the assessment and service plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for the greatest degree of independence;
- B. Be treated with dignity and respect;
- C. Participate in the development of a written service plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and receive a copy of the written service plan;
- D. Have all services explained, including expected outcomes and possible risks;
- E. Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50;
- F. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
  - Under age 18 and lawfully married;
  - Age 16 or older and legally emancipated by the court; or
  - Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.
- G. Inspect their service record in accordance with ORS 179.505;
  - Requests must be made in writing. CFD will provide copies within a reasonable timeframe.
  - The individual may be asked to pay for material costs and staff time to locate and copy the record, though access will not be denied because of inability to pay;
  - If the release of the record would be harmful to services, access may be denied;
  - The inspection of the record must take place in the presence of the therapist or other clinical staff;
  - If errors are found in the record, the individual may request an amendment;
- H. Refuse participation in experimentation;
- I. Receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence;
- J. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
- K. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
- L. Have religious freedom;
- M. Be free from seclusion and restraint;
- N. Be informed at the start of services and periodically thereafter of the rights guaranteed by this rule;
- O. Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented;
- P. Have family and guardian involvement in service planning and delivery;
- Q. Have an opportunity to make a declaration for mental health treatment, when legally an adult;
- R. File grievances, including appealing decisions resulting from the grievance;
- S. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
- T. Exercise all rights set forth in ORS 426.385 if the individual is committed to the DHS; and
- U. Exercise all rights described in this rule without any form of reprisal or punishment.

## CENTER FOR FAMILY DEVELOPMENT NOTICE OF PRIVACY PRACTICES

This notice describes how clinical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY

*If you have any questions about this notice, please contact CFD's Contact Person, Shanti Rios at 1258 High Street, Eugene, OR 97401, 541/342-8437.*

### Who Will Follow This Notice

This notice describes the privacy practices followed by all CFD employees.

### Your Health Information

This notice applies to the information and records we have about your health, status, and the health services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, diagnoses, services, procedures, and similar types of health-related information.

*We are required by law to give you this notice.* It will tell you about the ways in which we may use and disclose protected health information (PHI) about you and describe your rights and our obligations regarding the use and disclosure of that information.

### How We May Use and Disclose Health Information About You Without Your Authorization

**For Treatment.** We may use health information about you to provide you with clinical services. We may disclose health information about you to other health care providers who are involved in your services. For example, information may be shared to create and carry out a plan for your services.

**For Payment.** We may use and disclose health information about you to get payment or to pay for the services you receive. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a service you are going to receive to obtain prior approval or to determine whether your plan will pay for services.

**For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other clients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you or to help us decide what additional services we should offer.

**Required By Law and for Law Enforcement.** We will disclose health information about you when required to do so by federal, state or local law or in response to a court order.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others.

**For Drug and Alcohol Program Clients:** Federal and State law require your written consent each time we release health information. The Consent will specify who is to receive the information, the purpose of the release of information, and a time period after which the Consent will terminate. You may change or cancel a Consent at any time. However, if we are unable to fulfill our requirements related to services, payment or health care operations, we may choose to discontinue providing you with health care services.

*In most instances, we will need specific, written authorization from you in order to disclose mental health information; drug/alcohol diagnosis, treatment or referral information; HIV/AIDS information; or genetic testing information, including situations listed below.*

### Uses and Disclosures in Special Situations

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations. Please notify us if you do not wish to be contacted for appointment reminders, or if you would not like to receive information about other health services. If you advise us **in writing** that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

**Appointment Reminders.** We may contact you as a reminder that you have an appointment for services at our office.

**Alternative Health Services.** We may tell you about other possible service options that may be of interest to you.

**Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your written permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

**Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. This is not relevant for clients in the Adult and Youth Recovery Programs.

**Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

**Family and Friends.** We may disclose health information about you to your family members or friends if you so choose. In addition, we may assume you agree

to our disclosure of your personal health information to your spouse when you bring your spouse with you into the room during services or while services are discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room of your health status.

#### Other Uses and Disclosures Require Your Written Authorization

We will not use or disclose your health information for any purpose other than those listed above without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may cancel that *Authorization*, **in writing**, at any time. If you cancel your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures made before your cancelled the *Authorization*.

#### Your Privacy Rights

##### Right to Inspect and Copy

- In many cases, you have the right to look at and copy your health information, such as clinical records that we keep.
- You must submit a written request to CFD's Contact Person, in order to look at and/or copy records. We may charge a fee for the costs of copying, mailing or supplies.
- We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

##### Right to Amend.

- If you believe health information we have about you is incorrect or incomplete, you may ask us to correct or update the information. You have the right to request this change as long as the information is kept by this office.
- To request an amendment, complete and submit a "Clinical Record Amendment/Correction Form" to CFD's Contact Person.
- We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. If your request is denied, 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. In addition, we may deny your request if you ask us to amend information that:
  - We did not create, unless the person or agency that created the information is no longer available to make the change
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

##### Right to a List of Disclosures

- You have the right to request a list, or an "accounting" of disclosures. This is a list of the disclosures we made of clinical information about you for purposes other than treatment, payment, health care operations, and the special circumstances involving national security, correctional institutions and law enforcement listed above. The list will not include the disclosures that were made with your written authorization.
- To obtain this list, you must submit your request **in writing** to CFD's Contact Person. It must state a time period, which may not be longer than seven years and may not include dates before April 14, 2003. Your request should indicate how you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you can decide if you want the list or not.

##### Right to Request Restrictions.

- You have the right to request a limitation on the health information we use or disclose about you for treatment, payment or health care operations. For example, you could ask that we not use or disclose specific information to a particular party.
- **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency services.
- To request restrictions, you may complete and submit the "Request for Restriction on Use/Disclosure of Clinical Information" to CFD's Contact Person.

##### Right to Request Confidential Communications.

- You have the right to choose how we communicate with you. For example, you can ask that we only contact you at work or by mail.
- To request confidential communications, you may complete and submit the "Request for Restriction on Use/Disclosure of Clinical Information and/or Confidential Communication" to CFD's Contact Person. You do not have to explain the reason for your request. We will accommodate all reasonable requests. Your request should state how you would like to be contacted by us.

##### Right to a Paper Copy of This Notice.

You will be given a copy of this notice. If you have not received a copy of it, you may request a copy at any CFD office location.

#### Changes to This Notice

Changes may be made to this notice. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

#### Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Shanti Rios, Assistant Director / Contact Person at 1258 High Street, Eugene, OR 97401 or 541/342-8437. You will not be penalized for filing a complaint.

# Center for Family Development Crisis Services

**541/342-8437**

Center for Family Development's (CFD) telephone is answered 8:00 am to 5:30 pm. After hours, there is an answering service who takes calls. In the case of a crisis, the Receptionist or answering service will contact your assigned therapist. If your therapist can not be reached, the on-call therapist will be contacted.

## Other Crisis Resources

(These crisis resources should be contacted only after CFD's on-call system has been utilized.)

White Bird Crisis Line: **541/687-4000**

Children & Adolescent Crisis Response Program: **888/989-9990**

If case of a medical emergency, call 9 1 1.

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# Servicios para Crisis

**541/342-8437**

El teléfono de CFD es contestado desde las 8:00 de la mañana hasta las 5:30 de la tarde. Después de estas horas, hay un servicio de contestación que recibe las llamadas. En caso de una crisis, la Recepcionista o servicio de contestación contactara a su terapeuta.

## Otros Recursos de Crisis

(Estos recursos de crisis deben ser contactados solo después de que el Sistema de Llamadas de guardia de CFD haya sido utilizada.)

White Bird Linea de Crisis: **541/687-4000**

Programa de Respuéstas a Crisis para Niños  
y Adolescentes: **888/989-9990**

En caso de una emergencia médica, llamar al 9 1 1

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### **No Show, Late Show and Late Cancellation Policies**

To ensure appropriate and consistent service, it is important that you attend all scheduled appointments.

If you are unable to attend any scheduled appointment, please call 541-342-8437 at least 24 hours in advance to cancel.

#### **No Show Policy**

**1<sup>st</sup> No Show:** If you do not call at least 24 hours ahead and/or do not show for an appointment, your therapist will call you to remind you of the agency's no show policy and will discuss any barriers to attendance.

**2<sup>nd</sup> No Show:** You may lose your standing appointment and/or not be able to schedule another appointment. You may need to call to see if an appointment is available that day.

**3<sup>rd</sup> No Show:** Your file may be closed.

#### **Late Show Policy**

If you arrive more than 15 minutes past your scheduled appointment time, your therapist may no longer be available to see you and you may need to reschedule.

#### **Late Cancellation Policy**

A late cancellation (cancelled in less than 24 hours of scheduled appointment) will be considered the same as a no show.

After three (3) no shows and/or late cancellations, your file may be closed.



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**Grievance Process Notice**

One of your rights as an individual receiving services and supports from Center for Family Development (CFD) is to express concerns or file a grievance. It is CFD's policy to settle grievances within 30 calendar days and in the easiest way so that you will feel satisfied. You have the right to file a grievance without being afraid of threats or retaliation of any kind. Your grievance will be handled in a confidential manner.

If you need to express a concern, please contact our office at **541-342-8437** and you will be directed to CFD's Quality Management Coordinator, who will address your concerns directly or discuss them with a supervisor.

If you wish to file a written grievance, please request a Grievance Form from the front office or mail your grievance in a letter to the Quality Management Coordinator. Be sure to include the result that you want.

**Would you like assistance understanding or completing the grievance process?  
Just ask and someone will be available to help.**

<b>CALL THESE NUMBERS FOR HELP</b>	
<i>Center for Family Development</i> 541-342-8437	<i>Disability Rights Oregon</i> 800/452-1694
<i>The Governor's Advocacy Office</i> 541-945-6904	<i>Oregon Health Authority Ombudsperson</i> 877/642-0450
<b>If you have Trillium Community Health Plan:</b> <i>Trillium Member Services</i> 541/485-2155 Toll-free: 800/910-3906 Toll-free TTY: 866/279-9750	

**Expedited Review:** You may request an expedited review if the matter of the grievance is likely to cause you harm before the grievance process timeline of 30 days. The Quality Management Coordinator will review your grievance and respond in writing within 48 hours of receiving the grievance. The written response will include information about the appeal process.

**Appeal Process:** If you are not satisfied with the decision, you may request an appeal within 10 working days of receiving the Quality Management Coordinator's response. Contact the Governor's Advocacy Office or Oregon Health Authority at the numbers listed above. You will receive a written response to your appeal within 10 working days of receiving your request. If you are not satisfied with the appeal decision, you may request a second appeal.

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GRIEVANCE FORM

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

Date of Birth: \_\_\_\_\_

Parent or Guardian Name (if applicable): \_\_\_\_\_

Name of Therapist: \_\_\_\_\_

Please describe the nature of your grievance (You may use other pages, if necessary, or attach documents): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

What do you think should be done to resolve this grievance? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have discussed this concern with a CFD staff member, name of staff member: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of person filing grievance

\_\_\_\_\_  
Date

## THIS INFORMATION APPLIES TO ADULTS ONLY:

### Declaration for Mental Health Treatment

Center for Family Development is required to inform you that you have the right and opportunity to make a Declaration for Mental Health Treatment.

A Declaration for Mental Health Treatment lets health care professionals know your preferences regarding mental health care treatment if you are ever unable to make these decisions for yourself. It also allows you to name a person to advocate for your choices.

If you would like to more information, talk to your therapist. Your therapist can give you a copy of **A Guide to Oregon's Declaration for Mental Health Treatment**.

The form can also be found online at [www.oregon.gov/oha/amh/forms/declaration.pdf](http://www.oregon.gov/oha/amh/forms/declaration.pdf)

### Voter Registration

Center for Family Development is required to inform you that you have the right and opportunity to register to vote. If you are not already registered to vote, registration forms and information can be found in the lobby or by speaking with the receptionist. After you complete the form, the receptionist can mail it for you.

**Authorization to Use and Disclose Protected Health Information**

\_\_\_\_\_  
(Name of individual for whom records or information is to be disclosed)

\_\_\_\_\_  
(Date of Birth)

**Select One:**     Exchange information with                       Provide information to                       Receive information from

**Authorized Agency or Individual Name:** \_\_\_\_\_

**Phone/Fax:** \_\_\_\_\_

**Information to be Disclosed:**

I authorize Center for Family Development to release the following information from my records, unless restricted as below.

Please **initial** those that apply:

- \_\_\_\_\_ Mental health information  
\_\_\_\_\_ Drug/alcohol diagnosis, treatment, or referral information  
\_\_\_\_\_ HIV/AIDS information  
\_\_\_\_\_ Genetic testing information

**Restrictions (optional):**

Include ONLY the following information: \_\_\_\_\_

**The purpose of this disclosure is to:**

Coordinate services     Fulfill individual's/guardian's request     Other: \_\_\_\_\_

I understand that my records are protected by State Law (ORS 192.553-192.581, ORS 179.505) and Federal privacy regulations in the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 & 164. I understand that the information specified above will be disclosed based on this authorization.

For individuals involved in CFD's Recovery Program, confidentiality of this record is protected by Federal Law 42 CFR Part 2. Any information that identifies an individual as involved in the Recovery Program cannot be disclosed without written consent except in limited circumstances as specified in these regulations. Federal Law 42 CFR Part 2 prohibits unauthorized disclosure of Recovery Program records.

I understand that CFD has no control over possible re-disclosure of the information by the receiving agency or individual. I understand that CFD may not condition services, payment, enrollment in the health plan, or eligibility for benefits on whether I sign this Authorization.

I understand that this Authorization may be revoked in writing at any time, except to the extent that action has been taken prior to revoking it. Should I decide to revoke this Authorization prior to its expiration, I understand that I must do so in writing by submitting notification to my therapist or to the CFD Records Custodian. Unless revoked, this Authorization shall remain in effect until **90 (ninety) days following service conclusion.**

**Select One:**     I do NOT want a copy of this Authorization     I am being provided with a copy of this Authorization

**I understand that my signature below authorizes a disclosure of information and records between the above designated parties.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

**Definition of Personal Representative:**

**For Adults:** A person with legal authority to make healthcare decisions on behalf of the adult. Supporting documentation required.

**For Youth:** A parent, guardian, or other person acting in the place of a parent with legal authority to make healthcare decisions on behalf of the minor child. Supporting documentation may be required.

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Relationship to Individual

\_\_\_\_\_  
Staff Initials

## Facts About Tobacco Use

- Tobacco addiction is the most common addiction in the United States
- For every 5 deaths per year in this country, at least 1 is due to smoking
- Smoking causes 9 out of 10 cases (90%) of lung cancer.
- Smoking causes nearly all cases of chronic obstructive pulmonary disease (COPD), chronic asthma/bronchitis or emphysema.
- Smokers are twice as likely to die from stroke or heart attack, compared to non-smokers.
- Smokers miss more days of work than non-smokers.
- Smoking is also a risk factor for cancer of the mouth, throat, stomach, pancreas, kidney, bladder, cervix, liver, esophagus, uterus, colon, and leukemia.
- Each day, nearly 6,000 children under 18 years of age start smoking; of these, nearly 2,000 will become regular smokers. That is almost 800,000 annually.
- Approximately 90 percent of smokers begin smoking before the age of 21.
- Adolescents who smoke regularly can have just as hard a time quitting as long-time smokers.
- Of adolescents who have smoked at least 100 cigarettes in their lifetime, most of them report that they would like to quit, but are not able to do so.

## Quitting Tobacco: Handling Cravings... Without Smoking

### Nicotine and Your Body and Mind

- As a smoker, you are used to having a certain level of nicotine in your body. You control that level by how much you smoke, how deeply you inhale the smoke, and by the kind of tobacco you use. When you quit, cravings develop when the body wants more nicotine.
- When you are exposed to smoking triggers or even when you use a small amount of nicotine, your mood changes, and cravings for tobacco can go up as well as your heart rate and blood pressure. Cravings are NOT "just in your head."

### What To Expect

- Cravings usually begin within an hour or two after you stop smoking, peak for several days, and may last several weeks.
- The urge to smoke will come and go. Your cravings will be strongest in the first week after you quit using tobacco. Cravings usually last only a very brief period of time.
- You may also experience cravings that follow each other in rapid succession. As the days pass, the cravings will get farther apart. There is some evidence that mild occasional cravings may last for 6 months.

### What To Do

- Remind yourself that cravings will pass.
- As a substitute for smoking, try chewing on carrots, pickles, sunflower seeds, apples, celery, or sugarless gum or hard candy. Keeping your mouth busy may stop the psychological need to smoke.
- Try this exercise: Take a deep breath through your nose and blow out slowly through your mouth. Repeat 10 times.
- Avoid situations and activities (like drinking alcohol) that you normally associate with smoking.

### Nicotine Replacement Options

- Nicotine cravings may be reduced by using nicotine replacement products, which deliver small, steady doses of nicotine into the body.
- Nicotine replacement patches, gum, lozenges, nasal spray, and inhaler appear to be equally effective.
- Prescription medications and alternative methods, such as hypnosis, acupuncture and acupressure have shown to be helpful in controlling cravings.

### How To Get Help

- Develop a plan to stop smoking with your CFD therapist.
- Contact Oregon Tobacco Quit Line (877) 270-7867/ [www.oregonquitline.org](http://www.oregonquitline.org)

This fact sheet was adapted from material developed by the Tobacco Education and Prevention Program of the Arizona Department of Health Services and the Arizona Smokers' Helpline of the University of Arizona.

## LOW-COST or FREE MEDICAL SERVICES

<b>Charnelton Community Clinic</b> (Community Health Centers of Lane County)	All ages	541-682-3550 151 W 7 <sup>th</sup> Ave, Suite 100, Eugene <a href="http://www.lanecounty.org/chc">www.lanecounty.org/chc</a>	Maternal/child health information and home visits; maternity case management/referral; WIC services; child and adult immunization appointments; communicable disease prevention; HIV counseling and testing, and sexually transmitted disease appointments. Sliding-fee scale to zero.
<b>Riverstone Clinic</b> (Community Health Centers of Lane County)	All ages	541-682-3550 2073 Olympic St, Springfield <a href="http://www.lanecounty.org/chc">www.lanecounty.org/chc</a>	Offers primary medical care, pediatric care, behavioral healthcare, family planning services and Healthy Kids/OHP enrollment. LTD Bus Routes 13 and 18.
<b>Lane County Behavioral Health Primary Care</b> (Community Health Centers of Lane County)	All ages	541-682-3608 2411 Martin Luther King Jr Blvd, Eugene <a href="http://www.lanecounty.org/chc">www.lanecounty.org/chc</a>	Services include treatment for children, families, and adults. Services can be accessed through a variety of programs focusing on mental health issues. Lane County Behavioral Health Services is a public mental health provider receiving funding from state mental health grants and client fees.
<b>Volunteers in Medicine Clinic</b>	Adults	541-685-1800 2260 Marcola Rd, Springfield <a href="http://www.vim-clinic.org">www.vim-clinic.org</a>	Free health care services to adults with low incomes and no insurance whose income falls between 85 – 200 percent of the federal poverty level. Qualified individuals receive free primary care and mental health services, prescriptions, lab testing, women’s health care, and more.
<b>White Bird Medical Clinic</b>	Adults	541-484-4800 1400 Mill St, Eugene <a href="http://www.whitebirdclinic.org">www.whitebirdclinic.org</a>	General family medicine (no prenatal): sliding-fee scale (mornings); full fees/some insurance (afternoons). Referrals, labs, dispensary. Call or come by for more information.
<b>Eugene School District 4J School Based Health Centers</b>	Up to age 19	North Eugene Health Center - 541-790-4445 South Eugene Health Center -541-790-8020 Churchill Health Center - 541-790-5227 Sheldon Health Center - 541-790-6644	Medical services to students and siblings enrolled in 4J. Call for appointments. Physicals; routine exams, including sports physicals; immunizations; vision/blood pressure screening; diagnosis/treatment of minor illness/injuries; reproductive care; tobacco/drug/alcohol prevention/cessation; mental health counseling. Insurance billed, including OHP; sliding-fee scale. No service withheld due to inability to pay. Call for appointments.
<b>Springfield Schools Health Center</b>	All ages	541-682-3550 1050 North 10 <sup>th</sup> St, Springfield	Comprehensive health care to Springfield students and their families, with uninsured children and adults seen on a sliding-fee scale based on the federal poverty level. Services at low cost to uninsured students: well or sick child checks, immunizations, injury/wound care, family planning, medication or contraceptive management and counseling. \$50 fee for sports physicals; \$15 administration fee for vaccines (free to students as needed). Assistance available to access OHP.

## LOW-COST or FREE DENTAL SERVICES

<b>Children's Dental Center/Assistance League of Eugene</b>	Children	541-790-5181 Churchill High School 1850 Bailey Hill Rd, Eugene	Dental care for area public school children from families with low incomes and no insurance.
<b>White Bird Community Dental Clinic</b>	Adults	541-344-8302 1415 Pearl St, Eugene <a href="http://www.whitebirdclinic.org">www.whitebirdclinic.org</a>	Dental care for Lane County residents on a sliding-fee scale; OHP accepted. Emergency clinics by lottery. On-going dental care by appointment. New patients must fill out screening paperwork. For clinic details and the most current information visit the website or call.
<b>Lane County Dental Society</b>	All ages	541-686-1175 2300 Oakmont Way, Suite 110, Eugene <a href="http://www.lanedentalsociety.org">www.lanedentalsociety.org</a>	Free dental information and referral. For details and the most current information visit the website or call.
<b>Lane Dental Clinic</b>	All Ages	541-463-5206 2460 Willamette St, Eugene <a href="https://www.lanecc.edu/dentalclinic">https://www.lanecc.edu/dentalclinic</a>	Low-cost, full-service dental clinic. Free evaluations; OHP accepted. The clinic is open to the general public with emphasis on adult patients who have not had regular preventive dental care. For details and the most current information visit the website or call.
<b>Caring Hands Worldwide</b>	All Ages	541-937-2786 <a href="mailto:randy@caringhandsworldwide.org">randy@caringhandsworldwide.org</a> P.O. Box 459 Lowell, OR 97405 <a href="http://www.caringhandsworldwide.org/national">www.caringhandsworldwide.org/national</a>	For individuals and families under 150% of the federal poverty level who do not have Oregon Health Plan or other insurance coverage and do not qualify for Care Credit and veterans without VA or other dental coverage. Services: cleanings, fillings, and extractions for all ages.



## Recovery Program Expectations

While involved in services in the Recovery Program, you are expected to:

- Participate in all services, including all assessment and evaluation procedures, group and individual sessions and educational components, to the best of your abilities.
- Help with service planning and be certain you understand all service goals and specific activities.
- Follow group guidelines. See group guidelines poster in group room.
- Abstain from use of alcohol and other non-prescribed mood-altering substances while in services.
- Tobacco use, in any form (including e-cigarettes), is not permitted on program facilities or grounds; if you wish to smoke, you must wait until session breaks and leave facility property.
- Not carry weapons while attending appointments. Guns, knives and weapons of any kind are banned on facility property.
- Provide urine samples when requested by treatment providers.
- Pay any service fees assessed, including insurance co-pays, at the time of appointment.
- Notify the agency of any intended absences from services at least 24 hours prior to the scheduled appointment. See no show policy.

Non-compliance with any of the above expectations can result in denial of services and may be grounds for termination from the Recovery Program. If you have any questions about these expectations, please ask your primary therapist for clarification.

## Important Urinalysis (UA) Information

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### Dilute UA Samples

- A dilute UA sample is caused by drinking a lot of liquid in a short time before giving the UA sample, or drinking a steady amount of water over a long period of time.
- When a sample is dilute, the lab cannot objectively determine whether there has been recent substance use.
- It is your responsibility to avoid providing dilute samples. These are the easiest ways to avoid dilute samples:
  - Drink less liquid in the 2-4 hours before providing a UA sample. The lab suggests drinking no more than two 8-ounce glasses of liquid in the two hours before providing a UA sample.
  - Eat a meal with high levels of protein about one hour before providing a sample. Protein can increase the level of creatinine in your system. The lab tests the amount of creatinine in your sample to determine whether it is dilute or not.
- If you are not carefully monitoring your liquid intake before providing a UA sample, you could provide a dilute sample.

### False Positive UA Results

- Products that contain alcohol, even trace amounts, can be detected in urinalysis tests.
- The lab cannot definitively determine whether someone has consumed products with trace amounts of alcohol, or whether the person has consumed alcohol recreationally. Due to this grey area, a positive UA result is considered positive regardless of circumstances.
- In addition to products with trace amounts of alcohol, other foods and medications can cause false positive UA results. For example, eating poppy seeds can cause a false positive result for morphine. We encourage you to:
  - Avoid eating poppy seeds while in treatment.
  - Check labels and ingredients on food and liquid packaging.
  - Check with doctors to find out if any medications contain chemicals that will be detected in urinalysis tests.
  - Make sure your therapist has a copy of your current medication prescriptions.

*Please talk with your therapist if you have questions or concerns about dilute UA samples or false positive UA results, or if you have questions about specific products, food, or medications.*

**\*\*\* FOR DUI PROGRAM CLIENTS \*\*\***

**If you are enrolled in CFD's DUI Program, a positive UA result without a valid prescription or a UA result of "specimen is dilute" will restart the time for your documented substance abstinence.**

### **CFD's Recovery Program Financial Suspension Policy**

1. Fees are due at the time of the assessment and at each service throughout treatment to avoid suspension from the program.
2. Monthly statements will be sent to you for any balance due. Payments are due by the 25<sup>th</sup> of each month. Suspension will take effect on the 26<sup>th</sup> of the month if a balance of \$400 or more is due.
3. If you are suspended from the program, it is important to note the following:
  - a. You must ensure that your account is paid in full (\$0 balance) **within 30 days** of the date of suspension to be reinstated into the program;
  - b. During the suspension period;
    - i. Any progress toward successful completion will be suspended and will resume upon reinstatement;
    - ii. You must provide a urine sample (UA) weekly. A positive UA result without a valid prescription or a UA result of "specimen is dilute" will restart the time for documented abstinence as outlined within the UA Authorization; and
    - iii. Continued payment will be required when a UA is completed. Costs are \$20 or \$35 per UA depending on test determined by therapist.
  - c. Following full payment of your balance, reinstatement will occur upon completion of a negative and non-dilute UA;
  - d. Failure to be reinstated will result in non-compliance and the file will be closed.

**If you experience financial hardship while engaged in services at CFD, please discuss with your therapist and/or CFD billing department to avoid financial suspension.**

## **Center for Family Development Adult Recovery Program Structure**

The following stages outline the treatment components for successful completion of Center for Family Development's treatment program.

### **Stage 1: Early Abstinence**

Purpose: To establish or solidify abstinence and begin to deepen the therapeutic process

Components:

- Participation in two group therapy sessions weekly.
- Individual sessions. Frequency to be determined by therapist. Family sessions included if applicable.
- Monitored UAs (may include ETG testing). Frequency to be determined by therapist.
- Engagement in at least one drug-free structured support activity.
- Participation in other health and wellness groups as appropriate.

### **Following at least 30 days verified clean time:**

### **Stage 2: Early Recovery**

Purpose: To sustain abstinence and address deeper recovery issues

Components:

- Participation in two group therapy sessions weekly.
- Individual sessions. Frequency to be determined by therapist. Family sessions included if applicable.
- Monitored UAs (may include ETG testing). Frequency to be determined by therapist.
- Engagement in at least one drug-free structured support activity.
- Participation in other health and wellness groups as appropriate.

### **Stage 3: Continued Recovery**

Purpose: To sustain abstinence as treatment services are decreased

Components:

- Participation in group as appropriate.
- Individual sessions every other week. Family sessions included if applicable.
- Monitored UAs (may include ETG testing). Frequency to be determined by therapist.
- Engagement in at least one structured support activity.

### **Successful Completion**

- Completion of service plan components.
- At least 30 days clean and sober, substantiated by UA results, self-report, and collateral report, as applicable.
- Completion of eight psychoeducational group sessions and at least eight skill-building and processing group sessions.
- Attendance of one tobacco cessation and one infectious disease education session as required by the State of Oregon.
- Regular involvement in at least one drug-free structured support activity.
- With understanding from referring body (e.g. DHS, PO).

# Center for Family Development

## DUII Program Information

(541) 342-8437

Center for Family Development (CFD) provides Information Only Treatment and/or Rehabilitation Treatment for individuals who have received a DUII.

### CFD's DUII Services Include:

- Initial Assessment
- Individual Therapy
- Weekly 2-hour DUII Group Sessions
- Urinalysis (UA) Testing
- Discharge and Relapse Prevention Planning
- Additional services based on need

### Program Specifics

- The frequency of individual sessions is determined with the assigned therapist at time of the initial assessment.
- Weekly group session attendance is mandatory.
- Weekly face-to-face contact is required by the court. Failure to maintain weekly face-to-face contact may result in a restart of 90 days of continuous abstinence.
- Failure to adhere to planned services, including attending individual and group appointments and participating in UA testing, could lead to termination and reporting as non-compliant.
- An individual will be required to restart 90 days of continuous abstinence when there is:
  - A UA test result that comes back positive or dilute
  - A self-report of substance use
  - an ADSS report of a positive interlock device result

### Program Costs

- CFD accepts Oregon Health Plan and some private insurance plans.
- If the insurance coverage does not cover treatment services, a \$325 monthly fee will be assessed.
- First payment is due at time of assessment, this includes insurance copays. Please call the Billing Department with any questions or to make a payment in advance of your scheduled appointment.
- Completion of treatment will occur after all fees are paid in full.

### Group Topics

- |  |   |
|--|---|
| Topic 1: Alternatives to Intoxicated Driving                                       | Topic 7: Use of Alcohol and Other Drugs & their effects on driving              |
| Topic 2: Therapist Choice  | Topic 8: Trigger and Coping Skill Development                                   |
| Topic 3: Physiological & Psychological Effects of Alcohol and Other Drugs of Abuse | Topic 9: SUDs Recovery Support Services   |
| Topic 4: Family Roles & Addictions   | Topic 10: Hazards of Addiction Switching/Tobacco & Vaping                       |
| Topic 5: Substance Use Disorders (SUDs) signs and symptoms: Cannabis               | Topic 11: DUII Laws & Consequences in Oregon; Blood Alcohol Concentration (BAC) |
| Topic 6: Social & Cultural Aspects of Substance Use                                | Topic 12: Decision making/thinking errors                                       |

### Successful Completion

Compliance with the following State of Oregon, referring Alcohol and Drug Screening Specialists (ADSS), and CFD program requirements will result in a successful completion:

- Demonstrated 90 days of continuous abstinence during the last 90 days of the program, verified by UA results.
- Completion of the 12 educational groups specified above.
- Payment of all fees in full. The DUII Treatment Completion Certificate, and DMV Certificate when applicable, will be processed once fees have been paid in full.

## Medical Marijuana Use in the Recovery Program

CFD's Recovery Program strongly suggests that individuals remain abstinent from all non-prescribed psychoactive substances, including cannabis, during the entire time in treatment. An OMMP Card is **not** a prescription for cannabis.

A Certificate of Completion will not be issued if cannabis use is evidenced by documented UA results and self-report within at least the last continuous 30 days.

A Certificate of Completion will only be issued when the following conditions are met:

1. The individual has a valid OMMP Card and a copy is in the individual's record.
2. The individual's PCP has provided written communication stating the medical purpose for cannabis use, and this communication is documented in the individual's record.
3. The individual does not have a current Cannabis Use Disorder (CUD) diagnosis. (The primary therapist will evaluate and monitor evidence throughout treatment, ruling in or out CUD diagnosis.)
4. DUII Program only: Written communication permitting the use of cannabis within an Oregon DUII Program is required at the time of the Recovery Program assessment. Written communication consists of approval by the individual's referral source (if services are mandated) and a court-authorization. This communication is documented in the individual's record.

**Even when all these conditions are met, a presiding judge may make the decision that cannabis cannot be used during treatment.**

## Interlock Device Installers

### Eugene

#### **Eugene #1 A LifeSafer of Oregon, Inc.**

995 Tyinn Street, Suite 5

Eugene, OR 97402

(800) 328-9890

[www.LifeSafer.com/oregon](http://www.LifeSafer.com/oregon)

#### **Eugene Full Throttle Custom – Advanced**

#### **AlcoholMonitoring by Guardian Interlock**

776 Powers Street, Suite B \*Financial Assistance  
Provided\*

Eugene, OR 97402

(800) 499-0994

[www.guardianinterlock.com](http://www.guardianinterlock.com)

#### **Interlock Experts – Alcohol Detection Systems, Inc.**

2508 Oakmont Way

Eugene, OR 97401

(800) 553-2794

(855) 443-3678

[www.interlockexperts.com](http://www.interlockexperts.com)

### Springfield

#### **Auto Sound Choice & Security – AutoSafe/Draeger Safety Diagnostics, Inc.**

2309 Main Street

Springfield, OR 97478

(800) 977-0091

[www.ignitioninterlock.biz](http://www.ignitioninterlock.biz)

#### **Caldwell's Automotive – Start Smart of Oregon**

2310 Main Street

Springfield, OR 97477

(800) 880-3394

(818) 206-0091

[www.SmartStartofOregon.com](http://www.SmartStartofOregon.com)

#### **Interlock Experts – Alcohol Detection Systems, Inc.**

3816 Main Street

Springfield, OR 97478

(800) 553-2794

(855) 443-3678

[www.interlockexperts.com](http://www.interlockexperts.com)

**CENTER FOR FAMILY DEVELOPMENT  
RECOVERY PROGRAM**

**RECOVERY PROGRAM GROUPS**

**SEE OUR AGENCY WEBSITE FOR CURRENT GROUP LISTINGS**