RYAN WHITE PART A ELIGIBILITY APPLICATION

ART 1: APPLICANT INFORMATION

CHECK IF YOU ARE HIV POSITIVE: ☐ YES ☐ NO ☐ UNKNOWN (PLEASE PROVIDE A COPY OF HIV LAB TEST THAT SHOWS STATUS)			
Date:	Ryan White Number (If have one):		
First Name:	Middle:	Last Name:	
Date of birth:	☐Male ☐Female ☐Transgender	Gender at Birth:	
Race ☐Asian ☐American Indian or Alaskan Native ☐Black or African American ☐White ☐Native Hawaiian or Pacific Islander ☐Other _____	Ethnicity ☐Hispanic ☐Not Hispanic	Language Spoken:	
Are you pregnant? ☐ Yes ☐ No ☐ Don't know			

PART 2: LIVING ARRANGEMENTS

Do you have a housing need? ☐ Yes ☐ No	Do you rent or own? ☐ Rent ☐ Own	Monthly Payment: $
Address where you currently live		
Street Address:		
City:	State:	Zip:
County:		
Mailing Address (if different)		
Street Address:		
City:	State:	Zip:
Home Telephone:	Work:	Other Contact:
Email:		
How many adults live with you? _____ How many children live with you? _____ (under 18 years of age)		
How do you prefer to be contacted? ☐ Home Phone ☐ Work Phone ☐ Other Contact Phone ☐ Mail ☐ Email _____ ☐ Other (specify)_____		

PART 3: MEDICAID AND OTHER INSURANCE PROGRAMS

Do you have an existing health insurance policy: ☐ Yes ☐ No	
If yes, Provide name of insurance company:	
If no, does your employer offer health insurance as a benefit? ☐ Yes ☐ No	If no, do you have proof from employer that insurance is not provided? (Proof shown) ☐ Yes ☐ No
Are you taking prescription drugs? ☐ Yes ☐ No If yes, please list:	
Screening for other programs: Please check if you are participating in one of the following programs; and bring the award letter, eligibility letter or card as proof. ☐ Medicaid ☐ Medicare ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Temporary Assistance for Needy Families (TANF) ☐ Women, Infants, and Children (WIC) ☐ Other:	
Do you have a Case Manager? ☐ Yes ☐ No	

Name:	Agency:	Phone:

RYAN WHITE PART A ELIGIBILITY APPLICATION

PART 4: HOUSEHOLD MONTHLY INCOME (GROSS INCOME)

Skip Part 4 If you have proof of eligibility for one of the above programs.

Are you a veteran? ☐ Yes ☐ No	Are you receiving veteran's benefits? ☐ Yes ☐ No

Household Income means gross income from all sources received by the applicant and the applicant's spouse (if married).

Name (First and Last)	Relationship of person to you	Monthly Work Income	Monthly Social Security	Monthly SSI Retirement Income	Unemployment, Child support, public assistance, other	Monthly Totals	Check if no income:
	Applicant						☐
							☐
							☐
							☐
							☐
							☐

If "no income" is checked: provide a statement as to how food, clothing, and shelter are being provided to you.	**Total Monthly Household Income:**

Do you have a checking account? ☐ Yes ☐ No	If yes, what is your current balance?	
Do you have a savings account? ☐ Yes ☐ No	If yes, what is your current balance?	
Name of Employer(s):		
Are you self-employed? ☐ Yes ☐ No	If yes, what type of business?	
Business Street Address:		
City:	State:	Zip:

PART 5: RIGHTS AND RESPONSIBILITES

Initial each item shown.	
	I understand that I am responsible for giving truthful and correct information on this application to the best of my knowledge. Failure to be truthful may prevent or delay a determination of eligibility to receive services.
	I understand that if I knowingly give information that is not true or withhold information and receive services that I am not eligible to receive, I may be lawfully punished and have to reimburse the Provider for services.
	I understand the information I provide may be verified that may include computer matching, and the information I give about my income may be checked.
	I understand that the information will be kept confidential in accordance with Florida and Federal law.
	I understand not all services I am eligible to receive may be available, accessible, or funded; and I may not meet specific program qualifications for some programs.
	I understand that at any time during the application process, I can be denied eligibility if my actions are uncooperative, disruptive of office procedures, threatening or hostile toward staff.
	I understand that the staff cannot discriminate because of race, color, sex, age, disability, religion, nationality, or political beliefs.
	I understand that I have the right to ask for a fair hearing if I think the decision of my case was unfair or incorrect.

SIGNATURES

Signature of applicant:	Date:

FOR ELIGIBILITY STAFF ONLY:
Eligibility Staff: _____
Date Determined Eligible: _____ Date of Appointment: _____
Date Referred to: Case Management _____ ADAP_____ Other _____
Date Determined Ineligible: _____ Date of Supervisory Review: _____
Fair Hearing Information was provided: ☐ Yes ☐ NO

CAREWARE DATA MANAGEMENT SOFTWARE AUTHORIZATION TO SHARE INFORMATION

Date:	**Service Provider Name:** CAN COMMUNITY HEALTH, INC.

By signing below, I _____ (your name) am aware that **CAN Community Health, Inc.** (Service Provider Name) is part of a collaborative group of organizations that provide Ryan White CARE Act Part A, Part B, Part C, Part D, and General Revenue/Patient Care Network Services. I agree to allow the Service Provider listed above, the City of Jacksonville Social Services Division, as the Ryan White Part A grantee, the Florida Department of Health – Duval County as the Ryan White Part B grantee, and the Neptune Technologies Inc., as the data manager and the agencies listed below, to exchange among them, information regarding the year of my HIV positive diagnosis, proof of HIV status, HIV/AIDS disease stage at intake, mode(s) of transmission and TB status at intake.

I understand that this information will be used to appropriately coordinate Ryan White Part A, Part B and General Revenue/Patient Care Network Services provided to me. I also understand this information may be used for linkage to services, billing purposes, quality assurance and contract monitoring activities. It is expressly understood that this information will include identifying and demographic information which includes name, gender, date of birth, address, zip code, guardian (if I am a minor), age, race/ethnic background, primary language, annual income, size of household, country of origin, federal poverty level, number of family members and/or significant other receiving Ryan White funded services. I understand that group level statistical data (not name identification) drawn from this information will be accessed by the funding sources for the purpose of developing necessary reports. Refusal to sign this Authorization to Release information can affect coordination of my care and I will assume financial responsibility for services provided.

I understand that the Jacksonville Area Ryan White Network uses and electronic record keeping database software system called "CAREWare Data Management System" (CAREWare) CAREWare is a computer software program specifically developed to help collect information and coordinate services for people with HIV disease. CAREWare is networked among the organizations listed below to assist Providers in coordinating my care. Data management services through CAREWare are maintained by Neptune Technologies, Inc.

I understand that Neptune Technologies, Inc. will have access to my information for system maintenance and will not be permitted to disclose such information without my written consent.

By signing below, I agree to hold all agencies named in this consent harmless of any liability associated with the release of information as authorized in this consent.

I may revoke this consent at any time by signing the revocation line below or by informing, in writing, the agency holding this original consent form.

I understand that the following statement binds any entity receiving information as a result of this release:
"This information has been disclosed to you for/from records whose confidentiality is protected by State Law. State Law prohibits the below named agencies and any Ryan White Part A, Ryan White Part B and General Revenue/Patient Care Network Provider from making any further disclosure of any such information without the specific written consent of the person to whom such information pertains or as otherwise permitted by State Law. A general authorization for release of medical and non-medical information is not sufficient for this purpose." Section 381.004, Florida State Statutes.

CAN Community Health, Inc.	Gateway Community Services, Inc.
AIDS Healthcare Foundation (AHF)	Jacksonville Area Legal Aid, Inc. (JALA)
Catholic Charities	Lutheran Social Services of NE FL (LSS)
Florida Department of Health – Baker County	Northeast Florida AIDS Network (NFAN)
Florida Department of Health – Clay County	UF Cares/Rainbow Center
Florida Department of Health – Duval County	UF Health Jacksonville Medical Center
Florida Department of Health – Nassau County	River Region Human Services
Florida Department of Health – St. Johns County	Other (specify):

Client or Legal Representative Signature:	**Date:**
Relationship of Client to Legal Representative:	**Ryan White Number:**
Witness Signature:	**Date:**
If Revoking Consent – Date Revoked:	

Note to Receiving Agencies: This information has been disclosed to you from records whose confidentiality is protected by State Law. State Law prohibits you from making any further disclosure of such information without specific written consent of the person to who such information pertains, or as otherwise permitted by State Law. A general authorization is not sufficient for this purpose.

AUTHORIZATION TO RELEASE INFORMATION

Date:	**Service Provider Name:**

By initialing below, I _____ (your name) authorize _____(Service Provider Name) to release and exchange my Protected Health Information, specifically the information initialed below. I understand that I may revoke this authorization at any time, except to the extent that the program has already released it. I also understand that the City of Jacksonville Social Services Division, Ryan White Part A Administrative Agency and the Florida Department of Health Duval County Ryan White Part B, pay for services, and as such, will have access to my HIV status, medical records and social service records for the purpose of providing treatment, finance, operations, auditing, and planning. Failure to release the information shall make me financially responsible for any expenses incurred in medical and non-medical treatment.

PLEASE INITIAL NEXT TO THE FOLLOWING YOU AUTHORIZE TO RELEASE:

	HIV Status		Laboratory Values
	Medications		Prescriptions
	Physician Orders		Substance Abuse Information
	Case Management Records		Financial Edibility Records
	Physician Progress Notes		Nursing Progress Notes
	Mental Health Information		Other (specify):

I also authorize, the following selected agencies and/or individuals(s) to release and exchange my Protected Health Information specified above:

PLEASE INITIAL NEXT TO THE FOLLOWING YOU AUTHORIZE TO RELEASE:

	AIDS Healthcare Foundation (AHF)		Florida Department of Health – St. Johns County
	Catholic Charities		Gateway Community Services, Inc.
	CAN Community Health Inc. (CAN)		Jacksonville Area Legal Aid, Inc. (JALA)
	Carter's Ortega Pharmacy		Lutheran Social Services of NE FL (LSS)
	Central Pharmacy		Northeast Florida AIDS Network (NFAN)
	CommCare Pharmacy		Owens Pharmacy
	Edgewood Pharmacy		Panama Pharmacy
	Flagler Community Pharmacy		UF CARES/Rainbow Center
	Florida Department of Health – Baker County		UF Health Jacksonville Medical Center
	Florida Department of Health – Clay County		River Region Human Services
	Florida Department of Health – Duval County		WAAS Pharmacy
	Florida Department of Health – Nassau County		Other (specify):

All the information I hereby authorize to be shared by or released to or from the specified agencies will be held strictly confidential and may not be re-disclosed by either party without my written consent. I understand that Section 381.004(3) of the Florida Statutes insures confidentiality of information contained in my medical records.

I understand that this authorization will remain in effect one year from the date signed unless I specify an earlier/later expiration date.

Signature of Client/Legal Representative:	**Date:**
Relationship to Client of Legal Representative:	**Date:**
Signature of Witness:	**Date:**
If revoking consent – Date revoked:	

Note to Receiving Agencies: This information has been disclosed to you from records whose confidentiality is protected by State Law. State Law prohibits you from making any further disclosure of such information without specific written consent of the person to who such information pertains, or as otherwise permitted by State Law. A general authorization is not sufficient for this purpose.

CLIENT CONSENT TO FAX CONFIDENTIAL INFORMATION

Date:	**Ryan White Number:**
Last Name, First Name:	Date of Birth:

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization to release certain types of sensitive medical information. Ryan White Network Providers may fax confidential information to a provider or receive faxed information that was request from a Provider with your permission. Faxing such information is voluntary. You will not be denied services based on a refusal to allow your confidential information to be faxed.

Steps will be taken to make sure your information arrives, safely, but faxes can be misdirected.

I _____(Name of Client/Legal Representative), do hereby authorize _____ (Agency or individual in possession of records) _____(address of agency or individual) to fax the following information (Initial any or all that apply):

	STD records		TB records
	HIV/AIDS records **		Drug/alcohol treatment records
	Psychiatric/psychological information/records		Adult and child abuse information
	Other (specify): ** Proof of HIV in the form of Western Blot, Elisa Lab Test, P-24 Antigen or detectable viral load.		Other (specify):

The information will be faxed to:

Provider Name (fax recipient):	
Contact Person:	
Provider Phone Number:	
Provider Fax Number:	

Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

If a Client Withdraws Consent:	
Client or Legal Representative Signature:	Date Revoked:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

CONSENT TO SEND ELECTRONIC COMMUNICATION

Date:	**Ryan White Number:**
Last Name, First Name:	

By supplying my email address, I consent to staff communicating with me by email regarding various aspects of my care, which may include, but shall not be limited to, financial documents, test results, monitoring, and counseling. I understand that email is not a confidential method of communication and may not be secure and that there is a risk that any communication through email regarding my care may be intercepted and read by a third party.

I also understand and agree that at any time I may opt out of communications by email by providing notice in writing to the organization selected below.

I understand that I am responsible for any fees incurred – standard rates will apply.
This form will be completed at least once a year unless the contact information changes.
I understand that I have the right to change my mind and have this service stopped. I must sign the form below to no longer receive electronic communication.

Check the appropriate organization below:

☐	AHF	☐	NFAN
☐	CAN Community Health	☐	Lutheran Social Services
☐	Department of Health Duval County	☐	River Region
☐	Gateway Community Services	☐	UF CARES
☐	Jacksonville Area Legal Aid		

Contact Information

☐	EMAIL:
☐	CELL PHONE:

SIGNATURES

I **consent** to receive electronic communication from the organization selected above:

Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	

I **DO NOT** give consent to receive electronic communication from the organization selected above:

☐	EMAIL:
☐	CELL PHONE:
Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	

INITIATION OF SERVICES
GENERAL RELEASE AND ACKNOWLEDGEMENT CONSENT

PART 1: CONSENT TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS			
Date:		**Ryan White Number:**	
Last Name, First Name:		Date of Birth:	
Name of Agency:			
Agency Address:			
I, consent to use and disclosure of Protected Health Information for treatment, payment or health care operations. This includes the release of the following information listed below:			
☐ Medical	☐ Sexually Transmitted Diseases	☐ Alcohol/Drug Abuse	☐ HIV/AIDS
☐ Tuberculosis	☐ Case Management Information	☐ Psychiatric/Psychology	☐ Other:

PART 2: MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST
(Only applies to Medicare Clients)
As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release Protected Health Information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART 3: ASSIGNMENT OF BENEFITS (ONLY APPLIES TO THIRD PARTY PAYERS)
As Client/Representative signed below, I, assign to the above named agency all benefits provide under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personal responsible for charges not covered by this assignment.

PART 4: SIGNATURES	
By my signature below I verify the above information and receipt of the notice of privacy rights:	
Client or Legal Representative Signature:	Date:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

If a Client Withdraws Consent:	
I, _____withdraw this consent effective _____(date).	
Client or Legal Representative Signature:	Date Revoked:
Legal Representative Relationship to Client:	
Witness Signature:	Date:

4615 Phillips Hwy.
Jacksonville, FL 32207
(904) 508-0710

HIPAA Acknowledgement

I understand that as part of my health care, CAN Community Health, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand and have been provided with a *Notice of Privacy Policies* (Notice) that provides a more complete description of information uses and disclosures.

I understand that CAN Community Health is not required to agree to restrictions requested. I understand that I may revoke my permission in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that CAN Community Health reserves the right to change their notice and policies, in accordance with Section 164.520 of the Code of Federal Regulations. A copy of our current Notice is available upon request.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity; and I consent to such disclosure for these permitted uses, including disclosures via fax.

I authorize CAN Community Health, to release information about my appointments, billing and/or financial information, and medical information to the following individuals:

Check all that apply

☐ **Spouse** ☐ **Parents** ☐ **Children** ☐ **Legal Guardian** ☐ **Grandparents** ☐ **Other**

Name:_____ **Phone #**: _____

Name:_____ **Phone #:** _____

This list may not be all inclusive and I recognize that my healthcare providers may have to use their best judgment in some instances where they communicate to others involved in my care.

Additionally, I authorize CAN Community Health to leave information concerning my appointments, billing or financial information, and medical information on my answering machine/voice mail at the phone number(s) which I have provided. I understand that receiving information regarding my health can be delayed if messages cannot be left.

I understand that in order to revoke the authorizations above (except to the extent that the organization has already taken action), I must request this revocation in writing to the Compliance Officer and that until such written document is received, this authorization will be followed.

Patient Signature	Patient (Print Name)	Date
Guardian's Signature	Print Name & Relationship	Date
Witness Signature	Witness (Print Name)	Date

4615 Phillips Hwy.
Jacksonville, FL 32207

CAN Community Health

Notice of Privacy Practices Acknowledgment Form

Name:_____ **ID#:** _____

Facility/Site/Program: CAN Community Health

I have received a copy of the Comprehensive Care Center Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: X_____**Date:** _____
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name:_____Role: _____
(Parent, guardian, etc.)

Witness:_____Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
Date

- ■ Face to face meeting
- ___ Mailing
- ___ Email
- ___ Other _____

Reason Individual or Representative did not sign this form:

___Individual or Representative chose not to sign
___Individual or Representative did not respond after more than **one** attempt
___Email receipt verification
___Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

___Face to face presentation(s) _____
___Telephone contact(s) _____
___Mailing(s) _____
___Email _____
___Other _____

Staff Signature:_____**Date**: _____

Print Name:_____**Date:**_____

4615 Phillips Hwy.
Jacksonville, FL 32207

NOTICE OF PRIVACY PRACTICES

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.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. CAN Community Health can act as each of the above business types. This medical information is used by CAN Community Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by CAN Community Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment.* CAN Community Health *may use or disclose your health information for case management and services.* CAN Community Health *may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain personnel to improve CAN Community Health's health care operations. CAN Community Health may send you appointment reminders, information about treatment options or other health- related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by CAN Community Health and the FL Department of Health's divisions, bureaus, and offices.
- Investigations and audits by the State's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by CAN Community Health.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by CAN Community Health will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to CAN Community Health.

INDIVIDUAL RIGHTS

You have the right to request CAN Community Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. CAN Community Health is not required to agree to any restriction. However, in situations where you or someone on your behalf pays for an item or service in full, and you request information concerning said item or service not be disclosed to an insurer, CAN Community Health will agree to the requested restriction.

You have the right to be assured that your information will be kept confidential. CAN Community Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by CAN Community Health.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. CAN Community Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by CAN Community Health.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, CAN Community Health will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. CAN Community Health will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures CAN Community Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

CAN Community Health may mail or call you with health care appointment reminders.

CAN Community Health DUTIES

CAN Community Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how CAN Community Health keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. CAN Community Health has the responsibility to notify you following a breach of your unsecured protected health information.

As part of CAN Community Health's legal duties this Notice of Privacy Practices must be given to you. CAN Community Health is required to follow the terms of the FL Department of Health Notice of Privacy Practices currently in effect.

CAN Community Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the FL Department of Health website at www.myflorida.com and will be available by email and at all CAN Community Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. CCC and the Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).
HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

DH150-741, 09/13

CLIENT FEE ASSESSMENT FORM

Date:		**Ryan White Number:**
First Name:	Middle:	Last Name:
Address:		

Under the Ryan White HIV/AIDS Treatment Extension Act of 2009, clients provided services funded through the Ryan White program must be charged fees for services based on a sliding fee schedule. For those clients whose income is less than or equal to 100% of the official poverty level, no charges will be imposed. For those clients whose income is greater than 100% of the Federal poverty level, fees will be imposed based on the following fee schedule.

Group	Client Fee Group	First Visit per Month	Second Visit Per Month	Subsequent Visits per Month
A	100% or less	0	0	0
B	>100% <=200%	25	25	25
C	>200% <=300%	35	35	35
D	>300%	45	45	45

Client's Fee Group is:	Client's fee will be:
Client's Income:	Federal Poverty Level:

I understand that documented health care services that I pay for, which are related to my illness and not eligible for payment through Ryan White, will be considered and deducted when determining my overall cost of services through the Ryan White program. I further understand that I am responsible for submitting this documentation to my service provider.

Client Signature:	Date:
Witness Signature:	Date:

My current income is:

Which is % of the Federal Poverty Level

I am aware that I am assessed a fee of:

I am able / unable (circle one) to pay the following amount:

Client Signature:	Date:
Witness Signature:	Date:

Comments

4615 Phillips Hwy.
Jacksonville, FL 32207
(904) 508-0710

RYAN WHITE HIV/AIDS PROGRAM PART A
CLIENTS RIGHTS, RESPONSIBILITIES AND GRIEVANCE / APPEAL PROCEDURE

RIGHTS

- You have the right to receive timely, respectful, high quality services from the staff of all providers without regard to your age, ethnicity, gender, disability, religion, sexual orientation, values, beliefs, and marital status.
- You have the right to request copies of all signed documents and have access to your service record.
- You have the right to participate in the development of your plan of care.
- You have the right to choose your provider and the type of services you will receive.
- You have the right to receive current information and education about the disease, medicines, treatment and self-help measures.
- You have the right to appeal decisions with which you do not agree. (*see instructions below*)
- You have the right to file a grievance if you are not satisfied how you have been treated. (*see instructions below*)
- You have the right to request an interpreter to enhance communication.
- You have the right to refuse recommended treatment plans based upon your understanding of the risks and benefits without pressure from the health care professional; however, please note that adherence to treatment and or a plan of care is a requirement in order to receive the Ryan White funded services.

RESPONSIBILITIES

- You are responsible to conduct yourself in a courteous and respectful manner, threatening and abusive language or behavior will not be tolerated and client services may be suspended or terminated and some cases referred to law enforcement.
- You are responsible for keeping all appointments.
- You are responsible for notifying the provider of services if any illness interferes with scheduled appointments.
- You are responsible for working with your Case Manager to develop a plan of care.
- You are responsible for providing all documentation needed to assist in enrolling you in any eligible programs or services.
- You are responsible for notifying your Case Manager when you have problems in obtaining services or when you are dissatisfied with your care.
- You are responsible for following the instructions of your health care provider to the best of your ability.
- You may be responsible for a portion of the costs of y our health care services.
- You are responsible for notifying your Case Manager of any changes such as address, income, and living arrangements.

GRIEVANCE PROCEDURE

- If you are dissatisfied with services you are receiving, you may file a written grievance with your Case Manager's Supervisor. The grievance will be managed internally by your service provider.

APPEAL PROCEDURE

- If you are dissatisfied with a provider's decision pertaining to a Ryan White issue, you may file a written appeal with the Case Managers Supervisor.
- The supervisor will meet with you. If you are not satisfied with the results of the meeting, you may, within 30 days, request a meeting with your service providers designated officer.
- If you are unable to resolve the issue after meeting with the service providers designated officer, you may, within 30 days, file your appeal in writing to: Ryan White Program Manager, City of Jacksonville, Behavioral and Human Services Division, 1809 Art Museum Dr, Jacksonville, FL 32207.
- The Ryan White Program Manager will respond to you in writing within 14 days of receipt of the appeal informing you of the time and place of the Lead Agency meeting.
- At the meeting you may be accompanied by a friend, relative, legal counsel or other spokesperson.
- The decision of the is final.

I have had the opportunity to discuss and I am fully aware of the Rights, Responsibilities and Grievance / Appeal Procedures outlined above. I am aware that failure to comply may result in disenrollment from the program.

Client Signature X:_____ **Date:** _____

Case Manager Signature:_____ **Date:** _____

4615 Phillips Hwy.
Jacksonville, FL 32207
(904) 508-0710

Financial Policy

Medicaid: CAN Community Health. accepts Medicaid.

Managed Care Plans (HMO): CAN Community Health, Inc. files insurance claims for managed care groups in which we participate. These policies often require co-pays. Patients are responsible for that co-pay at the time of service.

Medicare: CAN Community Health, Inc. files insurance claims for Medicare. We accept Medicare allowable amounts as payment. Patients are responsible for charges applied to their deductible, any co-insurance and non-covered charges.

Other Insurance (PPO. POS): Patients are responsible for charges applied to their deductible, any co-insurance, and other non-covered charges.

Self-Pay: All services are required to be paid in full at the time of service.

Summary: We accept payment for covered services from insurance plans in accordance with our contracts. Our patients are responsible for applicable co- insurance and deductible amounts, and for services that are not covered by insurance.

Providing quality medical care for our patients is our primary concern. It is, however, the responsibility of the patients to know and understand their insurance policies and guidelines. **All co-pays and deductibles are due at the time of service.**

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I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visits. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account incurred by me.

I have read and understood the office policy as stated above and agree to accept the responsibility described.

_____ _____

Patient/ Responsible Party Signature Date