OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

Hamaspik, Inc.

Designated Representative Authorization Form

This form allows you or your legal representative to authorize a family member or friend to receive information about your health care and to assist you in providing guidance to your home care workers. This form does not authorize the individual below to make other health care decisions about you. In order to authorize someone to make health care decisions for you, if you become unable to make decisions for yourself, you need to complete a Health Care Proxy. We have also included a copy of that form for you.

Member Name _____ Date of Birth _____

1. I authorize Hamaspik Choice to disclose my health information to the following individual for purposes of assisting with my treatment and payment for care:

   Name of Individual: _____ (the "Individual")

2. I understand that the Individual may only receive information regarding my treatment for HIV, Mental Health or Substance Abuse if I check the boxes below specifically authorizing the disclosure of such information:
   - ☐ **Alcohol/Drug Treatment**, which may include information related to your diagnoses, medications and dosages, lab tests, substance use history, discharges, employment, living situation and social supports, and health insurance claims history
   - ☐ **Mental Health Information**
   - ☐ **HIV-Related Information**

3. I further authorize the Individual to request an appeal or grievance on my behalf or to direct my CDPAS services.

4. I understand the following:
   - If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I can request a list of people who may receive or use my HIV-related information without authorization.
   - I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
   - I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
   - Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.
   - This authorization will expire 30 days after I am no longer receiving services from Hamaspik.

_____ _____

Signature of Beneficiary or Legal Representative Date

_____

Relationship to Beneficiary

Please send complete form by mail to: Hamaspik, Inc., 58 Route 59, Suite 1, Monsey NY 10952. If you have questions, please call us at: 1-833-426-2774.

Hamaspik Inc.

Informal Supports Form

Member's Name: _____

Informal Supports:

1. Name:_____ Relationship:_____

Address:_____ Phone:_____

Assistance with:

- ❑ Meal Preparation and Eating
- ❑ Housework
- ❑ Finances
- ❑ Medications
- ❑ Shopping
- ❑ Accompaniment to MD apt
- ❑ Other:_____

- ❑
- ❑ Bathing
- ❑ Personal Hygiene
- ❑ Dressing
- ❑ Locomotion
- ❑ Toilet use/incontinence care
- ❑ Bed Mobility

Days available: _____ Time Available: _____

I am willing to voluntarily provide the services identified above.

Signature of informal supports: _____

2. Name:_____ Relationship:_____

Address:_____ Phone:_____

Assistance with:

- ❑ Meal Preparation and Eating
- ❑ Housework
- ❑ Finances
- ❑ Medications
- ❑ Shopping
- ❑ Accompaniment to MD apt
- ❑ Other:_____

- ❑
- ❑ Bathing
- ❑ Personal Hygiene
- ❑ Dressing
- ❑ Locomotion
- ❑ Toilet use/incontinence care
- ❑ Bed Mobility

Days available: _____ Time Available: _____

I am willing to voluntarily provide the services identified above.

Signature of informal supports: _____

I am willing to accept services from the above listed informal supports. **Member Signature: _____**

Consumer /Designated Representative
Acknowledgement of the Roles and Responsibilities for Receiving
Consumer Directed Personal Assistance Services

I acknowledge that Consumer Directed Personal Assistance Services (CDPAS) allows chronically ill and/or physically disabled members receiving home care services greater flexibility and freedom of choice in obtaining such services.

In order to receive CDPAS I understand the respective roles and responsibilities of the consumer and the _____Health Plan (Health Plan).

RESPONSIBILITIES OF THE HEALTH PLAN

The Health Plan will:

1. Determine whether the member is on the most current Plan Roster.

2. Provide the member requesting personal care services with information about how to qualify for CDPAS and other community based long term care services.

3. Provide the member with written educational materials outlining the roles and responsibilities for the member/designated representative if member expresses an interest in CDPAS.

4. Assess whether the member is eligible to receive home care or personal care services.

5. Determine if the member is able and willing to assume all responsibilities associated with receiving the service, or has a designated representative or other identified adult, able and willing to act on the member's behalf.

6. Determine whether member is eligible to receive CDPAS.

7. Assess and document the member's health patient centered care plan to assure adequate supports are available to meet the member's needs.

8. Authorize the type, amount and level of services required by the member.

9. Develop a plan of care with the member, outlining the tasks to be completed by the personal assistant. The plan of care document will be maintained with Plan and a copy will be provided to the member.

10. If it is determined that the member is no longer eligible to continue receiving CDPAS, or Plan terminates the member's receipt of CDPAS the MCO will assess on an ongoing basis whether the member requires personal care, home health care or some other level of service.

11. Provide the member with appropriate notices including a notice of fair hearing for reduction, termination of the level and amount of services or determining that the member is not eligible or no longer eligible to receive CDPAS.

RESPONSIBILITIES OF THE MEMBER

The Member/Designated Representative (Member) will:

1. Review the information provided by the Plan about CDPAS and understand the roles and responsibilities of the Plan, the fiscal intermediary and the Member.

2. Be responsible for recruiting, hiring, and training, supervising, scheduling and terminating the personal assistant(s) of the member's choosing in adequate numbers to meet the needs of the member.

3. Maintain an appropriate home environment for the safe delivery of care required by the member.

4. Train the personal assistant(s) to implement the plan of care.

5. Comply with labor laws, providing equal employment opportunities as specified in the agreement between Member and the Fiscal Intermediary (FI).

6. Inform the Plan and the FI of any change in status or condition including but not limited to: hospitalizations, address and telephone number changes, vacations within 5 business days.

7. Assure the accurate and timely submission of the personal assistant's required paper work to the FI including time sheets, annual worker health assessments, and required employment documents.

8. Develop and maintain a contingency plan to assure adequate supports are available to

meet the member's needs.

9. Review and sign the personal assistant's timecards assuring that the hours reflect the actual number of hours worked within the weekly authorized hours.

10. Cooperate with the Plan and agree to comply with Medicaid Managed Care Program requirements including but not limited to availability for required reassessments.

11. Report and return to MCO any overpayment or inappropriate payments from the Medicaid program made to Consumer Directed Personal Assistants.

I have read and understand the roles and responsibilities of the Plan and me in order to receive CDPAS.

_____

Member/ Designat Representative Print Name

_____ _____

Member/ Designated Representative Signature Date

_____ _____

Witness Date

October 1, 2012

DOH-4359 (2010)

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

COMPLETE ALL ITEMS *INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN*

1. Patient Identifying Information *(Use Additional Paper If Necessary)*

PATIENT NAME	CIN	DATE OF BIRTH	SEX

ADDRESS: APT/STREET	CITY	STATE	ZIP CODE

TELEPHONE NO. ( )	MEDICARE NO.	IF CURRENTLY HOSPITALIZED: Name of Hospital	DATE OF ADMISSION:	ANTICIPATED DATE OF DISCHARGE

TO ABOVE ADDRESS? ☐ YES ☐NO IF NO EXPLAIN: _____

2. General Information

PHYSICIAN NAME	LICENSE #	TELEPHONE NO. ( )

ADDRESS: STREET	CITY	STATE	ZIP CODE

If the examination was conducted by a Physician's Assistant, Specialist's Assistant, or Nurse Practitioner, Identify:
Name _____ Profession: _____ License # _____

PLACE OF EXAMINATION: _____

DATE OF EXAMINATION: _____

3. Medical Findings

NOTE: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

Height: _____ Weight: _____

For the condition(s) requiring personal care:

Primary Diagnosis _____ ICD-9-CM Code _____

Secondary Diagnosis _____ ICD-9-CM Code _____

Describe the patient's current medical/physical condition _____

Is the patient's condition stable? ☐ Yes ☐ No

Is the patient appropriate for Hospice care? ☐ Yes ☐ No

Describe the current treatment plan and therapeutic goals including the prognosis for recovery: _____

Describe any prohibited activities or functional limitations: _____

Is the patient self-directing? ☐ Yes ☐ No

Is the patient able to summon help by any means? ☐ Yes ☐ No

If no, explain _____

Is the patient able to ambulate independently? ☐ Yes ☐ No With devices? ☐ Yes ☐ No Other Assistance? ☐ Yes ☐ No

Describe: _____

Is the patient continent of bowel? ☐ Yes ☐ No of bladder? ☐ Yes ☐ No

Catheter/Colostomy Needs: _____

List all current medications (prescription and OTC) and note dosage and frequency and any special instructions (attach additional sheet if necessary):

Can the patient self-administer medications: ☐ Yes ☐ No

If the patient requires a modified diet or has other special nutritional or dietary needs, describe: _____

Please indicate any task, treatments or therapies currently received, or required by the patient: _____

Does the patient require assistance with, or provision of, skilled tasks (e.g. monitoring of vital signs, dressing changes, glucose monitoring, etc.)?

☐ Yes ☐ No

If Yes, please indicate:

Based on the medical condition, do you recommend the provision of service to assist with skilled tasks, personal care and/or light housekeeping tasks?

☐ Yes ☐ No

Contributing Factors:

Describe contributing factors including but not limited to the social, family, home or medical (e.g. muscular/motor impairments, poor range of motion, decreased stamina, etc.) situation that may affect the patient's ability to function, or may affect the need for home care or that may affect the patient's need for assistance with skilled tasks, personal care tasks and/or light housekeeping. Please include any other information that may be pertinent to the need for assistance with home care services.

IT IS MY OPINION THAT THIS PATIENT CAN BE CARED FOR AT HOME. I HAVE ACCURATELY DESCRIBED HIS OR HER MEDICAL CONDITION. NEEDS AND REGIMENS, INCLUDING ANY MEDICATION REGIMENS, AT THE TIME I EXAMINED HIM OR HER. I UNDERSTAND THAT I AM NOT TO RECOMMEND THE NUMBER OF HOURS OF PERSONAL CARE SERVICES THIS PATIENT MAY REQUIRE. I ALSO UNDERSTAND THAT THIS PHYSICIAN'S ORDER IS SUBJECT TO THE NEW YORK STATE DEPARTMENT OF HEALTH REGULATIONS AT PARTS 515, 516, 517 AND 518 OF TITLE 18 NYCRR, WHICH PERMIT THE DEPARTMENT TO IMPOSE MONETARY PENALTIES ON, OR SANCTION AND RECOVER OVERPAYMENTS FROM, PROVIDERS OR PRESCRIBERS OF MEDICAL CARE, SERVICES OR SUPPLIES WHEN MEDICAL CARE, SERVICES OR SUPPLIES THAT ARE UNNECESSARY, IMPROPER OR EXCEED THE PATIENT'S DOCUMENTED MEDICAL CONDITION ARE PROVIDED OR ORDERED.

INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT

Physician's Signature _____ Date _____

PLEASE SIGN AND RETURN COMPLETED FORM WITHIN 30 CALENDAR DAYS OF EXAMINATION TO:

_____

_____

_____

_____

_____

_____

New York State Department of Health

PHYSICIAN'S ORDER FOR PERSONAL CARE/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES INSTRUCTIONS

COMPLETE ALL ITEMS. ***(Attach additional sheets, if necessary)***. **INCOMPLETE FORMS WILL BE RETURNED TO THE PHYSICIAN. INCOMPLETE OR MISSING INFORMATION MAY DELAY SERVICES TO THIS PATIENT.**

1. Patient Identifying Information

- **Patient Name.** Enter the patient's name.
- **CIN.** Found on the patient's Medical Assistance ID card.
- **Date of Birth.** Enter the patient's date of birth.
- **Sex.** Enter the patient's gender.
- **Address and telephone number.** Enter the patient's address and telephone number.
- **Medicare #.** Enter the patient's Medicare number if available.
- **If currently hospitalized.** If the patient is hospitalized at the time of completion of the physician's order, indicate the name of the hospital, date of admission, and anticipated date of discharge.
- **Discharge to above address. I**f the patient is to be discharged to an address other than the address listed above please explain.
- **General Information**

Physician's Name, License #, Address, Telephone. Enter information for the physician signing the order. Enter either the physician's license number as issued by the New York State Department of Education or the provider billing number issued by the New York State Department of Health Medicaid Management Information System.

- **Examination conducted by other than a physician**. If patient was examined, and the order form completed by a physician's assistant, specialist's assistant, or nurse practitioner, complete the required information.
- **Place of Examination.** Indicate the location (office, clinic, home, etc) of the examination of the patient.
- **Date of Examination**. Enter the date the patient was examined. This must be within 30 days of the date the physician signed the form.

3. Medical Findings

Note: Indicate **N/A** if an item does not apply to this patient or **Unk** if the requested information is unknown to the physician signing this form.

- **Height, Weight.** Enter the patient's height and weight.
- **Primary and Secondary Diagnosis.** Enter the primary and secondary diagnosis with ICD-9-CM codes for the primary and secondary conditions which result in the patient being evaluated for home care services.
- **Describes the current condition.** Describe the patient's current medical/physical condition, including any relevant history.
- **Stability.** Check **Yes** if the patient's condition is not expected to show marked deterioration or improvement. **A stable medical condition** shall be defined as follows:
  (a) the condition is not expected to exhibit sudden deterioration or improvement; and
  (b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and
  (c) (1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or
  (2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.
- **Hospice.** If the patient's condition is terminal, indicate if the patient is appropriate for Hospice services.
- **Describe the current treatment plan**. Include therapeutic goals and prognosis for recovery and anticipated duration of the current treatment plan.
- **Limitations.** Indicate any functional limitations or prohibited activities.
- **Self-Directing.** Indicate if the patient is self-directing. Self-directing means that the patient is capable of making choices about activities of daily living, understanding the impact of the choices, and assuming responsibility for the results of the choices. A **No** response to this item should be reflected in the description of the patient's condition as documented in the applicable section.
- **Able to Summon Help.** Check **Yes** if the patient is able to summon assistance in an emergency situation by any means. If the patient is not able to summon assistance, check **No** and explain.

- **Ambulation.** Indicate the patient's ability to ambulate independently, or with the need for assistance or devices. Specify assistance/devices used or needed.

- **Bowel/Bladder.** Indicate if the patient is continent. Describe any catheter or colostomy needs.

- **Medications Required**. List all prescription and over-the-counter medications the patient is taking and note dosage, frequency and any special instructions.

- **Medication Administration**. Indicate the patient's ability to self-administer medications.

- **Dietary Needs.** Indicate if the patient has special nutritional or dietary needs, i.e. low salt or high potassium.

- **Tasks/Treatments/Therapies.** Indicate any tasks, treatments or therapies which the patient receives or requires in the home and describe.

- **Need for completion/assistance with skilled tasks.** If the patient requires assistance with skilled tasks including, but not limited to, glucose monitoring, wound care, vital signs, describe the need for such assistance.

- **Recommendation to provide assistance.** Check **Yes** if, in your opinion, the patient can be maintained in his or her home with provision of home care services.

- **Contributing factors to need for assistance**. Please indicate the functional deficits that support the need for the provision of home care services. Please include any pertinent information you may have regarding the patient's surroundings, physical condition or other factors that may affect the ability of the patient to function in the community or the patient's need for assistance with personal care tasks.

4. **Physician's Signature/Date of completion.** The signature of the ordering physician as identified in Item 2. Note that by signing this document, the physician certifies that the patient's condition and needs are accurately described. Forms lacking a signature and/or date are not acceptable.

5. **Return Form To.** The local district or other case management entity to whom the form is to be returned.

Hamaspik Choice, Inc.

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

Hamaspik Inc.

Acknowledgement Form

Member's Name: _____ Meeting Date and Time: _____

Member Acknowledgement:

- ❑ I acknowledge that I was visited today by my Nurse Assessor/ Care Manager.

  Purpose of visit:

  - ❑ Plan of Care Review and UAS assessment visit
  - ❑ Acute Assessment Visit
  - ❑ Care Management Visit
  - ❑ Other

- ❑ I acknowledge review of my Plan of Care
- ❑ I agree with what is written in my plan and am satisfied with my Plan of Care
- ❑ I am not requesting any changes to my Plan of Care, and I understand I may ask for changes to my Plan of Care in the future
- ❑ **I am requesting changes to my Plan of Care**
  Requested Changes _____

I acknowledge that I was educated about:

- ❑ Flu Vaccine
- ❑ Fire Safety, Evacuation, and Natural Disaster Preparedness. I received educational materials about these topics.
- ❑ Plan services including dental, vision, audiology, transportation, social day care, adult day care, PCA and CDPAS services.
- ❑ Plan's policies for service requests, service authorizations, complaints, appeals and fair hearings
- ❑ Plan's policies on Advance Directives, information about Power of Attorney, Health Care Proxy, MOLST.
- ❑ Other _____

The meeting was held at a time and location that was convenient for me □YES □NO

I choose who should participate in the meeting □YES □NO

Individuals present at visit:

Name	Title/Relationship	Signature	Date

Member Acknowledgement:

I have been a part of the Person Centered Service Planning Process to the best of my ability. I agree with what is written in my plan. I understand my rights and/or I have someone I trust who can help me with them. I understand that my plan will be reviewed regularly and that I can ask for it to be reviewed sooner. I agree to this plan being shared with the people that need it to provide my services. I was given a choice of my service providers. I know who to talk to if I want to change my services or my Person Centered Plan of Care.

Member or Representative Signature: _____ Date: _____