



STEPHEN KLEIN WELLNESS CENTER

Patients' Bill of Rights

Project HOME Healthcare Services strives to provide person-centered holistic health care. In order to promote trust, create closer Patient/Provider communication and the highest level of care, all sites within PHHS presents and visibly posts in public spaces the following Rights and Responsibilities for Patients, clients, and their families:

As a consumer of Project HOME Healthcare Services I have a right to:

- Have my health assessed and cared for.
- Receive information about medications, including its purpose, the way to take it, and the possible side effects.
- Be assigned a primary provider.
- Request that a family member or friend be with me and speak up for me.
- Be informed of why a test or treatment is needed and how it will help me.
- Be informed of my test results.
- Receive in understandable language adequate information from my provider concerning my diagnoses and its related treatment. In the event that I refuse treatment, I will be informed of the possible medical consequences.
- In certain cases, another facility may have services that PHHS does not have. In some situations, my provider or another staff member at PHHS will refer me to another facility.
- Be given reasonable and respectful personal consideration, and to expect information about my health to be treated confidentially.
- Know the name and position of the provider who is caring for me.
- Be informed of policies and procedures, fees and charges for services made by PHHS.
- Receive an appointment time that works with my schedule during the hours that PHHS is open. I should not have to wait too long for services without an explanation.
- Receive an explanation about my bill.

- Be heard if I have suggestions or complaints.
- Be able to receive care regardless of ability to pay.
- Have my dignity respected as a Patient.

We welcome all persons to receive services at PHHS regardless of race, religion (creed), disability, sex, sexual orientation, gender identity, age, national origin (ancestry), citizenship, or veteran status.

As a Patient you are responsible for:

- Providing information to my provider about past illnesses, hospitalizations, medications, including prescriptions, over-the-counter medications, vitamins, herbs, or any other drug or substance that I may be taking, and other matters related to my health.
- Informing my provider about any allergies and adverse reactions I have had to medicines.
- Informing my provider about past and present problems related to my health to the best of my ability, including but not limited to problems with mental illness and substance use.
- Cooperating with all health personnel and asking questions if I do not understand something.
- Assisting my provider by adhering to the instructions and medical orders provided.
- Respecting the property of other persons and the property of PHHS.
- Making and keeping appointments or informing PHHS as soon as possible if I cannot keep an appointment.
- Providing information necessary for bills to be paid by my medical insurance and for realizing that I have the ultimate responsibility for paying all bills. PHHS will correct errors in the bill. Payment of the bill is expected.
- Bringing my current insurance card to each visit, if I have one.
- Informing PHHS of any changes to my address, household information or financial status.

We strongly encourage Patients to apply for any and all health benefits for which they are entitled.

At any time, if you have any questions or concerns about your rights and responsibilities, please contact:

William Kurtycz, Vice President of Healthcare Services at 215-320-6187 ext. 2434

Patrick Doggett, MD, Director of Integrated Healthcare Services, at 215-320-6187 ext. 9593

Charo Rogers, Director of Operations, at 215-320-6187 ext. 7951





NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Project HOME is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this Notice of Privacy Practices (“Notice”) that we maintain in Project HOME concerning how we may use or disclose your PHI. By federal and state law, we must follow the terms of the Notice that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

Changes to this Notice. The terms of this Notice apply to all records containing your PHI that are created or retained by Project HOME. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your records that Project HOME has created or maintained in the past, and for any of your records that we may create or maintain in the future. Project HOME will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WHO TO CONTACT FOR FURTHER INFORMATION:

If you have questions about this Notice, requests or complaints related to the permitted or required uses and disclosure of your PHI by Project HOME and your rights with respect to your PHI to please contact:

Monica Medina McCurdy, Vice President, Healthcare Services and Privacy Officer, 1845 N. 23rd Street, Philadelphia, PA 19121, 215-235-3110 ext. 5614; or

Psychiatric Rehabilitation Services, attn: Gillian Raskin, 1515 Fairmount Avenue, Philadelphia, PA 19130.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

- 1. Treatment.** Many of the people who work for Project HOME – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you.
- 2. Payment.** Project HOME may use and disclose your PHI in order so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.
- 3. Health Care Operations.** Project HOME may use and disclose your PHI to operate our business. Project HOME may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for Project HOME. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Project HOME may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Project HOME may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Project HOME may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Project HOME may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take a child to the pediatrician’s office for treatment of a cold. In this example, the babysitter may have access to this child’s medical information.

8. Disclosures Required By Law. Project HOME will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- 1. Business Associates.** We may share your PHI with certain business associates that perform services for us so that they can perform the job we have asked them to do. For example, we may use another company to perform billing services on our behalf. To protect your PHI, we require the business associate to appropriately safeguard the PHI.
- 2. Public Health Risks.** Project HOME may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.
- 3. Health Oversight Activities.** Project HOME may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 4. Lawsuits and Similar Proceedings.** Project HOME may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the requested PHI.
- 5. Law Enforcement.** We may release PHI if asked to do so by a law enforcement official: (a) regarding a crime victim in certain situations, if we are unable to obtain the person’s agreement; (b) concerning a death we believe has resulted from criminal conduct; (c) regarding criminal conduct at our offices; (d) in response to a warrant, summons, court order, subpoena or similar legal process; (e) to identify/locate a suspect, material witness, fugitive or missing person; and (f) in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
- 6. Deceased Patients.** Project HOME may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
- 7. Organ and Tissue Donation.** Project HOME may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to

facilitate organ or tissue donation and transplantation if you are an organ donor.

8. Serious Threats to Health or Safety. Project HOME may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. For example, Project HOME may share your PHI (including details of your COVID-19 test status, test results and symptoms) with staff at our residences so they can implement protocols to protect the health and safety of staff and other residents.

9. Military. Project HOME may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Project HOME may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Project HOME may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

E. YOUR RIGHTS REGARDING YOUR PHI

12. Workers' Compensation. Project HOME may release your PHI for the following purposes regarding the HIAF program to maintain about you:

1. Confidential Communications. You have the right to request that Project HOME communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice, specifying the requested method of contact, or the location where you wish to be contacted. Project HOME will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit Project HOME's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. To inspect or copy PHI about you, you must submit your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. Project HOME may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Project HOME may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for Project HOME. To request an amendment, you must submit your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. You must provide us with a reason that

supports your request for amendment. Project HOME will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by Project HOME, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request a list of certain non-routine disclosures Project HOME has made of your PHI. This includes uses or disclosures for purposes other than treatment, payment, health care operations, disclosures made directly to you or for which you have provided written authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure or include dates before April 14, 2003. Your first request within a 12-month period is free of charge, but Project HOME may charge you for additional lists within the same 12-month period. Project HOME will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of the Notice, even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact the Privacy Officer or Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with Project HOME or with the Secretary of the Department of Health and Human Services. To file a complaint with Project HOME, contact the Privacy Officer or Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Project HOME will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Your authorization is required for any use or disclosure of PHI for marketing communications or the sale of PHI that involves financial payment to Project HOME. You may revoke an authorization at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the purposes described in the authorization. Please note that we are required to retain records of your care.

9: State Laws on the Privacy of Certain Health Information. Pennsylvania provides special privacy protections for particularly sensitive conditions or illnesses such as HIV/AIDS, mental health, and substance abuse.

HIV/AIDS: We will not disclose any HIV-related information, except in situations where the subject of the information has provided us written consent allowing the release or where we are authorized or required by law to make the disclosure.

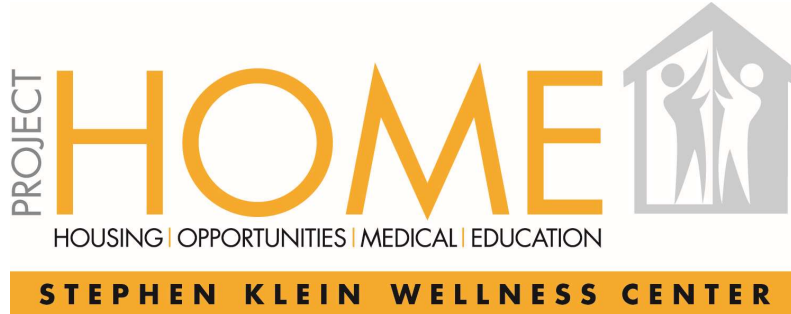
Mental Health: Any records related to involuntary mental health treatment (inpatient or outpatient) or voluntary inpatient treatment will not be disclosed without your written consent. Any mental health information disclosed will be limited to relevant information necessary for the purpose for which the information is sought.

Drug/Alcohol Abuse Treatment: We will not disclose any information related to drug and/or alcohol abuse treatment without your written authorization. Even with written authorization, we will only release such information under the following circumstances: (a) to medical personnel exclusively for the purposes of treatment or diagnosis; or (b) to government or other officials exclusively for the purpose of obtaining benefits due to you as a result of drug or alcohol abuse.

We may release information related to drug and/or alcohol abuse treatment under the following circumstances: (a) in emergency medical situations where your life is in immediate danger and the information is released solely for the purpose of providing medical treatment; and (b) in response to a court order.

F. EFFECTIVE DATE.

This Notice is effective as of September 25, 2013.



Consent for Treatment and Acknowledgement of Privacy Practices

Name: _____ Date of Birth _____

By signing below:

- I hereby consent to receive routine treatments and procedures that my medical, dental, and behavioral health providers believe will improve my health. Routine treatments and procedures includes but is not limited to asking questions about my physical and mental health and history, discussing my concerns and problems, a physical exam, prescribing medicine, and administering treatments. I understand that my providers will work with me to diagnose and treat my health issues. **At any point, I have the right to refuse treatment.** (Further rights and responsibilities are listed in the Patient’s Bill of Rights)
- I consent to the exchange of prescription medication information via e-prescription for continuity of care.
- I acknowledge the receipt of the Notice of Privacy Practices by Project HOME
- I acknowledge the receipt of the Code of Conduct by Project HOME
- I understand that I am financially responsible for all fees charged for my treatment, even if not covered by my insurance benefits.

Signature of Patient/Client or Personal Representative

Date

OFFICE USE ONLY

Inability to obtain acknowledgement:

To be completed only if no signature is obtained. If it is not possible to obtain the individual’s acknowledgement, describe the reasons why the acknowledgement was not obtained.

- Individual refused to sign.
- Communications barriers prohibited the ability to obtain the acknowledgement.
- An emergency situation prevented us from obtaining the acknowledgement.
- Other (please specify):

Signature of Project HOME Representative

Date

Project HOME Healthcare Services - Code of Conduct

Project HOME Healthcare Services includes three separate locations:

The Stephen Klein Wellness Center | 2144 Cecil B. Moore Avenue, Philadelphia, PA 19121

The Hub of Hope Clinic – Located at the Hub of Hope | 1401 JFK Blvd. Sub-Concourse Level, Philadelphia, PA 19103

The Pathways Clinic – Located at Pathways to Housing | 5201 Old York Road, Ste. 108, 4th Floor, Philadelphia, PA 19141

Our primary goal is to offer quality healthcare and wellness services to our community members. We expect to provide this care in an environment that is safe, where there is mutual respect. We recognize there are many issues affecting individuals in our community which can sometimes lead to disruptive behavior. This behavior may impact staff or other people in the immediate surroundings. While we attempt to handle these situations with awareness and care, we will not subject our staff, patients, or other community members to unsafe, disruptive, or inappropriate behavior. This includes, but is not limited to:

- Having weapons of any kind
- Creating a dangerous environment (such as smoking or vaping on the premises).
- Using profane or disrespectful language
- Unwanted physical contact
- Sexual harassment

Individuals who continue to behave in an ill-mannered way, face a possibility of suspension or discharge from services.

Our team enjoys serving this community. We have an expectation for our community members to fully utilize the services offered at PHHS while ensuring each person conducts themselves in a respectful and civil manner.

Sincerely,

The Team

FACT SHEET: What if I don't have health insurance?

Project HOME/Stephen Klein Wellness Center is a “federally qualified health center” or FQHC. This means that Project HOME/Stephen Klein Wellness Center is able to bill health insurance, as well as have more resources to continue to provide care to those without health insurance.

Below are some important policies that people who do not have health insurance should be aware of. **These policies went into effect starting on MONDAY, March 10, 2014.**

- Staff at Project HOME Healthcare Services will ask patients to pay an upfront fee unless their service is covered by an insurance company with whom we have an existing contract.
- The amount of the fee will be determined by one’s family¹/household² income³ and family/household size.
- In order to qualify for the sliding fee discount plan patients need to complete the Sliding Fee Application on the patient demographics form and provide income documentation. Examples of income documentation are provided at the front desk upon request. Our Benefits Counselor can assist patients to complete this application as necessary. The data provided on the application is entered into our Practice Management system which calculates the fee that is owed for the visit.
- We will ask you to complete a Sliding Fee Application on an annual basis in order to receive the sliding fee discount.
- If your income decreases and you think you may be eligible for a lower fee, please notify the Benefits Counselor and bring in your income documentation.
- Very important: We will provide the same high quality services even if someone unable to pay all or any fee at the time of the visit.

In addition to the Sliding Fee Application, the Benefits Counselor at Stephen Klein Wellness Center is able to assist patients with the following financial services:

- Complete an application for Medical Assistance with the Department of Public Welfare
- Apply for a government subsidy and enroll in the Health Insurance Marketplace (a.k.a. Obamacare or www.healthcare.gov).
- Apply for permanent disability through the Social Security Administration
- Link people, including veterans, to housing, employment and educational opportunities through Project HOME
- Assist people with applying for other public benefits such as LIHEAP, SNAP, or WIC.

¹ **Definition of Family:** A family is a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family (Source: U.S. Census Bureau, Current Population Survey Definitions)

² **Definition of Household:** A household consists of all the people who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live with any other persons in the structure and there is direct access from the outside or through a common hall. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. (Source: U.S. Census Bureau, Current Population Survey Definitions)

³ **Definition of Income:** Income is defined as money that a family or household receives on a weekly, monthly or annual basis to be used for their day to day living expenditures. See “Examples of Proof of Income” document for examples of acceptable documentation.

New Patient Demographic Form

Today's Date: ____ / ____ / ____
MM DD YYYY

Patient Name: _____
Last First M.I.

Preferred/Affirmed Name (if different from legal name): _____

Social Security #: _____ **Date of Birth:** ____ / ____ / ____ **Assigned Sex at Birth:** Male Female
MM DD YYYY

Gender Identity: Male Female Transgender (circle FTM/MTF) Nonbinary Other _____ Prefer not to say
Sexual Orientation: Straight Gay/Lesbian Bisexual Queer Other _____ Prefer not to say
Preferred/Affirmed Gender Pronouns: He/Him/His She/Her/Hers They/Them/Theirs Other _____

Home Address: _____ **Preferred Contact Phone:** (____) _____

Home Work Cell

Other Phone: (____) _____

Apt/Suite # _____ Home Work Cell

Email address: _____

City _____ State _____ Zip _____

Race: Black/AfrAmer White/Cauc Asian Other _____ **Ethnicity:** Hispanic/Latino? No Yes

Preferred Language: _____ **Preferred Gender of Provider:** Female Male No Preference

Please check off the applicable response(s) for your contact notes and preferences:

- Interpreter required
- Hearing impaired
- Mute
- Visually impaired
- Do not leave a message if I do not answer the phone
- Leave a message if I do not answer the phone

Sliding Fee Discount Application: We offer Sliding Fee discounts to charges, copays and coinsurance to patients whose income is at or below 200% of the federal poverty level. These discounts are based on household income and number of people in a household. You will be asked to update this information on and annual basis. Please refer to the Sliding Fee Discount Charts accompanying this application for the most current discount schedule, which is updated annually based on Federal Poverty Guidelines.

Total Income: \$ _____ **week/two weeks/month/year (circle one)** **Number of people in household:** _____

Household Income				
Person	First Name	Last Name	Amount	Frequency (Circle one)
You	_____	_____	\$ _____	Weekly Monthly Yearly
Spouse	_____	_____	\$ _____	Weekly Monthly Yearly
Children	_____	_____	\$ _____	Weekly Monthly Yearly
Other	_____	_____	\$ _____	Weekly Monthly Yearly
Other	_____	_____	\$ _____	Weekly Monthly Yearly
TOTAL			\$ _____	Weekly Monthly Yearly

I, the undersigned patient or the parent, spouse, or legal guardian of the patient, certify under penalty of perjury that the information above is correct.

Signature _____

Date _____

TURN OVER TO COMPLETE THE OTHER SIDE:

New Patient Demographic Form

Today's Date: ____ / ____ / ____
MM DD YYYY

What is your living situation? (check one)

- Street Homeless
- Halfway House/Agency
- Own or rent house/apartment
- Temporary housing
- Supportive housing
- Shelter
- Other _____

What is your insurance status?

- Uninsured
- Keystone First
- Health Partners
- Medicare
- Medicaid only (no Keystone or HP)
- Other _____

I am interested in becoming a dental patient: No Yes

Registered to vote at current address? No Yes

Veteran? No Yes

Migrant Worker Status: Seasonal Worker Migrant Worker Not a Farm Worker

Parent/Guardian Information: Please list all individuals who are parents with custody or legal guardians with custody.

Name: _____ / ____ / ____
Last First Relationship Date of Birth

Telephone number: _____

Name: _____ / ____ / ____
Last First Relationship Date of Birth

Telephone number: _____

Name: _____ / ____ / ____
Last First Relationship Date of Birth

Telephone number: _____

Emergency Contact: _____
Last First Relationship

Phone: _____

- Home Work Cell

Address: _____

How did you hear about us? _____

Patient or Parent/Guardian Signature

Date



Text Message Opt-In & Consent Form

Project HOME Health Services (PHHS) offers the option to send text messages to you as a patient to provide you with important information, to remind you of your appointments, or to check in with you.

PHHS only sends text messages for these purposes. Patients will not be able to communicate with their doctor or nurse via text message; a phone call is required for any information patients want to share with PHHS. The patient can opt-out at any time by texting “**Stop**” to 206-375-0584.

PHHS will not cover the cost your telephone company may charge to receive text messages. Standard text messaging rates apply.

Occasionally, text messages can get lost or intercepted before they get to your phone. Therefore, PHHS cannot guarantee that you will receive the messages.

PHHS strongly recommends that you protect your phone with a password to prevent others from reading your text messages. It is important to inform us if your phone number changes.

I _____ agree to get text messages from Project Home Health Services at the number(s) listed below.

I understand that this consent form expires 12 months after the date I sign this form. I must re-enroll for PHHS texting services after 12 months to continue services.

Cell phone number: _____
Relationship: ___self___ other: Name _____
Signature: _____ Date _____

Cell phone number: _____
Relationship: ___self___ other: Name _____
Signature: _____ Date _____

Patient Name: _____ **Date of Birth:** ____/____/____
Last First month day year

What do you like to be called: _____ **Assigned Sex at Birth:** _____ **Gender Identity:** _____

Past Health History: Have you ever been diagnosed with the following conditions?					
<u>Condition</u>	<u>Date Diagnosed</u>	<u>Condition</u>	<u>Date</u>	<u>Condition</u>	<u>Date Diagnosed</u>
<input type="checkbox"/> High blood pressure	_____	<u>Diagnosed</u>		<input type="checkbox"/> Post-Traumatic Stress	_____
<input type="checkbox"/> Diabetes (high blood sugar)	_____	<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> High cholesterol	_____	<input type="checkbox"/> Acid Reflux	_____	<input type="checkbox"/> Anxiety	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/> Bipolar Disorder	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Thyroid Disease	_____	<input type="checkbox"/> Schizophrenia	_____
<input type="checkbox"/> Emphysema / COPD	_____	<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> Other (please specify)	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Cancer	_____	_____	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> HIV	_____	<input type="checkbox"/> _____	_____
		<input type="checkbox"/> Anemia	_____		

FOOD ASSISTANCE

Project HOME has an emergency food pantry for patients who are having difficulty buying food at this time. Our healthcare providers can assist you.

1. Within the past 12 months we worried if our food would run out before we had money to buy more. NO YES
2. Within the past 12 months the food we bought did not last and we did not have money to buy more. NO YES

Please circle "O" your answer

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Almost daily
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Feeling nervous, anxious, or on edge	0	1	2	3
4. Not being able to stop or control worrying	0	1	2	3
5. In the last year have you ever drunk or used drugs more than you meant to?			Yes	No
6. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?			Yes	No
7. Many people have thought they would be better off dead. Have you ever tried to kill yourself?			Yes	No
8. When stressed and angry, some people do things they might later regret. Have you ever hit, choked, punched, or otherwise hurt someone you're in a relationship with?			Yes	No
9. In the last year, have you controlled where your partner goes, who they talk to, or how they spend their money?			Yes	No
10. In the last year, have you been hit, choked, punched, or otherwise hurt by someone you're in a relationship with?			Yes	No
11. In the last year, has your partner controlled where you go, who you talk to, or how you spend your money?			Yes	No
12. Do you feel unsafe in your current relationship, or is there a partner from a previous relationship who is making you feel unsafe now?			Yes	No



Surgical History: (please list below including dates)

Hospitalizations/Emergencies: (please list below including dates)

Tobacco Use: Never Former: Quit Date _____
 Current Smoker: packs/day _____ # years _____

Current Alcohol Use: No Yes #drinks/week _____

Recreational Drug Use: No Yes Type: _____

Is there a gun in your home: No Yes

Do you have a living will: No Yes

Occupation: _____

Employer: _____

Relationship Status: _____

Spouse/Partner Name: _____

Children Names and Ages: _____

Family History: Include mother, father, siblings. Please check all that apply and list which family members are affected.

- High blood pressure _____
- Heart Disease _____
- Cancer _____
- Diabetes _____
- Stroke _____
- Thyroid Diseases _____
- Blood Disorders _____
- Genetic Diseases _____

Psychosocial History: (Please list any psychiatric, psychological, or substance abuse treatment including type and dates)

Health Screening:
When was your last (if applicable): Date:
 Check for Diabetes _____
 Cholesterol Check _____
 Colonoscopy _____
 HIV Test _____

FOR PERSONS ASSIGNED FEMALE AT BIRTH:
Are you on birth control, if so, what kind? _____
When was your last (if applicable): Date:
 Last Menstrual Period? ___/___/___
 Pap Smear _____
 Mammogram _____

Medications: List prescription and non-prescription medications, birth control, home remedies, vitamins, herbs, etc.

Medication Name	Dosage	How Many Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (please list any drug and food allergies) None Yes _____ **Latex Allergy** No Yes

SKWC/LCD MLP

A PARTNERSHIP BETWEEN LEGAL CLINIC FOR THE DISABLED & PROJECT HOME

DO YOU NEED LEGAL HELP?

Welcome to the Steven Klein Wellness Center. We are committed to improving the health and well-being of our patients. In our efforts to address the unmet legal needs of many of our patients, Project HOME has joined with the Legal Clinic for the Disabled. This partnership allows us to work together with lawyers in our office to make sure our patients get all the help they might need. Please complete this form to help us see if this program can help you.

*****PLEASE HAND THIS FORM TO YOUR NURSE OR DOCTOR WHEN COMPLETED*****

Your answers are private

Today's date: _____

Please answer YES or NO below

1. INCOME & INSURANCE SUPPORTS

- | | | |
|---|-----|----|
| a) Have you been <u>denied</u> cash or medical assistance from DPW in the past 30 days? | Yes | No |
| b) Do you have questions about Social Security Benefits (SSI/SSDI)? | Yes | No |
| c) Have your food stamps been reduced or cut off in the past 30 days? | Yes | No |

2. HOUSING & UTILITIES

- | | | |
|--|-----|----|
| a) Do you have problems with your landlord getting home repairs (mold, rodents,leaks)? | Yes | No |
| b) Have you received a letter from your landlord threatening to evict you? | Yes | No |
| c) Have you received a letter from PHA threatening to cut off your housing benefits? | Yes | No |
| d) Are you having problems with utility bills? | Yes | No |

3. CONSUMER DEBT

- | | | |
|--|-----|----|
| a) Are you having any problems with creditors for new or old debt? | Yes | No |
|--|-----|----|

4. PERSONAL AND FAMILY SAFETY AND STABILITY

- | | | |
|---|-----|----|
| a) Have you been hit, or threatened by your spouse, intimate partner, or family member? | Yes | No |
| b) Do you want information about separating from your spouse or getting a divorce | Yes | No |
| c) Are you worried about child support or custody? | Yes | No |

5. PERSONAL PLANNING DOCUMENTS

- | | | |
|---|-----|----|
| a) Do you want someone to handle financial matters for you? | Yes | No |
| b) Do you want someone to make health care decisions for you if you are unable to do so? | Yes | No |
| c) Do you have questions about creating a will? | Yes | No |
| d) Are you worried about who will care for your children if your family is unable to do so? | Yes | No |

WOULD YOU LIKE TO SPEAK WITH AN ATTORNEY ABOUT ANY OF THESE ISSUES? YES NO

PLEASE GIVE OR SCAN AND EMAIL TO PETER VALLE, ESQ.

t. 215.587.3179 | f. 215.587.3166

pvalle@lcdphila.org

AUTHORIZATION and RELEASE

I authorize Stephen Klein Wellness Center to provide my name and contact information to the attorneys and staff of the Legal Clinic for the Disabled, Inc.

CLIENT NAME – PLEASE PRINT

CLIENT SIGNATURE

DATE

PROVIDER INFORMATION	PATIENT INFORMATION
NAME: _____	NAME: _____
PHONE #: _____	PARENT/GUARDIAN: _____
	PHONE# _____ LL <input type="checkbox"/> CELL <input type="checkbox"/> WORK <input type="checkbox"/>
	OTHER PHONE# _____ LL <input type="checkbox"/> CELL <input type="checkbox"/> WORK <input type="checkbox"/>
	MESSAGE OK? YES <input type="checkbox"/> NO <input type="checkbox"/>

PLEASE GIVE, FAX/OR SCAN & EMAIL TO:

PETER VALLE ESQ. LEGAL CLINIC
FOR THE DISABLED 1513 RACE STREET
PHILADELPHIA, PA 19102

t. 215.587.3179 | f. 215.587.3166
pvalle@lcdphila.org

Authorization for Disclosure of Confidential Information
Protected Health Information (PHI) and Personally Identifiable Information (PII)

PATIENT, CLIENT OR PARTICIPANT NAME:		
Address (Street, City, State, Zip)	Date of Birth	Telephone
1. <input type="checkbox"/> In order to better coordinate services I receive at Project HOME, please share my confidential and personal information with other Project HOME programs (Checking this box is <u>NOT</u> mandatory in order to receive services).		
2. <input type="checkbox"/> DO NOT share my personal information with the following Project HOME programs/services:		
3. <input type="checkbox"/> Please share my confidential information between Project HOME and the following person and/or institution: Name of Person and/or Institution: _____		
Street Address		
City/State/Zip Code	Telephone	Fax
Please select one: 4. <input type="checkbox"/> Yes, please disclose my confidential/personal information to better coordinate services.		
5. <input type="checkbox"/> Yes, please disclose my confidential/personal information to better coordinate services EXCEPT for the following:		
<input type="checkbox"/> Case management progress notes and service plans <input type="checkbox"/> Medical Records (e.g. <i>history, physical exam, progress notes, emergency department records, in-patient records, radiology/lab results, genetic conditions</i>) <input type="checkbox"/> Dental Records	<input type="checkbox"/> Employment information <input type="checkbox"/> School/Training Program Information <input type="checkbox"/> Financial information <input type="checkbox"/> Records pertaining to health insurance billing <input type="checkbox"/> Other (please specify): _____	
Covering the period(s) of: _____		
6. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I further understand that information in response to this request may be related to diagnosis or treatment for HIV/AIDS, mental health care and treatment, and treatment for drug and alcohol abuse, which may not be re-disclosed by the recipient without my express written consent. If you prefer that we <u>NOT</u> disclose the following information, please indicate your preference below:		
<input type="checkbox"/> AIDS/HIV Information No, do not disclose	<input type="checkbox"/> Mental Health Care/Treatment No, do not disclose	<input type="checkbox"/> Drug & Alcohol Treatment No, do not disclose
Mail/fax/send requested information to Project HOME at:	Fax:	
	Phone:	
AUTHORIZATION (please check one)		
Length of authorization: 7. <input type="checkbox"/> One year from date of authorization <input type="checkbox"/> Other date (not to exceed one year) or event (e.g. authorization ends with _____ termination of tenancy):		
By signing below, I authorize Project HOME and/or Person or Institution named above to disclose my confidential information as detailed herein:		
_____ *Signature of Patient/Client/Participant or Personal Representative Print Name Date		
*If this Authorization is signed by someone other than the patient or client, please state reason (i.e. person is a minor) and indicate signer's relationship to the patient/client/participant: _____		
REVOCATION INFORMATION		
I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing to the address below. I understand that the revocation may not apply to information that has already been released in response to this authorization. <u>MAIL your revocation to:</u> Project HOME, Privacy Officer, 1515 Fairmount Avenue, Philadelphia, PA 19130.		

**Instructions for Completing Form
AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION
(Form version 10.01.2018)**

Item Number	Explanation
1 and 2	<p><u>Boxes 1 and 2 are for Project HOME residents and participants.</u> This is where a resident or participant can tell us it is okay to share their confidential/personal information with other Project HOME programs.</p> <p><u>Box #1 is an important box for a person receiving services from more than one PROJECT HOME department, for example, someone who is a RESIDENT, PATIENT AT PHHS, PRS PARTICIPANT, etc,</u> so that staff from those departments have permission to speak to each other. The form makes it clear that if a person does not want to check Box #1, we will not refuse to serve them.</p> <p>Box #2 allows a person to tell us that they don't want us to share information with certain programs. So, for example, a PATIENT who is also a RESIDENT may tell us not share their health information information with a Property Manager, or vice versa. This is where the Patient who is a Resident would tell us that.</p>
3	<p>This is where a person who is a PROJECT HOME RESIDENT, housing APPLICANT, PATIENT, PARTICIPANT, etc., can tell us where we can send information or request information from an <u>outside 3rd party</u>, such as a hospital, a family member, an Intensive Case Manager from DBH, or a home health aide, for example. If the person is agreeable, it is a best practice to obtain consent for the organization or entity, rather than a specific person. In this case, if that person is out of the office, or leaves their job, you can talk with someone else in their absence.</p>
4 and 5	<p>Boxes 4 and 5 have to do with <u>WHAT TYPE OF INFORMATION WE CAN OR CANNOT SHARE.</u></p> <p>Checking Box #4 allows us to share any type of information that is necessary to coordinate services.</p> <p>Checking Box #5 tells us that it is okay to share information, but there are certain exceptions to what we can share (by checking the boxes below).</p> <p>"Covering the period(s) of:" refers to the period of time about which information may be shared. For example "a hospitalization that occurred in 2006" or "from intake to current"</p>
6	<p>Box 6 states that we will share their confidential information pertaining to AIDS/HIV status, mental health care/treatment or drug/alcohol treatment UNLESS THEY CHECK OFF THE BOX TELLING US NO. <u>If the person is okay with us sharing this information to coordinate their care, they don't have to check anything.</u></p>
7	<p><u>One of the boxes here should be checked.</u> The top box states that the form is in force for one year from the date of signature. The bottom box allows the person to tell us how long they want the form in effect (less than one year) or to write in an event, such as termination of tenancy at PH. This form has to be reviewed</p>

annually with the patient/client/participant.