Illinois Breast and Cervical Cancer Program
Eligibility Determination Form

Shaded area is for IBCCP office use only

☐ **New Client** Registration Date: _____	☐ **Established Client** Annual Date: _____	☐ **Clinical Navigated Insured** Date: _____	**Cornerstone #** _____

Name: _____
Maiden Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
County: _____

Home Phone: _____
Cell Phone: _____
Age: _____ Birth Date: _____/_____/_____
Social Security #: _____-_____-_____
Alternate Contact: _____
Day Phone: _____

Income Eligibility: (circle one)
If single - total income before taxes or if married - total combined income before taxes: $_____ per month/year
Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: _____

Office Use Only: Income status for number in household:
At or below 250% of federal poverty level: ☐ Yes ☐ No Above 250% of federal poverty level: ☐ Yes ☐ No

Medical/Insurance Coverage: ***Check all that apply.***
☐ Medicare Part B – Not eligible for IBCCP
☐ Medicaid ID number _____
☐ I DO NOT have insurance
☐ I have Insurance – Name of Carrier: _____
☐ Are you covered under a parent or spouse insurance? ☐ No ☐ Yes
Does insurance pay for: Pap tests? ☐ No ☐ Yes
Mammograms? ☐ No ☐ Yes
Do you have a deductible that must be met before diagnostic procedures are covered? ☐ No ☐ Yes
How much is your deductible? _____
Please provide a copy of the front and back of your insurance card.

Preferred language for delivery of service:
☐ English (E)
☐ Spanish (S)
☐ Other (O): _____

Marital Status:
☐ Never Married (01)
☐ Married (02)
☐ Widowed (03)
☐ Divorced (04)
☐ Separated (05)
☐ Unknown (09)
☐ Other _____

Years of Education Completed:
☐ _____ (EO # of years)
☐ None (E000)
☐ Unknown (E099)

Employment Status:
☐ Employed full-time (35+ hours weekly) (EFT)
☐ Employed part-time (EPT)
☐ Not in the labor force (NLF)
☐ Other seasonal worker (OSW)
☐ Seasonal/Migrant Farm Worker (SMF)
☐ Unemployed (UNE)
☐ Unknown (UNK)

Are you of Hispanic or Latino origin? ☐Yes (01) ☐ No (00)

What races do you consider yourself? Mark ALL that apply.
☐ White
☐ Black or African American
☐ Asian
☐ Chinese
☐ Japanese
☐ Native Hawaiian/Other Pacific Islanders
☐ Korean
☐ Indian
☐ Filipino
☐ Vietnamese
☐ American Indian/Alaskan Native
☐ Other _____

How did you hear about this program?
☐ Poster (PO)
☐ Flier (FL)
☐ Brochure (BR)
☐ Newspaper (ME)
☐ Radio (ME)
☐ Television (ME)
☐ Case Management Outreach (C)
☐ Community Event (CE)
☐ State Promotional Campaign (ST)
☐ Physician or Health Care Provider (P)
Who: _____ Phone #: _____
☐ Website (Agency/State) (WB)
☐ Other (OTH), Specify: _____

What is the best time to schedule your appointments? (Please mark your choices.)
Day of the week: Monday Tuesday Wednesday Thursday Friday
Time of day: Early morning Mid morning Early afternoon Late afternoon
Preferred Healthcare Provider: _____

I understand that if I have given false information or intentionally failed to disclose information for this application, I may be subject to criminal prosecution, civil action or both. I certify under the penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature _____ **Date** _____

Winnebago County Health Department

Illinois Breast and Cervical Cancer Program
HEALTH ASSESSMENT

Name: _____ **Date:** _____

BREAST HEALTH QUESTIONS

YES	NO	
☐	☐	1. Do you perform a monthly breast self exam?
☐	☐	2. Have you noticed a lump in your breasts?
		3. If yes, which breast? Right _____ Left_____
☐	☐	4. Have you noticed any breast tenderness or pain?
☐	☐	5. If yes, did the breast tenderness or pain increase around the time of your menstrual period?
		6. If you answered yes to question #4, which breast? Right _____ Left_____
☐	☐	7. Have you noticed any spontaneous discharge from your nipples?
		8. If yes, which breast? Right _____ Left_____
☐	☐	9. Have you noticed any other symptoms related to your breasts?
		If yes, explain: _____
☐	☐	10. Have you ever had a clinical breast exam done by a doctor or nurse?
		11. If yes, list provider where clinical breast exam was done: _____
☐	☐	12. If yes, date of last exam (before this current visit): _____/_____/_____
☐	☐	13. Have you ever had a mammogram?
		14. If yes, list provider where mammogram was done: _____
		15. If yes, date of last two mammograms (before this current visit): _____/_____/_____, _____/_____/_____
☐	☐	16. If unknown was it more than 5 years?
☐	☐	17. Have you ever had breast cancer?
☐	☐	18. Has your mother, sister or daughter had breast cancer? If no, go to question 21.
		19. If yes, who? _____
		20. If yes, at what age? _____ years old
☐	☐	21. Do you have a breast implant or implants?
☐	☐	22. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
		23. If yes, which breast? Right _____ Left_____
		24. If yes, list the provider who performed the procedure_____
☐	☐	25. Did the results of this breast procedure require further follow up?

(OVER)

Illinois Breast and Cervical Cancer Program
HEALTH ASSESSMENT

CERVICAL HEALTH QUESTIONS

YES	NO	
☐	☐	26. Have you ever had a Pap test?
		27. If yes, list provider where Pap test was done: _____
		28. If yes, date of last two Pap tests: (before this current visit): _____/_____/_____, _____/_____/_____
☐	☐	29. If unknown was it more than 5 years?
☐	☐	30. Were your last Pap test results normal?
☐	☐	31. What was the date of your last menstrual period? _____/_____/_____
☐	☐	32. Have you had a hysterectomy?
☐	☐	33. If yes, was your cervix removed? I do not know_____
☐	☐	34. If you had a hysterectomy, was it due to a past history of cervical disease or cervical cancer?

TOBACCO QUESTIONS

YES	NO	
☐	☐	35. Do you smoke cigarettes?
☐	☐	36. If yes, are you ready to quit smoking?
☐	☐	37. If yes, are you interested in being referred to the Illinois Tobacco Quitline?

38. What date was the referral sent to the Tobacco Quitline? ___/_____/_____
(Question # 38 to be completed by IBCCP Lead and Consortia Agency staff for data purposes.)

Illinois Breast and Cervical Cancer Program
ACCESS TO QUALITY CARE QUESTIONNAIRE

Name: _____ **Date:** _____

ACCESS TO QUALITY CARE QUESTIONS

The questions below are related to the Affordable Care Act and will assist the Illinois Breast and Cervical Cancer Program (IBCCP) in gathering data to gain a better understanding of how the current healthcare changes will affect women who need IBCCP.

YES	NO	
☐	☐	48. Illinois has expanded their **Medicaid Program** and added **Marketplace Insurance Programs**. Do you know if you could be covered by either of these Programs?
☐	☐	49. Have you signed up for Medicaid?
☐	☐	50. If you signed up for Medicaid, do you have your Medicaid card?
☐	☐	51. If you have **not** signed up for Medicaid, have you signed up for the Marketplace Insurance Program?
☐	☐	52. If you have signed up for the Marketplace Insurance Program, do you have your Insurance card?

53. If you are currently not in either one of these Programs, why not? (Please check all that apply)

- ☐ Cost
- ☐ Doesn't Fit My Needs
- ☐ Lack of Understanding
- ☐ Unsure of How to Sign Up
- ☐ Rather Pay Penalty
- ☐ Lack of Resources to Sign Up
- ☐ Other _____
- ☐ Was Enrolled, but No Longer Enrolled

RESIDENCY QUESTIONS

The next set of questions is related to residency and will assist in providing healthcare services to the women who need IBCCP. You do not have to provide this information, and your application will not be affected in any way if you do not respond.

YES	NO	
☐	☐	54. Are you a US citizen?
☐	☐	55. Have you been a legal resident of the US for at least 5 years?

56. What is your country of origin? _____

Winnebago County Health Department

Illinois Breast and Cervical Cancer Program of Winnebago, Boone, and DeKalb Counties

CLIENT NAME: _____ Client Date of Birth: _____

Please list **all** persons living in the household on the worksheet. This includes client, spouse, children, step-children, grandchildren, elderly parents, and other family member or non-family members residing in the household.

Household Member	*Relationship to client*	*Age*	*Employment Income (Monthly)*	*Other Income (Monthly)*	*Source of Other Income**
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

*Other Income may include: Social Security, child support, spousal support, rental property, unemployment benefits, pensions, and trusts.

Client Signature _____ Date _____

*****PLEASE SEND PROOF OF INCOME FOR CLIENT AND SPOUSE*****

This section to be completed by IBCCP staff only:
Total Household Size (include only client, spouse, and children or stepchildren of the client who are under age 19) _____
Total Income (include income from only the individuals included in the total household size) $_____

Winnebago County Health Department

Illinois Breast & Cervical Cancer Program
Income and Age Affidavit

You are being asked to complete this form because you do not have written documentation of income and/or age.

I, _____, reside at _____

and attest to the fact that I have received $_____ income for the period covering a month/year (circle one). This is my income before taxes. I am single/married (circle one). This income supports _____ (number of people in household. I further attest that my birth date is ____/_____/_____ and that I am _____ years of age.

I understand that to perjure myself in order to obtain assistance is a fraudulent offense for which I will be terminated from the Illinois Breast and Cervical Cancer Program.

Signature _____

Witness _____

Date _____

**If you cannot provide proof of age and/or income you must provide a reasonable explanation why. IBCCP staff will evaluate upon receipt if we will accept your age/income affidavit alone.

Provide explanation here:

_____

_____

_____

_____

If any questions, please call the IBCCP office at 1-815-972-7250 or 1-800-511-4315.

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION

I. PROGRAM DESCRIPTION:

The Illinois Breast and Cervical Cancer Program (program) is a cooperative effort between the Illinois Department of Public Health, Office of Women's Health, and the U.S. Centers for Disease Control and Prevention (CDC). The program encourages routine breast and cervical cancer screening and provides free screening and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screening is to detect cancer, if present, at an early stage so it can be treated or cured. Screening for breast cancer involves a clinical breast examination and a mammogram (a breast X-ray). Screening for cervical cancer involves a pelvic examination and a Pap test (scraping from the cervix).

II. CONSENT TO PARTICIPATE AND RELEASE OF INFORMATION:

I understand and agree to the following:

- I will provide proof of age and income to determine program eligibility. If I have insurance coverage, I will provide a copy of my insurance card and written verification of covered services. If while enrolled in IBCCP I obtain insurance, I will inform Lead Agency staff.

- I give permission to my health care provider(s), hospital, clinic, laboratory and/or mammography facility to provide information concerning my breast and cervical cancer screening, diagnostic examinations and/or treatment status to program staff.

- I understand that the program must obtain certain statistical information for reports, including but not limited to age, income, insurance and any services I am provided through this program. This information may be used by the program and the CDC to learn more about breast and cervical cancer and to ensure the quality of services provided through the program. **My name will not be used in these reports, except as required by law.**

- My health care provider and/or the program staff will try to contact me regarding my test results. I understand that, despite efforts to find me, my health is my own responsibility and I may need to contact my provider for my test results.

- I understand that if the provider orders tests not covered by the program that I may be responsible for payment of those services as the program cannot pay for some diagnostic exams. A list of allowable services is available upon request.

- If I am diagnosed with a pre-cancerous or cancerous condition of my breasts or cervix, information from my IBCCP file will be released to the Illinois Department of Healthcare and Family Services. This information will be used to determine if I am eligible for state paid health benefits through Medicaid.

- If I am not eligible for Medicaid coverage, the program staff will assist with securing payment for treatment services through private sources, community based sources, other governmental grants or pro bono from a provider.

- If I am eligible for state paid health benefits through Medicaid, I give my permission for program staff to obtain information about my treatment for breast or cervical cancer. This information will be used to determine my treatment status and my continued enrollment in Medicaid.

- I have received literature and/or education on all of the following: breast self-exam, mammograms, and Pap tests.

- I will receive notification from the program staff to remind me when it is time for me to go back to my medical provider for my annual examination and follow-up testing, if appropriate.

- I will notify the program of any change in my address and/or telephone number.

- I will write or call the local program staff to inform them if I no longer wish to be a part of this program. This notification will be recorded in my program records.

- I understand the importance of keeping all appointments made for me so my care can be provided in a timely manner. When it is necessary to cancel or change an appointment, I will notify the agency of this change.

- Missed appointments or repeated "no show" appointments are not acceptable and I can potentially lose my ability to receive screening if this happens.

Client Signature _____ **Date** _____

Winnebago County Health Department

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH
BREAST AND CERVICAL CANCER PROGRAM
AUTHORIZATION TO OBTAIN INFORMATION

I hereby give consent to release the following information:

☒ Clinic Report
☒ Medical Reports
☒ Laboratory Report
☒ Other _____

Regarding:

Client's Name: _____

Client's Address: _____

Date of Birth: _____/_____/_____

To: **Winnebago County Health Department**
Attn: IBCCP (Illinois Breast & Cervical Cancer Program)
P.O. Box 4009
Rockford, IL 61110-0509
Phone: 815-972-7250

I agree to release said provider, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice. Unless I revoke sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photo static copy or facsimile of this consent will be valid as the original, even though such copy does not contain the original writing of my signature.

_____ _____
Signature Date

_____ _____
Witness Date

CONSENT and ACKNOWLEDGEMENT
Receipt of Joint Notice of Privacy Practices

I, _____(print name of client) do hereby consent to allow Winnebago County Health Department (agency name) and its designated employees and contractors to perform:

- Pelvic and/or breast examinations and screenings and
- Necessary diagnostic follow-up tests

I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the agency dated April 14, 2003.

_____
Signed

_____
Date

FOR STAFF USE ONLY:
I attempted to obtain an Acknowledgement of the Receipt of the Notice of Privacy Practices on behalf of the delegate agency. The agency was unable to obtain the Acknowledgement because:

- ☐ Client refuses to sign
- ☐ Other _____(specify)

_____ Staff member's initials _____ Date

(Staff: Place Acknowledgement in patient's medical record.)

Winnebago County Health Department

STATE OF ILLINOIS
CORNERSTONE
CORNERSTONE INFORMED CONSENT FORM

Name of Participant:

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (Month/Day/Year) _____ ○ Male ○ Female Participant s ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; Healthy Families Illinois; and Family Health History Questionnaire/Genetics.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Department of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client s name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize **Winnebago County Health Department** to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal; birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program; and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared;

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Department of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photostatic copy/fascimile of this consent will be as valid as the original.

For Child Participant:

_____
Signature of parent/legal guardian/caretaker/Date

OR

For Adult Participant:

_____
Signature of adult participant/Date

Signature of Witness: _____ Date: _____

Revised April 2011

Winnebago County Health Department

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM OF WINNEBAGO, BOONE, AND DEKALB COUNTIES

REQUIRED VERIFICATION

PLEASE READ THIS FORM CAREFULLY. THIS INFORMATION MUST BE RECEIVED BY IBCCP BEFORE YOUR APPOINTMENTS CAN BE SCHEDULED.

You **must** include the following verification with your enrollment/re-enrollment packet in order for your paperwork to be processed and your appointments to be scheduled. **This income requirement is for you and your spouse, if married.**

- **Age Verification** (required for new IBCCP clients only): include copy of your driver's license, ID card or birth certificate

- **Income Verification**: copy of 2 current paycheck stubs, W-2s, or first page of recent tax return 1040 for you and your spouse, if married
  - Income includes Social Security, Disability pay, unemployment, child support, alimony: provide documentation (copy of eligibility letter, copy of bank statement if direct deposits, copy of check stubs, etc.)
  - If self-employed, include copy of first page and expenses page of 1040 tax return
  - If you receive food stamps and have no documented income, your food stamp eligibility letter can count as eligible income: include a copy of the eligibility letter.

- **Deductions** from income: daycare expense, child support payment, alimony paid. Include documentation of deductions.

*****If you have no income or income documentation, please call our office at (815) 972-7250 or 1-800-511-4315 for more information.**

Medicaid Verification

If you have Medicaid, it should cover the charges for your exams and screenings. If you are on a spend-down, you may still qualify for the Program. **Please include the amount of any spend-down payment that is required to be paid by you**

Amount of spend-down $ _____

Insurance Verification

If you have private insurance, and it will cover any of the charges for your exams, you do not qualify for the program. If your insurance does not cover your annual exams and screenings, you must submit documentation that the specific services are not covered by the insurance. **Please include a copy of the front and back of your insurance card.**

*****If any questions, please call the IBCCP office at 1-815-972-7250 or 1-800-511-4315.**

WCHD Winnebago County Health Department

Promoting a Safer and Healthier Community Since 1854

Sandra Martell, RN, DNP
Public Health Administrator

JOINT NOTICE OF PRIVACY PRACTICES
Winnebago County Health Department

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.

The Winnebago County Health Department works with other practitioners in delivering services to you. The practitioners include doctors and medical personnel who are not part of the Winnebago County Health Department workforce. All of these practitioners will follow this Joint Notice of Privacy Practices in delivering service to you.

The Winnebago County Health Department and the practitioners involved in your care create a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. The uses and disclosures described in this Notice are applicable to the health department and all of the practitioners (collectively "we") who are part of this Joint Notice of Privacy Practices while they are delivering services at a health department facility or on behalf of the health department. This Joint Notice does not apply to service providers who are not part of the health department when they deliver services elsewhere or only on their own behalf.

We are required by federal and state law to maintain the privacy of your protected health information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain medical information about you in treating you. This medical information is called "protected health information" or "PHI". Your PHI is used by us to treat you. For example, we refer to PHI in treating you at the health department. We may also send your PHI to another physician or counselor to which we refer you for treatment. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We may use your PHI to obtain payment for the services that we render. For example, we may send your PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our clients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may use and disclose your health care information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI by the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional institutions and custodial situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal privacy laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, we will accommodate it.

Inspect and Access: You have a right to inspect information used to make decisions about your care. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at the health department offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with the health department by calling our Privacy Officer at (815)720-4000. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

We maintain a facility directory so that if family or friends ask us about your condition, we can tell them general information and the fact that you are here. If you do not want us to tell anyone you are here, please tell us now.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice on our website at http://www.wchd.org, or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

If we seek help from individuals or entities who are not part of this Notice in our treatment, payment, or health care operations activities, we will require the those persons to follow this Notice unless they are already required by law to follow the federal privacy rule.

EFFECTIVE DATE: April 14, 2003

S:/HIPAA/forms