Barnabas CENTER
CONNECTING PEOPLE, HELP AND HOPE

Common Intake for Services
(Financial assistance, Medical services, Dental services)

Date: _____

First Name: _____ Middle Initial: ____ Last Name: _____

Suffix: ☐ I ☐ II ☐ III ☐ IV ☐ Jr. ☐ Sr. DOB: _____

Address: _____

City & State: _____ Zip Code: _____

Nassau County Resident: Yes ☐ No ☐ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone_____

Race: ☐ Asian/Pacific Islander ☐ Black/African American ☐ White/Caucasian ☐ Native/American

☐ Multiracial ☐ Other _____ ☐ Decline to Answer

Gender: ☐ Male ☐ Female ☐ Non-binary

Marital Status: ☐ Married ☐ Single ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

How many adults (18 years and older) <u>including yourself</u> live at the same location as you? _____

How many children (17 years and under) live at the same location as you? _____

Reason for appointment at Barnabas Center:

☐ Rent Payment ☐ Utility Payment ☐ Medical Services ☐ Dental Services ☐ Bike

☐ Clothing ☐ Household items ☐ Empowerment Case Management Program

Are you: ☐ Living in a hotel/motel ☐ Renting ☐ Homeowner ☐ Living with friend/relative

☐ Living in a shelter/ transitional housing facility ☐ Living in a place not meant for human habitation

Are you going to lose your current housing in the next 30 days and have no other place to go?
☐ No ☐Yes

Are you currently employed? ☐ Yes ☐ No **Name of Employer**: _____

Are you retired or on Social Security Disability? ☐ Yes ☐ No

When did you last work (month and year): _____ **Highest school grade completed**: _____

Do you receive Food Stamps? ☐ No ☐ Yes Amount per month: _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Are you a US Military Veteran? : ☐ Yes ☐ No

Are you a United States Citizen? : ☐ Yes ☐ No

Do you have a valid ID/Driver's license? : ☐ Yes ☐ No

Do you have proof of <u>all the income</u> in your household? ☐ Yes ☐ No

Do you have a vehicle for transportation? : ☐ Yes ☐ No

Emergency Contact and Telephone #: _____

How did you hear about Barnabas Center? ☐ Former client ☐ Friend/Relative ☐ Barnabas Flyer

☐ Hospital ☐ Newspaper ☐ Barnabas Mobile Health Van ☐ Web Site ☐ Other_____

Please list other adults in your household besides yourself:

Last Name _____ First Name _____ Relationship _____ DOB _____

Last Name _____ First Name _____ Relationship _____ DOB _____

Last Name _____ First Name _____ Relationship _____ DOB _____

Please list children in your household (17 years old and younger)

Last Name _____ First Name _____ Relationship _____ DOB _____

Last Name _____ First Name _____ Relationship _____ DOB _____

Last Name _____ First Name _____ Relationship _____ DOB _____

Last Name _____ First Name _____ Relationship _____ DOB _____

Your Signature_____ Date _____

Barnabas Eligibility status:	◯ 300% of FPG **eligible Dental services only**
	◯ 300% of FPG eligible for Dental and Medical Services
	◯ 200% of FPG
Staff signature _____	

INCOME / EXPENSE INFORMATION

Participant Name: _____

YOUR MONTHLY GROSS INCOME

EARNED INCOME	$
UNEMPLOYMENT INCOME	$
CHILD SUPPORT	$
ALIMONY OR SPOUSAL SUPPORT	$
Soc.Sec./Soc. Sec. Disability	$
SSI	$
WORKERS COMPENSATION	$
FOOD STAMPS	$
TANF	$
VETERAN'S PENSION	$
PENSION FROM FORMER JOB	$
OTHER SUPPORT	$
	$
TOTAL	$

TOTAL HOUSEHOLD INCOME: $

OTHER HOUSEHOLD MEMBER GROSS INCOME

EARNED INCOME	$
UNEMPLOYMENT INCOME	$
CHILD SUPPORT	$
ALIMONY OR SPOUSAL SUPPORT	$
Soc.Sec./Soc. Sec. Disability	$
SSI	$
WORKERS COMPENSATION	$
FOOD STAMPS	$
TANF	$
VETERAN'S PENSION	$
PENSION FROM FORMER JOB	$
OTHER SUPPORT	$
	$
TOTAL	$

MONTHLY EXPENDITURES

RENT/Mortgage	$
ELECTRICITY	$
FOOD	$
PROPANE	$
WATER	$
CABLE TV	$
CAR PAYMENT	$
CAR INSURANCE	$
CHILD CARE	$
CREDIT CARD MINIMUM PAYMENT	$
TELEPHONE	$
CELL PHONE	$
MEDICAL/PRESCRIPTIONS	$
HEALTH INSURANCE	$
AUTO GAS	$
PAYROLL DEDUCTIONS	$
OTHER	$
TOTAL	$

SUMMARY

TOTAL HOUSEHOLD INCOME	$
TOTAL HOUSEHOLD EXPENSE	$
TOTAL INCOME - TOTAL EXPENDITURES	$

INTERVIEWER REMARKS:

_____

Interviewer Signature _____

Florida Statute 817 provides that willlful false statements or misrepresentation concerning income, asset or liability information relating to a financial condition are a misdemeanor of the first degree, punishable by fines and imprisonment 777.082 or 775.83.

_____
PARTICIPANT SIGNATURE

DATE _____

Revised 1-2016

BARNABAS CENTER, Inc.

1303 Jasmine Street, Suite 101, Fernandina Beach, FL 32034
Phone: (904) 261-7000 Fax (904) 277-2984

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

1. Client Name:		
2. SS # (last 4 digits):	DOB:	Phone #
3. Address:		

Sender and Receiver:
I understand & accept that Barnabas at times will collaborate with other community providers to coordinate services I receive from Barnabas. I hereby authorize Barnabas Center to: RELEASE/OBTAIN/ EXCHANGE INFORMATION WITH:

1. Landlord/Property Owner/Property Manager
2. Utility Company/Provider
3. Employer/Prospective Employer
4. Other Service Provider: (Please specify by name)

What to Disclose:

_____ Information Regarding Services Received
_____ Income Verification/Tenant Certification
_____ Intake/Assessment Information
_____ Legal
_____ Educational Information
_____ Other (please specify:)_____
_____ Information Related to Utility Bill/Usage/History
_____ Information Related to Rental Property/Usage/ History/Others in Residence

How Disclosure May Occur: __x___ Written ___x__ Electronic ___x__Verbal ___x__Fax

Purpose/Use of Disclosure
___x__ To determine services needed/provided
____x_ Documentation needed for determination of Crisis Assistance

Release Valid For:
_____ A single disclosure
_____ Continuing Disclosure for 30 – 60 – or 90 days from signature below
_____ Revoke Authorization as of _____

Consent: I have read and understand this information. I have received a copy of this form and I am the participant or am authorized to act on behalf of the participant to sign this document verifying authorization for the use or disclosure of the Protected Health Information under the above stated terms.

Date:
Client's Signature:
Signature of Witness:

Updated 8/2019

Barnabas Empowerment Program

Barnabas is here to give you the tools and support to be your best self.

Would you like one-on-one assistance with a Case Manager?

How can we help you, check all that may apply

☐ Job Search ☐ Resume Writing ☐ Interview Skills

☐ Budgeting ☐ Savings ☐ Communication Skills

☐ Goal Setting ☐ Local Resources ☐ Other_____

Please share your concerns:

_____

_____

_____

_____

_____

_____

Our Case Manager will be contacting you,

Name: _____(please print)

Phone:_____

Email:_____

☐ Please check if not interested.

BARNABAS MEDICAL/DENTAL SERVICES

As our patient, we offer you the choice to **voluntarily** answer the questions below. A Barnabas Resource Coordinator is available to talk with you about resources that may be helpful to you.

Date: _____

Patient Name: _____ Phone number _____

	In the past 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	___ Yes ___ No
	In the last 12 months, has your utility company shut off your service for not paying your bills?	___ Yes ___ No
	In the last 12 months, have you needed to see a doctor, but could not because of cost?	___ Yes ___ No
	In the last 12 months, have you needed to see a dentist, but could not because of cost?	___ Yes ___ No
	In the last 12 months, have you ever had to go without health care because you did not have a way to get there?	___ Yes ___ No
	Are you worried that in the next 2 months, you may not have stable housing?	___ Yes ___ No
	Are you afraid your health or safety may be at risk in your home?	___ Yes ___ No
	Do you have legal issues that are keeping you from getting a job or housing?	___ Yes ___ No
	Your Signature_____ Your Phone # _____	

Resource Coordinator signature_____

Date of Review with Patient _____

Revised 11/2019

Barnabas
CONNECTING PEOPLE, HELP AND HOPE

1303 Jasmine Street, Suite 101
Fernandina Beach, FL 32034
(904) 261-7000
www.BarnabasNassau.org

Assistance Policy

Barnabas Center is a local health and social service organization whose mission is to provide assistance to Nassau county residents in crisis. We strive to help individuals & families overcome crisis and achieve self-sufficiency. Services may include help with rent/mortgage & utility payment, food and medical and dental care. In order to be considered for any Barnabas's services certain documentation and eligibility requirements must be met by those seeking assistance.

ELIGIBILITY CRITERIA:

- Proof of **Nassau County residency is required** (examples: Florida driver's license, Florida picture I.D., proof of mail received at residence);
- Social security number must be verified;
- Proof that all appropriate household income is 200% or below the Federal Poverty Level (examples: previous 4 weeks' pay stubs, tax returns, social security statements);

PAST DUE RENT/ MORTGAGE ASSISTANCE

1. Copy of current lease or mortgage agreement.
2. Completed W9 by landlord (Barnabas will provide a blank W9).
3. Barnabas *Landlord Statement* form completed and signed by the landlord.

- **Barnabas personnel will contact landlord to verify information provided.**
- **Assistance will not be considered for individuals or families who live in landlord's main home, or who live in a family members' home or property, or for temporary housing.**
- **Assistance will not be considered for housing deposits.**
- **Proof of personal or household circumstances that have created a crisis situation that has caused the rent/mortgage to be past due and eviction possible.**

FIRST MONTH RENT ASSISTANCE for NEW HOUSING

1. Barnabas *New Housing: First Month Rent Assistance* form completed and signed by the landlord.

- **Deposits for the new rental and utilities must be paid in full prior to receiving Barnabas first month rent assistance. Assistance will not be considered for deposits.**

PAST DUE UTILITIES ASSISTANCE (electricity, water, gas)

1. Copy of past due or cutoff notice from the utility company.
2. Copy of the current rental or mortgage agreement.

- **Barnabas will first refer individuals and families to other local agencies for assistance with utilities.**
- **Barnabas may assist with utilities if other local agencies are temporarily out of funds.**

Financial assistance is only considered once in a 12 month period. If an individual or family returns for additional financial assistance within 24 months of the last time they received assistance, participation in budgeting help is required before Barnabas will consider additional financial assistance. A Barnabas Case Manager will also meet with participants prior to Barnabas considering additional financial assistance.

FOOD

- Assistance with food is available to individuals and families once every 30 days.

ADDITIONAL ASSISTANCE

- Certificates to Barnabas "New-To-You" resale store are available for qualifying individuals and families to help with urgent needed items such as clothing, sheets & furnishings.
- The Adult Bikes for Barnabas program provides bikes to participants needing transportation to and from work.

MEDICAL CARE

1. Barnabas medical care is available to adults 18 years and older who do not have medical insurance.
2. Fees are calculated on a sliding fee scale based on the current household income.
3. Services must be paid for in cash, credit card or debit card. Checks are not accepted.
4. Assistance with the purchase of medications prescribed by Barnabas medical personnel may be provided in an emergency situation only.

DENTAL CARE

1. Dental care is available to adults 18 years and older who do not have dental insurance.
2. Dental services are provided at reduced rates based on the dental service provided.
3. Services must be paid for in cash, credit card or debit card. Checks are not accepted.

REFERRALS – Barnabas personnel can assist with referrals to other agencies or programs.

Barnabas Center personnel reserve the right to disqualify individuals or families based on false or misleading information.

Updated 6/2016

Barnabas
Health Services, Inc.

NOTICE OF PRIVACY PRACTICES
Barnabas Center, Inc.
PHONE: 904-261-7000
FAX: 904-277-2984

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for Barnabas Inc.operations are: internal Barnabas programs providing you services; financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
uses or disclosures for health related research;
uses and disclosures to prevent a serious threat to health or safety;
uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
disclosures of de-identified information;
disclosures relating to worker's compensation programs;
disclosures of a "limited data set" for research, public health, or health care operations;
incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able

to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Barnabas
CONNECTING PEOPLE, HELP AND HOPE

1303 Jasmine Street, Suite 101
Fernandina Beach, FL 32034
(904) 261-7000
www.Barnabasnassau.org

SERVICE POLICY

A.It is the policy of Barnabas Center and Barnabas Health Services to encourage appropriate client / patient / client / participant behavior within all of its programs and sites. In the interest of maintaining a safe environment for clients, patients, participants, customers, volunteers, and staff, Barnabas reserves the right to refuse service to any person whose actions or behavior is inappropriate and includes, but is not limited to, any of the following:

1) Possession of weapon (s) of any kind;
2) Harassment, abusive or defamatory language, injuries, violence or threats of violence towards staff, volunteers, clients, patients, clients, participants, tenants or others on the property of Barnabas or affiliated with Barnabas;
3) Theft or damage of Barnabas property;
4) Lewd or obscene behavior;
5) False or misleading information submitted to obtain Barnabas services.

B.In the event of any inappropriate actions or behavior such as those noted above, Barnabas reserves the right to contact law enforcement to have the individual(s) removed from the premises.

C.Barnabas reserves the right to permanently refuse services to the individual(s) involved based on the seriousness of the individual(s) actions or behavior.

GRIEVANCE POLICY

A. It is the policy of the Barnabas Center to address any complaint or appeal of a participant in a timely manner.
B. Participants are encouraged to request a meeting with a member of the management staff to discuss their problems and concerns.
C. If the participant believes the issues and concerns were not addressed satisfactorily, a written grievance may be filed.
D. Participants of Barnabas Center have the right to file a written grievance concerning any aspect of the services received.
E. Participant grievance forms are available on Front Reception staff / volunteers and Health Services Reception staff/volunteers.
F. The written grievance is to be addressed to Barnabas Center / Attention Barnabas CEO. G. The Barnabas CEO or designated staff will be responsible for a response within three (3) business days of receipt of the grievance.

Barnabas
CONNECTING PEOPLE, HELP AND HOPE

1303 Jasmine Street. Suite
101 Fernandina Beach. FL
32034 (904) 261-7000
www BarnabasNassau.org

HOLD HARMLESS AGREEMENT

The Barnabas participant and or their families agree not to hold Barnabas Center, Inc., and its subsidiaries, a charitable, non-profit organization, its officers, directors, employees, and volunteers, for any liability. The participant further agrees to not hold the organization, its officers, directors, employees, and volunteers responsible for ill-effects, injury or loss (including death) that may result or arise out of or be related to any volunteer duties/services given to them by Barnabas Center, Inc. and its subsidiaries.

1303 Jasmine Street, Suite 101
Fernandina Beach, FL 32034
(904) 261-7000
www.BarnabasNassau.org

Barnabas
CONNECTING PEOPLE, HELP AND HOPE

PARTICIPANT BILL OF RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

1. Be treated with courtesy and respect;
2. Have protection of your need for privacy;
3. A prompt and reasonable response to your questions and requests;
4. Know what services are available; including whether an interpreter is available should you need one to translate;
5. Access to Barnabas services regardless of race, gender, age, national origin, religion, or handicap;
6. Refuse Barnabas services;
7. File a written grievance if you feel your rights have been violated or you feel you have been treated unfairly.

YOU ARE RESPONSIBLE FOR:

1. Providing accurate and complete information as required to receive Barnabas services;
2. Reporting changes in your required information;
3. Keeping scheduled appointments and giving a 24 hour notice if unable to keep an appointment;
4. Behavior that is not threatening, offensive or aggressive towards others;
5. Payment of any fees that is required for services.

Updated 2016

Barnabas
CONNECTING PEOPLE, HELP AND HOPE

Health Insurance Information

Patient full name: _____

What type of insurance do you have?

☐ Private ☐ MEDICARE ☐ United Health

☐ CHAMPVA (veterans) ☐ MEDICAID ☐ Sunshine Health

☐ Dental ☐ Humana Health

☐ Ambetter Health

☐ NONE

Barnabas will verify your insurance status.

Please provide your Social Security number: _____

Please provide your date of birth: _____

Print Name: _____

Signature: _____ Date: _____

Verification of insurance by Barnabas resulted in:

◯ Patient does not have insurance.

◯ Patient does have insurance:

Type: _____

Type: _____

Barnabas Staff signature: _____

Barnabas
CONNECTING PEOPLE,
HELP AND HOPE

REQUEST FOR DESIGNATION OF THOSE INVOLVED IN MY CARE

Are there people you want to be able to:

- Make/Cancel appointments on your behalf?
- Discuss your dental treatment?
- Discuss your financial account/ make payments on your account?

I request that Barnabas Health Services allow communication concerning the above patient's care to those individuals I have listed below. I realize that if agreed to, this designation will stay in effect until I complete a new HIPAA 4000 form.

Printed Name: _____ Relationship/Phone #: _____

Printed Name: _____ Relationship/Phone #: _____

Printed Name: _____ Relationship/Phone #: _____

Emergency Contact

An emergency contact should be someone who has an alternate telephone number than the one listed for you, as our patient, that we may call should we have an emergent health related issue involving your care.

Printed Name: _____ Relationship/Phone #: _____

Signature: _____ Date: _____

Must be signed by the patient or legal guardian. If you have legal paperwork that designates you as the caretaker, please provide copies of that paperwork.

Barnabas Health Services is not required to agree to all your requests, however, if reasonable and administratively feasible, we will make every effort to comply.

NOTE: As a designated advocate for the patient, this does not allow any designee to request records on the patient. Such action will require a signed authorization from the patient. Thank you.

Barnabas
CONNECTING PEOPLE, HELP AND HOPE

PARTICIPANT SIGNATURE PAGE

FOLLOWING REVIEW OF ADMISSION INFORMATION

I _____ have read the following Barnabas admission
Participant Name

policies and I understand and accept them as they relate to the assistance Barnabas is providing me.

☐ **Barnabas Assistance Policy** ☐ **Notice of Privacy Practices**

☐ **Hold Harmless Policy** ☐ **Participant Bill of Rights & Responsibilities**

☐ **Service Termination/Grievance Policy**

_____ _____
Participant Signature Date

_____ _____
Barnabas Volunteer/Personnel Signature Date