How to qualify for Barnabas Center Services

Our services are available to Nassau County residents whose income is 200% below the poverty income guidelines for crisis assistance and 300% for Medical and Dental. (see chart below)

Medical and Dental Services
Must not have:

- Medical insurance
- Dental insurance

Must provide:

- Valid photo ID
- Social Security Card
- Proof of Nassau County Resident
- (bank letter, utility bill)

Proof of Income

- Working- 4 weeks of pay stubs (2 for biweekly, 4 for weekly)
- Self-employed- Tax return until April or 3 months of bank statements
- Cash apps- 3 month statement
- SS or SNAP award letters
- Workers Compensation Letter
- Unemployment Letter

no screenshots will be accepted

Crisis Assistance Services
Please call 904-261-7000 for a pre-screen.

Food stamp and Medicaid application
Fernandina office, Tuesdays- Walk-in First come First serve 9am-3pm
Callahan office only by appointment. Call 904-261-7000 Ext 104

2026 Federal Poverty Guidelines

Monthly Income

Family Size	200% Crisis Assistance	300% Medical Dental
1	2,660	3,990
2	3,607	5,410
3	4,553	6,830
4	5,500	8,250
5	6,447	9,670

Annual Income

Family Size	200% Crisis Assistance	300% Medical Dental
1	31,920	47,880
2	43,280	64,920
3	54,640	81,960
4	66,000	99,000
5	77,360	116,040

Updated 02/2026

To avoid any delay in registering for Barnabas Center services, please ensure the following:

- write legibly, neat and clear
- all questions are answered thoroughly and accurately
- sign in all designated highlighted areas where a signature is required
- all required documentation must be submitted along with the application, including:
    - Photo ID
    - Proof of Income
    - Proof of Nassau County residence
    - Medical/ Dental history forms

Documentation that requires to be sent by email can be sent to forms@barnabasnassau.org

Applications that are incomplete, unsigned, illegible, or missing documentation will not be accepted.

If you require assistance in completing the forms. We are happy to help.

Thank you for your cooperation.

Updated 02/2026

Common Intake for 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? ______________

How many pets do you have in your home? _________

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

Do you have a picture ID : ☐ 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 Center Flyer

☐ Hospital ☐ Newspaper ☐ Barnabas Center Event ☐ 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 ______________

Office Use Eligibility status:	◯ 300% of FPG eligible for Dental Services only (**has health insurance**)
	O 300% of FPG and eligible for **both** Dental and Medical Services (**no insurance**) O **Medicaid Dental Insurance**/eligible for Dental Services **only**
	O 200 % of FPG (**limit required for financial assistance eligibility**)

Staff Signature: Date:

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 willful 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

Universal Authorization for Release of Health Information

I__________________ hereby authorize Barnabas Center Health Services Inc and its entities, its officers or agent to

(initial) ________ request and release _____ request only _____ release (permit inspection, transmit)
Information compiled in the ordinary course of business in connection with the health care of

Patient Name: ______________________ Date of Birth: ______________ Phone#_____________

Address: ____ Social Security # ________________

City: ________________________________ St: __________ ZIP: __________

____

Health Care Provider/Clinic/Hospital/ Other

I further understand and acknowledge that in complying with my request for release, such disclosure will require Barnabas Dental/Medical Clinic of Barnabas Center, Inc. and/or other authorized party to disclose, as provided under applicable federal law, Protected Health Information, as defined in 42. C.F.R. 160 et seq. Information to be disclosed:

- ▫ Complete Health Record
- ▫ Discharge Summary
- ▫ History and Physical Exam
- ▫ Consultation Reports
- ▫ Progress Notes
- ▫ Radiology Reports
- ▫ Abstract/Pertinent Information
- ▫ Emergency Department Record
- ▫ Laboratory Tests
- c: Other (Please Specify) ______________

I UNDERSTAND THIS MAY INCLUDE INFORMATION RELATING TO THE FOLLOWING UNLESS EXPRESSLY EXCLUDED BY CHECKING THE BOX (ES) BELOW:

▫ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
▫ Psychiatric Care (Behavioral Health)
▫ Treatment for Alcohol and/or Drug Abuse[2]
▫ Genetic Testing
▫ Sexually Transmitted Diseases (STDs)

The patient information requested above may not be further disclosed to any party under any circumstances except with the patient's written consent or as otherwise permitted by law. The information IS be used for the specified purpose below, unless specified otherwise (IF patient crosses out and initials):

- Data gathering
- Diagnosis & Evaluation
- Discharge Planning
- Continuity of Care
- Assessment/Treatment Planning
- Other ______________________

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked in writing, this authorization will NOT expire while I am receiving care at Barnabas Center.

A photocopy or FAX of this document is valid as the original.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein:

Signature of Patient of Legal Representative: ________________________________ Date ____________________

Except psychotherapy notes as provided under federal and state laws. [2]Prohibition of Redisclosure: This information has been disclosed from records whose confidentiality is protected by federal and state law. Federal Regulations (42. CFR Part 2) prohibit the receiver of these records from making any further disclosure of this information except with the specific written consent of the person who it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for the purpose.

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 Center 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 Center resulted in:

◯ Patient does not have insurance.

◯ Patient does have insurance:

Type: ________________________

Type: ________________________

Barnabas Center Staff signature: ________________________________

Patient Printed Name: ____________________
Date of Birth: ______________________________

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 Center Empowerment Program

Barnabas Center 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/Resource Coordinator?

How can we help you, check all that may apply

- [ ] Job Search
- [ ] Resume Writing
- [ ] Interview Skills
- [ ] Budgeting
- [ ] Savings
- [ ] Communication Skills
- [ ] Goal Setting
- [ ] Local Resources
- [ ] Apply for Insurance

Please share your concerns:

____

____

____

____

____

____

Our Case Manager/Resource Coordinator will be contacting you.

Name:______________________________

Phone: ______________________________

Email:______________________________

BARNABAS CENTER MEDICAL and 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 ___________________

BARNABAS CENTER SERVICES	Would you like to know about all the services available to you through Barnabas Center?	___ Yes
	Do you receive food stamps through the Florida SNAP program?	___ Yes
	Would you like assistance in applying online for food stamps through the Florida SNAP program?	___ Yes
	Are you worried that in the next 2 months, you may not have housing?	___ Yes
	Do you feel unsafe in your current living situation?	___ Yes
LEGAL ADVICE	Do you have legal issues that are keeping you from getting a job or housing?	___ Yes
	If you checked YES to any boxes above, would you like to talk with a Barnabas Resource Coordinator about any of these concerns? Your Signature_______________________________________	___ Yes

Resource Coordinator signature___________________________________ Date_____________

Updated Feb 2025

PARTICIPANT SIGNATURE PAGE

FOLLOWING REVIEW OF ADMISSION INFORMATION

I ____________________________ have read the following Barnabas Center admission
Participant Name

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

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

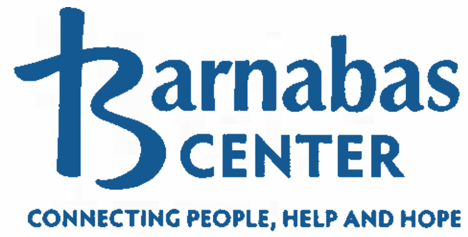
☐ **Hold Harmless Policy** ☐ **Participant Bill of Rights & Responsibilities**

☐ **Service Termination / Grievance Policy**

________________________________ ____________________
Participant Signature Date

________________________________ ____________________
Barnabas Center Personnel Signature Date

Revised 02/2026



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 help and hope to individuals and families in need throughout Nassau County. We strive to improve the stability, health and wellbeing of members of our community. Services may include help with rent/mortgage & utility payment, food, medical and dental care and bike for transportation to work or school. In order to be considered for any Barnabas's services certain documentation and eligibility requirements must be met by those seeking assistance.

ELIGIBILITY CRITERIA:

- Picture ID
- Proof of Nassau County residency: examples include proof of mail received at residence, bank statement, pay stubs, rental lease, Social Security letter of benefits, Food Stamp eligibility statement, letter of support.
- Proof of all household income: examples include previous 4 weeks' pay stubs, tax returns, social security statements, Re-employment Statement.
- If self-employed, a copy of a recent business tax return or business bank statement is required.

PAST DUE RENT/ MORTGAGE ASSISTANCE

1. Copy of current lease or mortgage.
2. Completed W9 by landlord (Barnabas Center will provide a blank W9).
3. Barnabas Center *Landlord Statement* form completed and signed by the landlord.
4. Barnabas Center personnel will contact landlord to verify information provided.
5. Assistance will not be considered for individuals or families who do not have a current lease or mortgage, in their own name.
6. Assistance for housing deposits is not available.
7. Proof of personal or household circumstances that have created a crisis that has caused the rent/mortgage to be past due and eviction possible.

Updated Feb. 2025

FIRST MONTH RENT ASSISTANCE for NEW HOUSING

1. Barnabas Center *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 Center first month rent assistance. Assistance for deposits is not available.

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 lease or mortgage.
3. Additionally, Barnabas Center may refer individuals and families to other local agencies for assistance.

Based on available funding, Barnabas Center may provide assistance twice a year. Any requests beyond twice a year will require a referral for an appointment with a Barnabas Center Resource Coordinator.

FOOD

1. Assistance with food is available to individuals and families through the Barnabas Center Pantry, Tuesday through Friday, 10am to Noon.
2. Families are encouraged to go to www.Barnabasnassau.org for dates and times of Barnabas Center mobile food distribution events in Nassau County.

MEDICAL CARE

1. Barnabas Center primary medical care is available to adults 18 years and older who do not have medical insurance and income is at 300% or below the current Federal Poverty Guidelines.
2. Proof of all household income must be provided.
3. A fee of $10 is required for each scheduled appointment.
4. Services must be paid for in cash, credit card or debit card. Checks are not accepted.

DENTAL CARE

1. Barnabas Center primary dental care is available to adults 18 years and older who do not have dental insurance and income is at 300% or below the current Federal Poverty Guidelines.
2. Proof of all household income must be provided.
3. Dental services are provided at reduced rates based on the dental service provided.
4. Services must be paid for in cash, credit card or debit card. Checks are not accepted.

EMPOWERMENT PROGRAM

This is a one-on-one program with a Barnabas Center Resource Coordinator to provide guidance and support in reaching personal goals and making positive life changes.

Eligibility for the program is automatic when eligibility is established for Barnabas Center's medical, dental, or financial assistance services.

A referral to the program's Resource Coordinator is required for individuals or families seeking financial assistance more than twice in one year.

ADDITIONAL ASSISTANCE

1. Certificates to Barnabas Center "New-To-You" resale store are available for qualifying individuals and families to help with urgent needed items such as clothing, houseware items & furniture.

3. The Adult Bikes for Barnabas Center program provide bikes to adults needing transportation to and from work.
4. The Barnabas Center Junior Bike Program is available for youth needing a means to get from home to school. Referral from Nassau County Schools social worker is required.

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.

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.

Reviewed Feb. 2025

PARTICIPANT BILL OF RIGHTS AND RESPONSIBILITIES

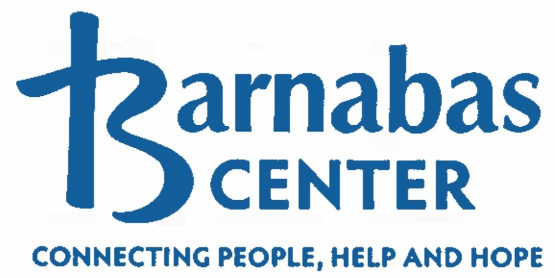
YOU HAVE THE RIGHT TO:

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 Center services regardless of race, gender, age, national origin, religion, or handicap.
6. Refuse Barnabas Center 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 Center 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 March 2025



HOLD HARMLESS AGREEMENT

The Barnabas Center 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.

SERVICE POLICY

A. It is the policy of Barnabas Center and Barnabas Center Health Services to encourage appropriate client, patient behavior within all programs and sites. In the interest of maintaining a safe environment for clients, patients, customers, volunteers, and staff, Barnabas Center 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, tenants or others on the property of Barnabas Center or affiliated with Barnabas Center.
3) Theft or damage of Barnabas Center property.
4) Lewd or obscene behavior.
5) False or misleading information submitted to obtain Barnabas Center services.

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

C. Barnabas Center 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 with Front Office Reception staff and Health Services Reception staff.
F. The written grievance is to be addressed to Barnabas Center / Attention Barnabas Center CEO.
G. The Barnabas Center CEO or designated staff will be responsible for a response within three (3) business days of receipt of the grievance.