Directions

Eligibility Processing

Page 1) **Eligibility Worksheet**— Do not leave blanks. If it does not apply, enter a line or N/A. This allows us to assess your financial capability and charge based on a sliding fee schedule. Household includes your immediate family only. (Spouse, partner, and children under 18)

Page 2) **Initiation of Services** — Complete YELLOW highlighted areas ONLY.

Page 3) **Notice of Privacy Practices Acknowledgement Form** — If you are the patient being seen, print your name on the first line and sign and date the YELLOW highlighted areas.
If you are signing for a child, Print the Child's name at the top, sign, and date the YELLOW highlighted areas and PRINT your name under Representative and list your role (parent/guardian/etc.)

Page 4) **Notice of Privacy Practices** — This is for you to keep for YOUR records.

The following items will be requested to complete your eligibility process:

- Photo ID
- Social Security Card
- Insurance Card(s)
- Pay-stubs covering 4 weeks of employment, if employed
- Food Stamp verification letter, or card, if applicable
- Verification of all other household income, if applicable

You have the choice to opt-out of the financial eligibility process. If you choose to opt-out, you will be 100% financially responsible for all services rendered.

After completion of all attached forms, please return to WINDOW #5

Please complete the application and return it by mail, fax, or in person along with all the required documents to: (Por favor complete y devuelva por Correo, Fax o en persona la solicitud incluida y todos los documentos requeridos:)

Fax: **(Envie todos los documentos por Fax)**

Department of Health
Registration Department
352-694-2563

USPS: (Envielos por Correo Postal)

Marion County Health Department
Attn: Registration
1801 SE 32nd Ave
Ocala FL 34471

In person: (Traigalos en persona)

Marion County Health Department
1801 SE 32nd Ave
Ocala FL 34471
352-629-0137

OR

Florida DOH Dental Office
Hampton Center
1501 W Silver Springs Blvd
Ocala FL 34475
352-622-2664

Eligibility Worksheet

#: ________ A WI
OFFICE USE ONLY

Language: English / Spanish / Other: __________ Hispanic: Yes / No Race: __________ Gender: M / F

Legal Name: ______________________________ **DOB** ____________ **SS#** ______________

Home Address: ______________________________ **City** ________ **State** ______ **Zip** ______

Mailing Address: ______________________________ **City** ________ **State** ______ **Zip** ______

Cell Phone # ______________ **Home phone #** ______________ **Email** ______________________

Do you have insurance? YES / NO Insurance Provider: ______________ **Policy #:** ______________________

Single ________ **Married** ________ **Separated** ________ **Divorced** ________ **Widowed** ________

◯ **I agree to receive phone calls/text messages reminding me of appointments.** ◯ **I am under the age of 18.**
I prefer to be contacted via: ___ cell phone ___ e-mail ___ postal mail

Spouse/Partner and your children

Under 18 years old	Relationship	DOB	Social Security #	Insurance/Medicaid #	Race	M/F

Please list everyone with any type of income in your family

Include all jobs, pensions, child support, social security, death benefit, alimony, unemployment/workers' compensation, veteran benefits, investments, trust funds, rental income, self-employment, public assistance, grants or any other income received.

Name	Employer or (type of income)	Gross Income	How often received Weekly, Bi-Weekly, Monthly

Other Sources of Income: (Note if you receive it Weekly=W, Bi-Weekly=BW or Monthly=M)

Public Assistance (AFDC) (FS) $____________
Unemployment/Compensation $____________
Government/Private Pensions $____________
Retirement/SSA $____________

Child Support $____________
Social Security (SSD/SSI) $____________
Rental Property $____________
Other Income: ________________ $____________

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: ______________________________ Relationship: ____________________

Phone Number: ____________________ Address: ______________________________________

PATIENT CERTIFICATION

I affirm that the information I am providing is true and correct. I understand if I provide false or inaccurate information that services may be discontinued and I will have to pay for all services received according to the fee schedule, FAC64fl 0. 003(5).

SIGNATURE: ______________________________ **DATE:** ____________________

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: ____

Name of Agency: _________Florida Department of Health in Marion County____

Agency Address: _________1801 SE 32nd Ave., Ocala, FL 34471____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

_______By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____________________________________ _______________________________________ _______________

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____________________________________ _____________________

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I, ____________________________________ WITHDRAW THIS CONSENT, effective _____________________

Client/Representative Signature | Date

State of Florida
Department of Health

Notice of Privacy Practices Acknowledgment Form

Name: ____ **Client ID#** __________________

Facility/Site/Program: _____Florida Department of Health in Marion County_________________

I have received a copy of the DOH Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: ____ **Date:** _______________________
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _________________________________ Role: ________________________
(Parent, guardian, etc.)

Witness: ____________________________________ Date: _______________________

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on ______________
date

___ Face to face meeting
___ Mailing
___ Email
___ Other _____________________

Reason Individual or Representative did not sign this form:
___ Individual or Representative chose not to sign
___ Individual or Representative did not respond after more than **one** attempt
___ Email receipt verification
___ Other ____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.
___ Face to face presentation(s) ____
___ Telephone contact(s) ____
___ Mailing(s) ____
___ Email ____
___ Other ____

Staff Signature: _______________________________________ **Title:** ____________________________________

Print Name: ____

Date: _________________

This form must be retained for a period of at least six years in the appropriate record.

DOH Notice of Privacy Practices Acknowledgement Form, DH 150-741, 09/13

NOTICE OF PRIVACY PRACTICES

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.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

This authorization will have an expiration date that can be revoked by you in writing.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department of Health within 30 days of the Department's receipt of your request.to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclosure Confidential Information form and submit the request to the county health department or Children's Medical Services office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time the Department is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

PARTICIPATION IN THE HEALTH IFORMATION EXCHANGE NETWORK

Access to information about your health history and medical care is critical to help ensure that you receive high-quality care and gives your healthcare provider a more complete picture of your overall health. This can help your provider make better decisions about your care. The

information may also prevent you from having repeat tests, saving you time, money and worry. Recent advancements in technology now support the safe and secure electronic exchange of important clinical information from one health care provider to another through Health Information Exchange (HIE) networks. The Department of Health and its County Health Departments participate in an HIE network, and also participate in several HIE networks with trusted outside health care providers who have electronic medical record systems. HIE enables your healthcare providers to quickly and securely share your health information electronically among a network of healthcare providers, including physicians, hospitals, laboratories and pharmacies. Your health information is transmitted securely and only authorized healthcare providers with a valid reason may access your information. By sharing information electronically through a secure system, the risk that your paper or faxed records will be misused or misplaced is reduced.

Participation in HIE is completely your choice.

Choice 1. YES to HIE participation. If you agree to have your medical information shared through HIE and you have a current Initiation of Services and consent to treatment form on file, you do not need to do anything. By signing the form, you have granted us permission to share your health information to HIE.

Choice 2. NO to HIE. You can choose to not have your information shared electronically through the HIE network ("opt out") at any time, by filling out the "Health Information Exchange Opt-Out" form available at the County Health Department. If you decide to opt-out of HIE, healthcare providers will not be able to access your health information through HIE. You should understand that if you opt out, the health care providers treating you are still permitted to contact us to ask that your health information be shared with them as stated in this Notice. Opting out does not prevent information from being shared between members of your care team. Please note, your opt-out does not affect health information that was disclosed through HIE prior to the time that you opted out.

Choice 3: You can change your mind at any time.
You may consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt-out form described under Choice 2.

Alternatively, you may opt out of HIE today and change your mind later by submitting DOH HIE Reinstatement of Participation Form.

PERSONAL HEALTH RECORDS (PHR) MOBILE APPPLICATION SYNCHRONIZATION WITH USER DATA

As part of the services provided by the Department of Health, you can download the companion PHR mobile application to access your personal health records. This application is the mobile version of Florida Health Connect portal.

The purpose of the PHR mobile application is to provide you with access to your health data from your mobile device, from anywhere at any time. You will be able to synchronize your Florida Health Connect account through the mobile application with your personal health data captured on your mobile device (Google Fit or Apple Health) to provide you with a 360 degree view of your health history and current health status. In order to provide you with a complete

view of your health data and status, you will be provided with the option to synchronize your Florida Health Connect mobile application with the Google Fit or Apple Health application installed on your mobile device.

Your Google Fit or Apple Health data will not be disclosed to any third parties without your express written permission.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning February 21, 2022 and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).