Clayton County Health District

Mario Majette, M.D., M.P.H.
District Health Director
1117 Battlecreek Road Jonesboro, GA 30236
Phone: (678) 610-7640 Fax: (770) 991-0024

Client Information Sheet

Please Print When Completing This Form

Appointment: _____ Walk-in: _____ Stand-by: _____ (Check One)

Date: _____ Reason for Visit: _____

Other health problems today?

_____

Last Name: _____ First Name: _____
(Client's Name)

Maiden Name: _____ Middle Name: _____

Are you a United States citizen? [ ] Yes [ ] No Do you smoke? [ ] Yes [ ] No

Date of Birth _____ Age _____ Social Security Number_____

Gender (at birth): _____ Gender Identity: _____ Race: _____

Marital Status: _____ Years of Education: _____

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ County: _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ County: _____

Email address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Parent/Guardian Name (if patient is a minor): _____

Name of Employer/School: _____

Name & Phone Number of Primary Care Physician: _____

Allergies: _____ Reaction: _____

_____ Reaction: _____

_____ _____
Client Signature Date

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CLAYTON COUNTY HEALTH DISTRICT

Declaration and Insurance Verification

Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information (Family Planning, STD, & Health Checks for Children):

Number of family members in the household: _____

Total family income: $ _____ [ ] Week [ ] Month [ ] Year

Proof of Income: [ ] Pay Stub [ ] W2 [ ] Social Security Verification [ ] Other (explain) _____

Do you have health insurance? [ ] Yes [ ] No

Client has health insurance coverage with the following: (Check ALL that apply)

- ☐ Medicaid
- ☐ Wellcare
- ☐ Peachstate
- ☐ Amerigroup
- ☐ Medicare
- ☐ Private Insurance _____ Name of Insurance Provider
- ☐ Patient does not have health insurance

Client does not have health insurance due to the following: (Check all exclusions that apply)

- ☐ I am a Native American receiving healthcare services through the Indian health service or tribunal organization.
- ☐ I am in a period of exclusion under my health insurance plan.
- ☐ I have exhausted my lifetime limits under my insurance plan.
- ☐ I have limited scope coverage such as dental, vision, long term care or coverage for specific illnesses, not including family planning and/or breast and cervical cancer screening.
- ☐ I have health insurance via a self-insured company that does not provide coverage for family planning and/or cervical cancer screening.

I verify that the information I have given above is current and accurate. I understand that I may be asked to provide written proof of any insurance exclusion as indicated above. I understand that qualifying for any special discounted fees will be based upon the information regarding my income and number of dependents as listed above. I understand that if I have insurance or fail to disclose insurance information, I will be held responsible for payment of services provided.

My signature below indicates that I have either read or had read to me the above regulations. I had an opportunity to ask questions and understand the guidelines as listed above.

_____ _____
Client Signature Date

OFFICE USE ONLY: Income Verified, Self-Declared at _____%

_____ _____
CCHD Witness (Employee) Date

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Privacy Policy
Notice of Health Information Practices

THIS NOTICE OF HEALTH INFORMATION PRACTICES DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Introduction

It is important to us that you understand what information we collect about you and how it is used. We want you to know that we limit the collection and disclosure of information to only that which we believe is necessary to serve you and administer our business.

This notice is effective April 1, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the health department a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

1. A basis for planning your care and treatment.
2. A means of communication among the many health professionals who contribute to your care.
3. A legal document describing the care you received.
4. A way that you or a third-party payer can verify that services billed were provided.
5. A tool in educating health professionals.
6. A source of data for medical research.
7. A source of information for public health officials charged with improving the health of this state and the nation.
8. A source of data for our planning and marketing.
9. A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
10. A source of supporting data, which allows us to receive state and federal funding to provide public health services.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy. You can better understand who, what, when, where, and why others may access your health information. It allows you to make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the property of the health department, the information belongs to you. You have the following rights:
1. To receive a paper copy of this notice of information practices upon request.
2. To inspect and/or receive a copy of your health record.
3. To amend your health record
4. To receive an accounting of disclosures of your health information.
5. To request communications of your health information by other means or at other locations.
6. To request a restriction on certain uses and disclosures of your information.
7. To revoke your authorization to use or disclose your health information except to the extent that action has already been taken.

Our Responsibilities

The health department is required to:
1. Maintain the privacy of your health information.
2. Provide you with this notice of our legal duties and privacy practices regarding information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are not able to agree to a requested restriction.
5. Agree to reasonable requests from you to deliver health information in other ways or at other locations.

We reserve the right to change our practices and to make those changes effective for all protected health information we maintain. Should our information practices change, we will post the revised notice in our facility and provide you with a copy on request. We will not use or disclose your health information without your permission except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you are comfortable with the content of this policy and will allow us to exchange information about you as outlined, then you need only to sign the acknowledgement attached. If you prefer to limit disclosure of information about you, please note that on the acknowledgement form and contact the [County] Board of Health Privacy Officer for further information.

If you believe your privacy rights have been violated, you can file a complaint with the health department's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. If you receive additional treatment from another physician, hospital, or laboratory we may share information with that provider about services you received in this facility.

We will use your health information for payment.

For example: A bill may be sent to you, a health insurance company, Medicaid, or Medicare. The information on or with the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may contact or share information with other providers for payment services.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples are the providers of our computer software where electronic records are kept. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Planning/Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that that you may be eligible for.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We may also disclose your health information to support funding from state and federal grants for the various public health services we provide and the administration of public health services.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

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Privacy Policy Signature Page

- ☐ I have had an opportunity to read/or request the Notice of Health Information practices from Clayton County Health District.
- ☐ I prefer to limit the disclosure of my health information and desire to speak with the Clayton County Health District Privacy Officer.

_____ _____
Signature Date

If signed by someone other than the client, please state relationship to client.

_____

I _____ gave the Notice of Health Information Practices to
(EMPLOYEE NAME)

_____ on _____ and he/she
(CLIENT NAME) (DATE)

refused to sign the acknowledgement receipt.

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FINANCIAL RESOURCES

1. Client Information

Name: _____
Last First MI

Address: _____
Street Address City State Zip County

Phone Number: _____ Social Security # _____

Date of Birth: _____ Race: _____ White _____ Black _____ Other

Marital Status: _____ Single _____ Married _____ Widowed _____ Separated

U.S. Citizen: [ ] Yes [ ] No GA Resident: [ ] Yes [ ] No _____ Years _____ Months

2. Insurance Information

Medicaid	Yes	No	Pending
Medicare Part A	Yes	No	Pending
Medicare Part B	Yes	No	Pending
Private Health Insurance	Yes	No	Pending

If Private Insurance:
Name of Company: _____
Policy/Group Number: _____
Any other benefit programs? _____

3. Household Members (Include parents if client is a minor)

Name	Age	Relation to Client	Gross Income per Month	Source

4. **Client Expenses**

Source of Debt	Yes	No	Amount
Rent/Mortgage			
Utilities			
Telephone			
Car Payment/Car Insurance			
Health/Life Insurance			
Hospital Bills			
Doctor Bills			
Child Support/Alimony			
Other			
Other			

Total Monthly Expenses $_____

NOTE: Income includes wages, rental income from apartments or boarders, child support, alimony, pensions, etc. Attach a paycheck stub for the last four weeks, most recent W-2, or notarized statement from employer verifying income. If applicable, attach statements of child support payments, public assistance award letter, Social Security Income letter, and form from unemployment check, etc. If no income is listed, explain how living expenses are met.

By signing this statement, I verify that the above information is correct to the best of my knowledge.

_____ _____

Client's Signature Date

_____ _____

Witness (Name and Title of CCHD Employee) Date

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Ryan White Sliding Scale Fee Application Form

Client Name: _____ Date: _____

Name of wage earners in the household:

_____

_____

_____

_____

Billing Address: _____

City: _____ State: _____ Zip: _____

Driver's License #: _____ SS#: _____

Number of Family Members: _____

Combined Annual Income: _____

Documents provided by client to prove income:

_____

_____

The Clayton County Health District staff member has explained to be my financial responsibility. My percentage of discount from Clayton County Health District's full fee is _____% based on my current income and family size. My period of eligibility starts on _____ and only lasts for a period of one year. I will need to be re-determined for this program on _____. I understand I must bring in more current documentation at that point.

_____ _____
Client Signature Date

_____ _____
CCHD Representative Signature Date

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Sliding Scale Fee Policy
Notice to Clients

This practice serves all patients regardless of ability to pay. Discounts for essential services are offered depending upon the family size and income.

Please bring proof of income with you to each visit.

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CLAYTON COUNTY
HEALTH DISTRICT

Name: _____ Date: _____

IN THE LAST THREE (3) MONTHS, HAVE YOU EXPERIENCED:	YES	NO	COMMENTS
Weight Loss			
Weakness /Fatigue			
Fever, chills, night sweats			
Lymph node enlargement			
Mouth infections of any kind			
Painful or bleeding gums			
Long-lasting sores on lips			
Visual disturbances			
Cough			
Shortness of breath			
Loss of appetite			
Painful or difficulty swallowing			
Nausea/vomiting			
Abdominal distention (abdominal bloating)			
Diarrhea			
Rectal or anal problems			
Hepatitis A, B, C, or jaundice			
Intestinal parasites			
Unusual bleeding or bruising			
Headache			
Difficulty concentrating			
Confusion			
Change in mental ability			
Seizures			
Depression			
Numbness/tingling			
Shingles (herpes zoster)			
Any new rash or skin discoloration			
Any skin problems that worry you			
PAST HISTORY			
Do you have any chronic illnesses?			
Have you ever had surgery?			
Have you ever received a blood transfusion?			
Are you taking any medications now?			

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Infectious Disease Control
Client Information Sheet

I am HIV+ [ ] YES [ ] NO Approximate Date of Test _____

I was infected through: (Check all that apply)

- ☐ Homosexual Contact
- ☐ Hemophilia Treatment
- ☐ Heterosexual Contract
- ☐ IV Drug Use
- ☐ Blood Transfusion
- ☐ Congenitally (infants only)
- ☐ Other

Physician's Name: _____ Phone Number: _____

Preferred Hospital: _____ Phone Number: _____

Have you been on any HIV medications? [ ] YES [ ] NO

1st Combination

1. _____
2. _____
3. _____

2nd Combination

1. _____
2. _____
3. _____

3rd Combination

1. _____
2. _____
3. _____

4th Combination

1. _____
2. _____
3. _____

CLAYTON COUNTY
HEALTH DISTRICT

Client Name	
Date of Birth	
Medical Records #	**SSN #**

AUTHORIZATION TO RELEASE INFORMATION

I hereby request and authorize: _____
(Name of Person/Agency Requesting Information)

_____
(Address)

to obtain from: _____
(Name of Person/Agency Requesting Information)

_____
(Address)

The following type(s) of information from my records (and any specific portion thereof).

_____

_____

for the purpose of: _____

_____

*I understand that the federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment, or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (**PLEASE CHECK ONE**)*

- ☐ *Ninety (90) days unless I specify an earlier expiration date here: _____*
- ☐ *One (1) year*
- ☐ *The period necessary to complete all transactions on matters related to services provided to me.*

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____
(Signature of Client) (Date)

_____ _____
(Signature of Witness/CCHD Staff) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

_____ _____
(Signature of Client) (Date of Withdrawal)

Kathleen Toomey, MD, MPH, Commissioner | Brian Kemp, Governor

Clayton County Health District
Mario Majette, MD, MPH
District Health Director
1117 Battlecreek Road Jonesboro, GA 30236
Phone: (678) 610-7199 Fax: (770) 603-4021

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____

DISCLOSURE: Clayton County Health District-Ryan White has my authorization to disclose my Medical Records to the following party(ies).

Name(s) and relationship to the patient:

_____

_____

_____

Signature of Patient: _____ Date: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

- ☐ **Incapacitated.** Patient is incapacitated due to: _____
- ☐ **Other:** _____

Signature of Representative: _____ **Date:** _____

Print Name: _____

Relationship to Patient:

- ☐ Parent
- ☐ Guardian
- ☐ Spouse
- ☐ Other: _____

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Ryan White Client Agreement Policy

1. **ELIGIBILITY**

Any person residing in Clayton County who is HIV positive is eligible for services. Clients outside this area will be considered on individual request. All new patients who present to the clinic requesting HIV services must present one of the following documents: Positive HIV test results, Viral Load, or CD4 report.

The Clayton County Health District 3-3 does not refuse services based on sex, age, religion, race, economic status, sexual orientation, or mode of transmission.

2. **SERVICES**

- Case management: all clients are assessed, and care plans established.
- Social services
- Mental Health/Substance abuse counseling referrals, when needed.
- Nutritional evaluation and counseling
- Medical services: all eligible clients will have a medical evaluation
- Financial assistance for labs, medication, and doctor's visit, per Ryan White guidelines of policy and procedures.
- Housing assistance
- Peer and client education
- Outreach opportunities/community involvement

3. **CLIENT'S RIGHTS & RESPONSIBILITIES**

This statement of Client's Rights and Responsibilities is designed to enable clients to act on their own behalf and in partnership with Clayton County Health District-Ryan White Staff to obtain the best possible HIV/AIDS care and treatment. Clients newly entering or currently accessing care, treatment, or support services for HIV/AIDS have the following rights and responsibilities.

Client's Rights

a. Clients have the right to be informed of the services the Ryan White Clinic provides how to obtain such services, and the reason for services not being provided.
b. Clients have the right to choose whether to apply for assistance through this program.
c. Clients have the right to receive the services needed; these my or may not include all the services desired.
d. Clients have the right to receive considerate, dignified, and respectful care and treatment by all CCHD personnel.
e. Clients have the right to refuse service or to terminate participation without recrimination.
f. Clients have the right to expect the agency will maintain confidentiality of all information in charts and records pertaining to the services received, except as otherwise required by law (unless it involves suicide, homicide, abuse of a child or incapacitated adult or specific danger to others). This does not apply to statistical data, which may be required by funding agencies.

Client's Responsibilities

a. Clients are responsible for bringing proof of income to every medical assessment visit.
b. Clients are responsible for making and keeping appointments for medical assessments every 3 months.
c. Clients are responsible for notifying the CCHD-Ryan White staff in advance if they must cancel an appointment. After 3 failed appointments, client will be contacted to discuss barrier to care.
d. Clients are responsible for providing, to the best of their knowledge, accurate and complete information about current and past health and illness, medications, and other treatment and services affecting their care.
e. Clients are responsible for informing the clinic or staff of any hospital admission or visit to the emergency room.

f. Clients are responsible for keeping appointments and commitments at this agency or inform the agency promptly if you cannot do so.
g. Clients are responsible for following the agency's rules and regulations regarding patient/client care and conduct.
h. Clients are responsible for being considerate of and respectful to the staff and fellow clients.
i. Clients are responsible for refraining from use of profanity, abusive or hostile language; threats, violence or intimidation; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; sexual harassment and misconduct.
j. Clients are responsible for maintaining the confidentiality of other clients receiving care or services at the agency by respecting their right to privacy and confidential services, and for keeping confidential information they may obtain while at CCHD-Ryan White (such as the identity of other CCHD clients or personal information discussed in groups).
k. Clients are responsible for informing the clinic or staff whenever they do not understand information they are given.
l. English is the primary language of our clinic. If a client does not speak, read, or write English, translation will be made available. If a translator is needed, the clinic staff must be notified 7 days in advance.
m. Clients should be aware that there is a Grievance Policy that can be obtained at the CCHD-Ryan White clinic.
n. Clients have a responsibility to follow through on actions as agreed upon in his/her individual client service plan.

4. INVOLUNTARY SUSPENSION OF SERVICES

When a client engages in behavior which impedes the agency's ability to provide services to that person or other clients, involuntary suspension may be necessary. Clients may be suspended under circumstances where the clients do not cooperate in the context of the CCHD-Ryan White Guidelines.

Reasons for suspension may include but are not limited to the following:

1. Aggressive or abusive behavior toward other clients, volunteers, or staff members.
2. Behavior that infringes on other clients' ability to receive CCHD-Ryan White services.
3. Behavior or mental status that interferes with the CCHD-Ryan White ability to provide services.
4. A medical diagnosis indicating the client is not HIV+ (does not have AIDS) and that no further medical testing is warranted.
5. Inability or unwillingness to follow rules.
6. Failure to keep appointments or follow through with recommendations.

Prior to suspension, whenever possible, appropriate staff will meet with the client and establish a written probationary contract under which the client may continue to receive services.

5. PAYMENT OF SERVICES

The maximum annual cumulative charges to an individual for HIV related services are based on the Federal Poverty Guidelines. Service fees are based client's income, using a sliding scale. Services will not be denied due to client's inability to pay. CCHD-Ryan White does not file Medicaid and Medicare. Clients will be responsible for filing their own private insurance claims.

The client is responsible for keeping up with their charges and letting the CCHD-Ryan White staff know when they have reached their billing percent limit, so they will no longer be charged.

I have read the CCHD-Ryan White Client Agreement Policy and have had my questions answered to my satisfaction. I agree to the policy and desire medical services through Ryan White Program at the Clayton County Health District.

_____ _____

Client Signature Date

_____ _____

Signature of CCHD-Ryan White Representative Date

Kathleen Toomey, MD, MPH, Commissioner | Brian Kemp, Governor

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Ryan White Client Grievance Procedure

1. **A client must file a complaint in writing to the Ryan White Program Coordinator (contact info below), within ten (10) business days regarding the disagreement or receiving notice that they are no longer enrolled in the program.**
    a. The written complaint must state the nature of the concern and the desired resolution.
    b. The complaint is reviewed by HIV/AIDS Consortium members and answered in writing within thirty (30) business days of its receipt, with a copy to the Infectious Disease Coordinator. If further information is needed from the client, then the client has five (5) business days to provide this information. The appeal is then answered within thirty (30) business days after receipt of the information.
    c. Failure to file a written appeal within ten (10) business days of the complaint or removal from the program, or failure to respond to the request for further information within five (5) business days waives the right to appeal.
2. **If the client is dissatisfied with the decision in Step 1, the client may submit the same complaint to the District Health Director within five (5) business days of the receipt of the initial decision.**
    a. Step 2 of the complaint must be submitted in writing specifying the nature of the complaint, the outcome desired, and stating hat the first step of the procedure has been followed.
    b. The District Health Director may appoint a review committee. Members of this committee cannot be Case Managers of the Ryan White Program. The committee will notify the client in writing of its decision, with a copy to the Ryan White Program Coordinator, within ten (10) business days of receiving the request to review the decision.
        i. However, if further information is needed from the client, the client has five (5) business days to supply it. The committee reviews this information and notifies the client of its decision within ten (10) business days of receipt of this information, with a copy to the Ryan White Program Coordinator.
        ii. Failure to respond to the request for further information within five (5) business days waives the right to appeal.
3. **If the client is dissatisfied with the decision in Step 2, the client may submit the same complaint to the state level HIV/AIDS Care Service Manager in the Prevention Services Section, within five (5) business days of the appellate decision.**
    a. Step 3 of the complaint must be submitted in writing specifying the nature of the complaint, the outcome desired, and stating that the second step of the procedure has been followed.

I have read the CCHD-Ryan White Grievance Policy and have had my questions answered to my satisfaction. I agree to the policy and am aware of the steps I must take to make a complaint.

_____ _____
Client Signature Date

_____ _____
Signature of CCHD-Ryan White Representative Date

Ryan White Program Coordinator
Kenisha Washington
kenisha.washington@dph.ga.gov
678-479-2209