Ladies First

VERMONT DEPARTMENT OF HEALTH

Thank you for your interest in Ladies First. We look forward to having you as a member.

Please fill out the enclosed application, read the privacy notice, and return the signed application. If you have questions, call 1-800-508-2222; or, for deaf and hard of hearing individuals, please use Vermont Relay Service 711 and give our number: 1-800-508-2222.

Checklist to complete your Ladies First application:

___ read and fill out the application (pages 1-4);
___ read the Notice of Privacy Practices (pages 5-8);
___ sign the Acknowledgement on page 4;
___ print and mail or fax us your signed application (pages 1-4);
___ keep the Notice of Privacy Practices (pages 5-8) for your records.

Mail your application to:

Vermont Department of Health
PO Box 70 Drawer 38 (LF)
Burlington, VT 05402-0070

Confidential fax:

802-657-4208

Ladies First Application

Ladies First offers FREE:
Mammograms, Pap tests, and cholesterol, blood pressure, and diabetes screenings.
There is also help for healthy eating, physical activity, and quitting smoking.

Mail this application to:
Vermont Department of Health, PO Box 70 Drawer 38 (LF), Burlington, VT 05402-0070

Ladies First
VERMONT DEPARTMENT OF HEALTH

For deaf and hard of hearing individuals, please use Vermont Relay Service 711 and give our number: 1-800-508-2222.

If you have questions or need interpretation services, call 1-800-508-2222.

Si vous avez des questions ou besoin de services d'interprétation, composez le 1-800-508-2222.

Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na 1-800-508-2222.

Si usted tiene preguntas o necesita servicios de interpretación, llame al 1-800-508-2222.

Haddii aad su'aalo qabto ama aad u baahan tahay adeeg tarjumaan, wac lambarka hoos ku qoran 1-800-508-2222.

Kama una maswali au unahitaji huduma za tafsiri, piga 1-800-508-2222.

စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-800-508-2222 သို့ဖုန်းဆက်ခေါ်ပါ။

यदि तपाईलाई दोभाषे सेवाको जरुरत परेमा, 1-800-508-2222 मा कल गर्नुहोस्।

Section 1: Tell us about yourself.

Name *(your legal name or as it appears on Social Security card)*:

Date of birth: _____ /_____ /_____

Social Security number:

Street address *(required)*:

E-mail address:

City State Zip Code

Primary phone number: ☐ Home ☐ Work ☐ Cell

( ) _____ - _____

Is it ok to leave a message? ☐ Yes ☐ No

What is the best time to reach you? ☐ Anytime ☐ 9:00–11:00 ☐ 11:00–1:00 ☐ 1:00–3:00 ☐ 3:00–5:00 ☐ After 5:00

Mailing address *(if different than above)*:

City State Zip Code

Alternate phone number: ☐ Home ☐ Work ☐ Cell

( ) _____ - _____

Is it ok to leave a message? ☐ Yes ☐ No

What is the best time to reach you? ☐ Anytime ☐ 9:00–11:00 ☐ 11:00–1:00 ☐ 1:00–3:00 ☐ 3:00–5:00 ☐ After 5:00

Do you live in Vermont? ☐ Yes ☐ No

Are you a U.S. Citizen or Qualified Alien? ☐ Yes ☐ No

Are you of Latino or Hispanic origin? ☐ Yes ☐ No

What race or races do you identify with?

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other
- ☐ Do not know
- ☐ Do not want to answer

What is the highest grade you have completed?

- ☐ Grades 1–8
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ College or technical school, 1 to 3 years
- ☐ College graduate – 4 years or more
- ☐ Never attended school
- ☐ Do not know
- ☐ Do not want to answer

Gross household income (before taxes): $_____ per year OR $_____ per month (gross weekly x 4.3)

Number of people who live on this income (please include yourself, spouse/civil union partner, and dependent children): _____

FOR OFFICE USE ONLY
Referring Clinic: _____ Fax #: _____

1/2013

Section 2: Tell us about your health history.

Do you have a doctor, physician assistant, or nurse practitioner? ☐ Yes ☐ No If yes, give us the name of provider and practice name.

Provider/Practice name: _____

Provider/Practice phone number: ( ) _____ - _____ If no, do you need help finding one? ☐ Yes ☐ No

Is this your first Pap test? ☐ Yes ☐ No If no, list the approximate dates/locations of your last **two** Pap tests.

Date: ___ /___ /___ Practice name: _____

Date: ___ /___ /___ Practice name: _____

Have you had an abnormal Pap test? ☐ Yes ☐ No

Is this your first mammogram? ☐ Yes ☐ No If no, list the approximate dates/locations of your last **two** mammograms.

Date: ___ /___ /___ Practice name: _____

Date: ___ /___ /___ Practice name: _____

Do you have any breast changes or concerns? ☐ Yes ☐ No

Have you had your cholesterol checked? ☐ Yes ☐ No If yes, when/where?

Date: ___ /___ /___ Practice name: _____

Do you smoke cigarettes? ☐ Every day ☐ Some days ☐ Not at all ☐ Don't know ☐ Don't want to answer

If yes, could we make a referral to the Vermont Department of Health Quit Network for you? ☐ Yes ☐ No

You have a better chance to quit if you use these resources: 1-800-QUIT-NOW (784-8669) www.vtquitnetwork.org

1. Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Don't want to answer

2. Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Don't want to answer

3. Have you ever been told by a doctor, nurse, or other health professional that you have diabetes?
   - ☐ Yes
   - ☐ No
   - ☐ Yes – Gestational (pregnancy) diabetes
   - ☐ Don't know
   - ☐ Don't want to answer

4. Has a doctor, nurse, or other health professional ever told you that you had any of the following: heart attack (also called myocardial infarction), angina, coronary heart disease, or stroke?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Don't want to answer

5. Has your father, brother, or son had a stroke or heart attack before age 55?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Don't want to answer

6. Has your mother, sister, or daughter had a stroke or heart attack before age 55?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Don't want to answer

Section 2, continued: Tell us about your health history.

7. Has either of your parents, your brother or sister, or your child ever been told by a doctor, nurse or other health professional that he or she has diabetes?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Don't want to answer

8. Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your high cholesterol?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

9. Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your high blood pressure?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/Not sure
   - ☐ Don't want to answer

10. Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your diabetes?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Not sure
    - ☐ Don't want to answer

11. Do you now smoke cigarettes every day, some days or not at all?
    - ☐ Every day
    - ☐ Some days
    - ☐ Not at all
    - ☐ Don't know/Not sure
    - ☐ Don't want to answer

12. Not counting decks, porches, or garages, during the past 7 days, on how many days did someone other than you smoke tobacco inside your home while you were home?

    Please circle number of days.

    Zero 1 2 3 4 5 6 7

    - ☐ Don't know
    - ☐ Don't want to answer

13. How many days per week do you participate in moderate physical activity for at least 30 minutes? (For example, brisk walking, bicycling, vacuuming or gardening.)

    Please circle number of days.

    Zero 1 2 3 4 5 6 7

14. How many CUPS of fruit do you eat each day?

    Please circle number of cups.

    Zero 1 2 3 4 5 6 or more

15. How many CUPS of vegetables do you eat each day?

    Please circle number of cups.

    Zero 1 2 3 4 5 6 or more

Section 3: Tell us if you have health insurance.

Name of insurance company:

Services covered: ☐ Doctors/Hospitals ☐ Outpatient ☐ Prescriptions ☐ Dental

Insurance company's mailing address:

Coverage start/end date *(required)*: _____ until_____ *(leave blank if there is no ending date)*

Policy holder's name:

Social Security number:

Policy or ID number:

Group or account number:

☐ I do not have health insurance. ☐ I recently applied for health insurance.

I currently have: ☐ VHAP/Medicaid ☐ Medicare Part B ☐ Catamount Health I have recently applied for: ☐ VHAP/Medicaid

Section 4: Do you need a ride?

Do you need a ride to your Ladies First appointment? ☐ Yes ☐ No

Section 5: How did you find out about Ladies First?

☐ Doctor, nurse or medical clinic (*name*): _____

☐ Friend, relative or acquaintance (*name*): _____

☐ Member or former member (*name*): _____

☐ Pamphlet or poster (*where*): _____

☐ Special promotion (*which*): _____ ☐ TV (*channel*): _____

☐ Newspaper (*name*): _____ ☐ Ladies First website ☐ Other: _____

How can Ladies First reach more women like you? _____

Section 6: Member consent – rights and responsibilities

When you join Ladies First, you give us permission to share information about your eligibility for Ladies First with other Agency of Human Services programs. We may also share your breast and cervical cancer screenings, heart disease risk factor screening, and diagnosis and treatment care with the following:

- Your doctor or nurse
- Hospitals, clinics, health care providers involved in your tests or treatment
- Centers for Disease Control and Prevention (the National Breast and Cervical Cancer Early Detection Program and WISEWOMAN Program)
- The Vermont Quit Network

Ladies First must collect and share information about your screenings, follow-up tests, and treatments to make sure you receive the care you need. We also need this information in order to pay your medical bills. You also might be eligible for other programs or services. Ladies First will keep this information private. We will only share your personal information with the people and organizations listed above in order to ensure that you receive quality health care.

Ladies First members can have private health insurance, including Catamount Health. If you have insurance, your insurer will be billed first, and Ladies First second. We will only pay for services covered by Ladies First, not non-Ladies First services. You may be responsible for co-pays or deductibles as they relate to private insurance you may have. Ladies First is unable to enroll or cover services for women who have VHAP, Medicaid, or Medicare Part B.

When you leave the program for any reason, the Department of Health will no longer have permission to share information about your care. To withdraw from Ladies First, please write a letter stating this and send it to: **Vermont Department of Health, P.O. Box 70, Drawer 38, Burlington, VT 05402-0070**.

In addition, please write to us within 30 days if you: 1) obtain private health insurance; 2) move out of state; 3) become eligible for Medicaid, VHAP, or Medicare Part B coverage; 4) end your existing private health insurance/Catamount Health; 5) change your legal name, street address, or mailing address. If we are not informed of these changes you may receive a bill.

Acknowledgement

To apply for Ladies First, you must check both boxes and sign below. Unsigned applications will not be processed and will be returned for signature.

☐ Yes, I have completed the application and have read the member consent.

☐ I hereby acknowledge that I received a copy of the Notice of Privacy Practices.

By signing here, I understand and agree that three months retroactive to the date signed below, the Ladies First program may exchange information about me as described above as long as I am part of this program.

Signature of applicant: _____ Date: _____

Agency of Human Services
Notice of Privacy Practices

This notice takes effect as of May 5, 2009

Please review carefully

This notice describes how medical and drug and alcohol related information, and other individually identifiable information about you, may be used and disclosed and how you can get access to this information.

Privacy practices re:
Health information
Pages 5-7

Privacy practices re:
Individually identifiable information
Page 8

"We" are the Agency of Human Services (AHS). AHS includes the Department for Children and Families; the Department of Disabilities, Aging and Independent Living; the Department of Health; the Department of Mental Health; the Department of Corrections; and the Office of Vermont Health Access. Our contractors and grantees include service providers throughout Vermont, such as parent-child centers, adult day centers, and community mental health centers.

When we provide you with health and social services, we will obtain individually identifiable information (identifying information), and sometimes health information, about you. Federal and state laws require us to protect this information.

This notice tells you about how we may use or share your identifying and/or health information and when we may not do so. It also tells you about your rights. The law requires that we give you this notice. The law requires us to follow the terms of the notice currently in effect.

FREE INTERPRETER SERVICES ARE AVAILABLE

Please tell us if you need an interpreter or other accommodation in order to read and understand this notice.

Veuillez nous faire savoir si vous avez besoin d'un interprète ou d'autres dispositions afin de lire et comprendre le présent avis.

Indique si necesita un intérprete u otro tipo de asistencia para poder leer y comprender esta notificación.

Molimo Vas obevestite nas ukoliko Vam je potreban prevodilac ili neka druga vrsta pomoći kako bi lakše razumeli ovo obaveštenje.

Tafadhali tuarifu kama unahitaji mkalimali au msaada mwingine ili uweze kusoma na kuelewa notisi hii.

Fadlan noo sheeg hadii aad doonayso turjibaan ama in lagaa caawiyo aqriska ama fahanka ogaysiiskaan.

ဤကြေညာချက်အား ဖတ်ရှုနားလည်ရန် စကားပြန် (သို့) အခြားလိုက်လျောမှု လိုအပ်ပါက ကျေးဇူးပြု၍ ကျွန်ုပ်တို့အား ဖော်ပြပါ။

နူ့တစကု ငွြကြ လ်က ခဆ၀ကျိ ပ်ုထ မငုဘဇပေုဘဇ ညျံရျ သု လ္တူးဆ်သျိ လုသဒိးမ္ဒႈ ကျ=ိငူး ါန်ပုဘဇ ခမုာကဆျုပုဗ

Privacy practices regarding: Health information

1. What health information does AHS have about me?

You and others may give us information about your health and health care when you apply for or receive our services. This may include information about your diagnosis, disability or treatment. This may also include financial and billing information.

2. What health information does AHS use and share?

We use and share only the minimum necessary health information that our staff or our contractors need to do their jobs.

3. When does AHS use or share my health information?

We may use and share your health information for treatment, payment, or health care operations which includes service planning and AHS administration. For example, we may use your information for the following reasons:

- To determine your eligibility for services or benefits
- To create and provide individualized service or treatment plans.

For example, we may share your information to make a plan for your treatment with nurses, doctors and other health care workers who treat you.

- To remind you of appointments.
- To tell you of other service supports or treatments that may be helpful to you or your family.
- To pay for your services.

For example, your doctor may send us your health information so that we can pay her.

We may also share your health information with contractors so that they can pay your doctor for us.

- To carry out our operations and manage our programs.

For example, we may use and share your health information to make sure people who care for you give you high quality services and are paid promptly and correctly. We may use and share your information to make sure you get the right services and to improve the services that you get.

4. Are there other times that AHS uses and shares my health information without my authorization?

There are limited times when we use and share information without your authorization. Sometimes the law allows or requires us to do this.

We may share your information without your authorization for the following personal reasons:

- With a family member or any other person you choose, relevant to their involvement in your care or payment for your care.
- To notify your family or other person responsible for your care of your location, condition or death.
- To a funeral director or medical examiner who needs the information to carry out their duties.
- For worker's compensation or other similar programs.

We may share your information without your authorization for the following special reasons:

- For public health activities such as preventing or controlling disease, injury or disability, and for keeping vital records of things such as births and deaths.
- For research purposes, subject to strict legal restrictions.
- With organizations that provide for organ donation and transplants.
- In response to a court or administrative order, subpoena, discovery request, or other process.
- To the police when required by law.
- To report a crime committed on our premises or against our staff.
- To report abuse or neglect to the appropriate authorities.
- To a health oversight agency for oversight activities authorized by law such as audits and investigations.
- To the United States Department of Health and Human Services for a compliance review or complaint investigation.
- To avoid a serious threat to the health or safety of a person or the public, or for law enforcement to identify or apprehend an individual.
- To carry out specialized governmental functions, such as to protect public officials, for national security, for military affairs, and to correctional institutions for certain purposes.
- With another agency administering a government program providing public benefits, with respect to eligibility or enrollment information, and to better coordinate, administer and manage related government programs.

Except for the reasons stated in this notice and permitted by law, we will not use or share your health information without your written authorization.

5. What if someone else needs my health information?

You may ask that we give your information to others, or we may ask your permission to do so. Before we share any information, you will be asked to sign an authorization form. The authorization form tells us what information to share, the purposes for sharing, and the identity of the person(s) with whom we will share. You can cancel your authorization at any time.

6. May I see my health information?

In most cases, you may see your health information. You should ask the Privacy Officer, in writing, to see it or to get a copy of it (see contact information on page 7). Safety or other legal reasons may limit the information that you see. We may charge a reasonable amount for copying.

7. May I change my health information?

If you think some of your health information in your record is incorrect, you may ask in writing that we correct it or add new information. You may ask that we send the corrected or new information to others who have received your health information from us.

We may not make the changes or additions if in our opinion the information is already accurate and complete or for other reasons. If we do not agree to change your information, we will tell you, in writing, why we do not agree. We will also note in your record that you asked us to change your information and that we did not agree to change it.

8. May I ask AHS to restrict how it uses and shares my health information?

You may ask that we restrict how we use and share your health information. Your request must be in writing and tell us what restrictions you want. We will consider your request but are not required to agree with it.

9. May I request that AHS communicate with me in a confidential way?

You may ask that we communicate with you by reasonable alternative means or at an alternative location. Your request must be in writing and tell us where and how we should contact you. We will try to honor your request.

10. May I get a list of when AHS has shared my health information with someone?

You may ask for an accounting of disclosures of your health information by us. You must make your request in writing to the Privacy Officer. The law does not require us to list every situation in which we have shared your information. For example, we do not have to list those times that we shared your information for AHS treatment, payment or health care operations or when we shared your information pursuant to an authorization signed by you.

11. What laws does AHS follow that apply to the privacy of my health information?

We follow the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA. We also follow any federal or state laws that give you greater privacy protections than HIPAA, whenever they apply. For example, we follow the federal confidentiality law concerning substance abuse treatment programs, 42 CFR Part 2, and state confidentiality laws concerning mental health records, 18 VSA § 7103.

12. May I have a copy of this notice?

Yes, you are entitled to a copy of this notice. You may ask us for a copy at any time. An electronic version is on our website, www.ahs.state.vt.us.

13. Can AHS change its privacy practices?

We reserve the right to change our privacy practices and this notice. Any changes in our practices will apply to information about you that we already have and to information that we receive in the future. We will post a copy of any new notice on our website, www.ahs.state.vt.us, and provide it to you by mail.

14. Who do I contact if I have questions about this notice?

Please contact the Privacy Officer by phone at 802-769-2160 or by mail at:

AHS Privacy Officer
Office of the Attorney General
103 South Main Street
Waterbury VT 05671-1201

15. How do I complain if I believe that my privacy rights have been violated?

You can complain to our privacy officer in writing or by phone. You can also complain to the Office for Civil Rights, DHHS, JFK Federal Building Room 1875, Boston, MA 02203.

You will not be retaliated against for filing a complaint. Benefits or services that you receive will not be affected by any complaint that you make to the AHS Privacy Officer or to the Office for Civil Rights.

Violations of 42 CFR Part 2 (drug and alcohol confidentiality law) is a crime. Suspected violations of this law may be reported to the United States Attorney in the district where the violation occurred.

VERMONT

Agency of Human Services
Notice of Privacy Practices

This notice takes effect as of May 5, 2009

Please review carefully

Privacy practices regarding: Individually identifiable information

In addition to health information privacy practices, AHS has guidelines concerning the confidentiality of information that identifies the individuals to whom we provide benefits and services.

What is individually identifiable information?

This is information created or received by AHS or its contractors or grantees that identifies, or reasonably could identify, an individual who receives services or benefits from AHS. Examples of identifying information are:

- Name
- Social security number
- Date of birth
- Address
- Phone number

When does AHS share or disclose my identifying information without my permission?

We may share or disclose your identifying information for our own program administration without your permission. Program administration means activities necessary to carry out the operations of AHS and consist of the following:

- Establishing eligibility and scope of services and assistance for which you have applied, including the identification and coordination of these services within AHS and with its contractors and grantees.
- Planning, providing, arranging, funding or paying for services and assistance for individuals and families.
- Coordination of benefits.
- Detecting fraud and abuse.
- Engaging in quality control and improvement activities.
- Emergency response and disaster relief.
- Complying with federal and state legal, reporting and funding requirements.

When does AHS need to have my permission before sharing or disclosing my identifiable information?

We need your written permission to share or disclose your identifying information in order to:

- Consider your eligibility for services other than those for which you have already applied.
- Coordinate your services with your providers who do not have a contract or grant with us.
- Consult with professionals outside of AHS in order to benefit from their expertise.
- Share with the persons of your choice.

If you do not give permission in the above circumstances, we may not be able to provide the full quantity and quality of services that may be available to you.