MONTGOMERY COUNTY SAFETY-NET PROGRAMS APPLICATION

COUNTY OFFICIAL USE ONLY:

eICM Contact ID: ____________________

Case Number: ____________________

Head of Household Name (Last, First, Middle)	Home Telephone		Work Telephone	Cell Telephone
Where Do You Live? (Number and Street)	**Apt. #**	**City**	**State**	**Zip Code**

Mailing Address (If different from home address)

What language do you speak? ☐ English ☐ Spanish ☐ Other ____________________

Are you or anyone in your household pregnant? ☐ Yes ☐ No **If yes, who?** __________ **Due Date** __________

Have you ever received a County health program benefit program? ☐Yes ☐No | Under what name? ____________________

SECTION A. HOUSEHOLD MEMBERS

Fill in the blanks for all the people in your household. Check **YES** for each person you are applying for. Check **NO** for each person you are not applying for. Check services you are requesting.

Please complete for each person who has a Social Security number

APPLYING FOR ☐ MONTGOMERY CARES ☐ CARE FOR KIDS ☐ MATERNITY PARTNERSHIP ☐ SENIOR DENTAL	NAME (Last, First, Middle)	RELATION TO YOU:	DATE OF BIRTH MM/DD/YY	GENDER M =Male F= Female	MARITAL STATUS M = Married S = Single D = Divorced P = Separated W = Widowed	*RACE (Indicate below for each person) A = Asian B = Black/African American C = White N = Amer-Indian or Alaska Native P = Native Hawaiian or Pacific Islander (You may select more than one code)	*ETHNICITY H/L = Hispanic/ Latino N/L = Non-Hispanic/ Non-Latino	SOCIAL SECURITY NUMBER (SSN)
☐ Yes ☐ No		SELF					☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	

***You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.**

SECTION B. ADDITIONAL INFORMATION

Name (Last, First, Middle)	Country of Birth	Do you have Health insurance ☐ Yes ☐ No If yes, is it: ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you have Health insurance ☐ Yes ☐ No If yes, is it: ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you have Health insurance ☐ Yes ☐ No If yes, is it: ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you have Health insurance ☐ Yes ☐ No If yes, is it: ☐ Private-Payer ☐ Employer-Based

SECTION C. EARNED INCOME

Does anyone in your household receive any income from employment? ☐ Yes ☐ No If yes, list all gross income (from full or part-time employment, self-employment, babysitting, odd jobs, day work, roomer/boarder payments,

NAME (Last, First, Middle)	EMPLOYER	RATE OF PAY (HOURLY)	NUMBER OF HOURS WORKED	GROSS AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED WE = Weekly BW = Bi-weekly MO = Monthly	JOB START DATE (MM/DD/YY)	JOB END DATE (MM/DD/YY)	STUDENT STATUS (Full or Part-time)

SECTION D. UNEARNED AND OTHER INCOME

List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others, and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

PERSON RECEIVING INCOME	TYPE (For benefits, Include Claimant ID#)	GROSS AMOUNT RECEIVED	HOW MANY TIMES A YEAR?

SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for Montgomery County to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date

Montgomery County Department of Health and Human Services
Notice of Privacy Practices Summary and Signature Page

What is the Notice of Privacy Practices?
We are required by law to provide you with a notice of our privacy practices. Our complete *Notice of Privacy Practices* is attached. The purpose of the *Notice* is to inform you about:

- Our legal obligation to protect your information.
- How we will share your information without your written permission.
- Rights that you have related to your information.
- Who you can contact to ask questions, make a request, or file a complaint.

How will we share your information?
Our Department provides a variety of health, income support and social services. To provide these services, we must ask you for personal information that may contain health, financial and other information that identifies you. We will keep your information safe and will only share it when the law permits us or requires us to do so. We will share your information as necessary to:

- Provide you with high quality and coordinated treatment and services. Example: Communicating information between programs to make referrals, determine eligibility or develop a care plan;
- Obtain payment for services. Example: Billing Medicaid;
- Manage our services and programs. Example: Reviewing the quality of the services you receive.

The attached *Notice* lists other reasons why we may share your information. If we need to share your information for reasons that are **not** listed, we will ask for your written permission. You have other rights related to your information that are listed on page 4 of the *Notice*.

Contact Information:
If you have questions about our privacy practices, want to make a request related to your information, or have a privacy concern, contact the staff person who is working with you, or our Privacy Official at 240 777- 3050. Additional contact information is provided at the end of the *Notice*.

Acknowledgement of receipt of the complete *Notice*:

__________________________________ ________________
Client or Authorized Representative (Sign your name) Date

____
Print your name

____________________ ___________________________
Signature of DHHS representative Signature of interpreter/translator if applicable
If unable to get acknowledgement, specify why: ________________________

H-1

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Montgomery County Department of Health and Human Services

Please print all information. Use a separate form for each person or agency with which information may be shared.

Client Last Name	First Name	Middle Initial	Date of Birth	Sex/Gender

The **Montgomery Cares** program has my permission to:

☐ **send to** ☐ **receive from** ☐ **verbally discuss the information I provide with:**

The Office of Eligibility and Support Services – Montgomery County Department of Health and Human Services
1401 Rockville Pike, Rockville, MD 20852.

Items covered by this release.

_____ Proof of age _____ Proof of income
_____ Proof of identity _____ Proof you live in Montgomery County

Reason this information is being shared: To determine my eligibility for the Montgomery Cares program

This authorization is valid (*Check only one. Not to exceed one year*)
☐ until_________(date) ☐ for 90 days ☐ until these conditions are met: ______________________

I understand that if I am deemed eligible for the Montgomery Cares program, I will be immediately enrolled in the program. I understand that my information will not be shared without proper written authorization.

I understand I can revoke this authorization at any time by submitting a request in writing to DHHS program staff. The revocation will become effective on the date DHHS receives it. The revocation will not apply to information that has already been used or disclosed through this authorization.

DHHS may not condition treatment, payment, enrollment or eligibility for services/ benefits based on whether I sign this authorization, unless authorization is required to determine eligibility for services/benefits.

I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to federal or State privacy laws, this information may no longer be protected and could be disclosed.

I understand that if this authorization pertains to alcohol or other drug treatment records protected by federal regulations at 42 C.F.R. Part 2, I can orally revoke this authorization, and my records may not be redisclosed without my written consent or as permitted by the regulations.

Signature of client **Date**

Signature of parent, guardian, or other authorized person **Date**

If signed by other authorized person, please describe authority to act on behalf of the client (*Please Print*)

Signature of DHHS staff member **Date**

Patient Consent for Eligibility Determination

All patients must provide some personal information to apply for Montgomery Cares or other health care program. Your information will be kept confidential and will NOT be shared with federal law enforcement agencies, it is considered confidential information. Confidential information is defined as any personal information including demographics, and work-related information (including income information).

- I consent to my primary care clinic, participating in Montgomery Cares, to send my information to the DHHS Office of Eligibility and Support Services (OESS), which will use this information to determine my eligibility for Montgomery Cares and other health programs.
- I understand that my information will be kept confidential and will not be shared with anyone outside of OESS.
- I consent to OESS contacting me directly to convey the results of my eligibility screening.
- I understand that if I am deemed eligible for the Montgomery Cares program, I will be immediately enrolled in the program.
- If you do not agree to share your information, your personal information will not be sent. You can have the eligibility screening completed in person by the eligibility worker at the clinic or at OESS offices. Information will still need to be presented at the time of screening with the worker.

I have read the information (or had it read to me) on this form and have been given the opportunity to discuss any of the above items with clinic staff. By signing below, I authorize OESS personnel or contractors to verify my eligibility for Montgomery Cares and other health programs and contact me as needed. See opposite side for additional applicant rights.

Applicant Signature ____

Clinic Staff Signature: ____

Date: ______________________________

Eligibility Screening Qualification Form

Date/Fecha: ___________________ Account Number: ___________________

Telephone Number /Número de teléfono: ____

Email/Correo electrónico: ____

Occupation/Trabajo: ______________________________ Employer/Empleador: ________________

Country of Origin/País de origen: ____

Last Grade Completed/Último grado que ha completado: ___________________________

Religion/Religión: ____

Emergency Contact Person/Persona que podemos contactar en caso de emergencia

Name/Nombre: ______________________________ Relationship/Relación: ________________

Telephone/Número de teléfono: ____

Por favor completar TODO el paquete/ Please complete the ENTIRE packet

Mercy Health Clinic

Medical Record Release Form

Last Name, First Name/Apellido, Nombre: ______________________________

Current Address/Dirección actual: ______________________________

____

Social Security Number/Número de Seguro Social: ______________________________

Date of Birth/Fecha de nacimiento: ______________________________

DO NOT WRITE BELOW THIS LINE/NO ESCRIBA DEBAJO DE ESTA LÍNEA (STAFF USE ONLY)

Provider, Hospital, or Clinic Name:

____

Address:

____

City: ____________ State: ________ Zip Code: ____________

Phone Number: ____________ Fax Number: ____________

If release/request of records is to be sent to Mercy Health Clinic, we would appreciate a summary of diagnostic studies, laboratory reports, x-rays, and any other pertinent data.

Obtain Records From ☐

Send Records To ☐

The release/request of records is to be sent to:

Mercy Health Clinic
7-1 Metropolitan Court, Suite 1
Gaithersburg, MD 20878
Fax 240-773-0308

Patient authorizes the release of his/her medical records as provided above:

Patient Signature/Firma: ______________________________ Date (Fecha): ____________

All Mercy Health Clinic (MHC) patients must read, sign and date. Patient must receive a copy.

MercyHealthClinic

Authorization Form for Family Members/Friends

I, ______________________, DOB: ______________, MRN#: ______________
give permission to all my health care and medical services providers to disclose and release my protected health information described below to:

Name(s): **Relationship:**

______________________ ______________

______________________ ______________

Health Information to be disclosed (Check all that apply):

☐My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐My complete health record, as above, with the exception of the following information (check as appropriate):

☐Mental health records

☐Communicable diseases (including HIV and AIDS)

☐Alcohol/drug abuse treatment

☐Other (please specify): ______________________

____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

Appointment time that works best with you: (check one)

☐Morning

☐Afternoon

☐Evening

Test results: If you are unavailable by phone can we leave a voice message?

☐No, you cannot leave a voice message.

☐Yes, you can leave a voice message.

Phone number: (   ) - ________ ________

This authorization shall be effective until: (Check one):

☐All past, present, and future periods, OR

☐Date or event: ______________________ unless I revoke it.

(**NOTE:** You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Patient Signature: ______________________ Date: ______________

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 PROTECTED HEALTH INFORMATION (PHI)

You PHI may be used and disclosed by Mercy Health Clinic, our office staff and other outside of our office who is involved in you care and treatment for the purpose of providing health care services to you.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose you protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

Health Care Operations: We may use or disclose, as needed, you protected health information in order to support business activities of the clinic. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (for example, billing transcription services) for our practice. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternative or other health-related benefits and services that may be of interest to you.

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination or care and assist providers and public health officials in making more informed decision. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by main, fax or through their website at www.crisphealth.org

I, ______________________________, have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. Accordingly, I knowingly and voluntarily authorize any Mercy Health Clinic member to use or disclose my medical information in the manner described above. I understand and agree that this authorization applies only to the extent that an Authorization is required by law in order to Mercy Health Clinic members to use or disclose my medical information in the manner described.

Patient Name: ______________________________ Date: ______________

Patient Signature: ______________________________

PATIENT'S RIGHTS AND RESPONSIBILITIES POLICY

Today's Date: ____________________

1. I understand that **Mercy Health Clinic (MHC)** is not a government program or insurance company, but **non-profit** clinic dependent on contributions and grants to cover operating costs.

2. I understand that I will not be turned away for the lack of payment. However; I understand that the clinic requests a contribution of **$25.00** for the first visit and **$15.00** for each follow up visit.

3. I understand that once my appointment is schedule it is my responsibility to remember the **date and time** and I **must** keep the appointment.

4. I understand that I must call the clinic within **24 hours to cancel or reschedule** my appointment at **240-773-0300 or via email/text** appointments@mercyhealthclinic.org

5. I understand that there will be a **$25.00 No-Show Fee** for a primary care missed appointments

6. I understand that there will be a **$50.00 No-Show Fee** for a specialty care missed appointments

7. I understand that there will be a **$15.00 Lost Replacement Card Fee**

8. I understand that the following reasons **CAN cause membership termination**:

   - **Noncompliance with treatment instructed by physician**
   - **Misconduct or rudeness**
   - **Misuse of service**

9. I understand that MHC is not responsible for the medical bills that may occur during a doctor's visits outside of the clinic for which for which the patient did not receive a Mercy Health Clinic referral form or if the patient did not follow given instruction.

10. I understand that MHC does not provide total medical care and that the clinic is only open a few days a week.

11. I understand that it is my responsibility to renew my **MHC Card every year** before the expiration date; otherwise I will not be able to keep my scheduled appointments with the doctor.

12. I understand that is my responsibility to inform MHC if there are any changes in my **income, address or phone number.**

Patient Name: ____________________ Patient Signature: ____________________

Eligibility Screener Name: ____________________ Eligibility Screener Signature: ____________________

A copy was given to the patient