# Tappe & Sanchez Support Services

**Client:**
**DOB:**
**Title XIX:**

## Contractually Required Paperwork

Effective January 1, 2023

**HIPAA: 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.**
At Tappe & Sanchez Support Services (TSSS), we understand the importance of keeping your private information confidential. Protected health information (PHI) includes all individually identifiable health information, including demographic data, insurance information, and other information used to identify you. 'Protected' means the information is protected under the HIPAA Privacy Rule.

**YOUR RIGHTS/RESPONSIBILITIES**

- Get an electronic or paper copy of your record
    - You can ask to see or get an electronic or paper copy of your record or services and other health information by notifying the privacy officer in writing. We will provide a copy or a summary of your health information, usually within 30 days of your request.
- Ask us to correct your record
    - You can ask us to correct information about you that you think is incorrect or incomplete. Ask the Privacy Officer how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
    - You can ask us to contact you in a specific way (for example or texting cell phone).
    - Ask us to limit what we use or share
    - You can ask us not to use or share certain PHI for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no".
- Get a list of those with whom we've shared information
    - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
    - We will include all the disclosures except for those about treatment, payment, and heath care operations, child abuse reports, and certain other disclosures (such as any you asked us to make or provided permission).
- If you have a legal guardian, that person can exercise your rights and make choices about your health information.
- File a complaint: if you feel your rights are violated by following the steps in the "Members Grievance" Policy provided to you (initial to indicate receipt: _____) or with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
    - 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

  We will not retaliate against you for filing a complaint.
- You have the right and choice of whether we share information with your family, close friends, or others involved in your care.
- We never share your information for marketing purposes, fundraising efforts, or sell your information.
- You are responsible for notifying provider(s) of any client injury or illness prior to provision of services.

**OUR USES AND DISCLOSURES**

- We typically use or share your health information in the following ways:

- We can use your information and share it with other professionals who are treating you or managing your care. Example: providing appointment times to your case manager.
- Run our agency, improve your care, and contact you when necessary. Example: We use health information about you to manage the service you receive.
- We can use and share your health information to bill and get payment from health plans and to assist with care management. Example: We give information about you to your health insurance plan so it will pay for your services.

**OTHER USES AND DISCLOSURES**

- We may share your information without your consent to prevent disease; report suspected abuse, neglect, or domestic violence; and to prevent or reduce a serious threat to anyone's health or safety.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law as well as oversight agencies for activities authorized by law and disability requests.
- We will not use or share your information for research.
- Lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your PHI.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. You must notify the privacy officer in writing if you change your mind.

For more information see: www.hhs.gv/ocr/privacy/hipaa/understanding/consumers/noticepp.hml.

**CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.

**PRIVACY OFFICERCONTACT INFORMATION:**

Sami Jo Tappe, TSSS' COO
Email: TappeSSS@outlook.com Phone: 515-745-5448 Address: 7044 Carey Ct, Johnston, IA 50131

The following documents can be found at Documents – Tappe & Sanchez Support Services Inc (tappesupportservices.com):

- **Client Rights and Responsibilities** (initial to indicate receipt: _____)
- **Member Grievances:** (initial to indicate receipt: _____)
- **Restraint Restriction and Behavioral Interventions** (initial to indicate receipt: _____)
- Receive the following service(s):
  - ☐ Behavioral Health Services: ☐FCS ☐BHIS ☐Respite
  - ☐ Intellectual Disability Waiver Services: ☐SCL ☐Respite

    Services to be provided on:

    ☐ As Needed Basis (client and/or parent responsible for scheduling)

    ☐ Certain Day(s)/Time(s): _____

    Service Location(s): ☐ Client's Residence ☐Community ☐ Provider's Residence

    Fees: Room and Board: $_____ Co-Pay: $_____

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____