Bailey House Park Ave Health Center • Ph#: 718-277-0386 **• Fax:** 929-480-9160

East New York Health Center • Ph#: 718-277-0836 **• Fax:** 929-480-9136

Client Handbook

Outpatient Substance Use Clinic

Revised 11/4/22

Last updated 04/22/2022

Housing Works/Bailey House OASAS Intake Checklist

Client Name ______________________________

	Staff Initials	Date
Treatment philosophy	________	________
Program expectations	________	________
NOPP + Consent for Treatment form- *signed on one page*	________	________
Client's Rights	________	________
Client Code of Conduct	________	________
HW & OASAS Telehealth consent	________	________
TRS-61 (consent for OASAS portal)	________	________
TRS-62 (LOCADTR consent)	________	________
TRS-AN (Justice Center consent)	________	________
Outreach agreement	________	________
Narcan overdose prevention	________	________
Tobacco free agreement	________	________
Client handbook acknowledgement	________	________
HW Substance use consent	________	________
Medical Screening –*copy provided to client for PCP*	________	________
Authorization for Release of Information Form(s)/HIPAA	________	________
Healthix	________	________
TRS-49 (Criminal justice involved consent) *if applicable*	________	________

Review that all forms are signed and dated by client and clinical staff, where indicated

Shared with front desk to upload into eICARE	________	________

Updated 11/4/22

HOUSING WORKS COMMUNITY HEALTHCARE

MRN #: ____________

REGISTRATION FORM

PATIENT INFORMATION

Legal Last Name:	Legal First Name:	Middle:	Today's Date:
Doe	Jane		2/16/23

Preferred Name (if different):	Date of Birth:	Social Security Number (optional):
	1/23/74	999-00-1111

Address:	Apt. #	Phone #	Voicemail OK? (Circle One)
1751 Park Ave		917-555-1234	**Yes** (circled) / No

City:	State:	Zip:	Email Address:	Patient Portal? (Circle One)
NY	NY	10035	jdoe@gmail.com	**Yes** (circled) / No

Parent or Gardian (*If 17 or younger*)

Emergency Contact	Relationship	Phone: #
Donna Smith	Sister	347-123-9876

Address (Emergency Contact):

City: State: Zip:

Preferred Pronoun: (Select All That Apply)

He ___ She ✓ They ___ Other ___ No pronoun preference ___

Language: (Circle One) — **English** (circled), French, Spanish, American Sign Language, Haitian Creole, Other: ______

Language Interpretation Needed? Yes **No** (circled)

Communication Barriers: (Circle One) — Legally Blind ___ No Barriers ___ Deaf ___

Race: (Select All That Apply)

Race	
American Indian/Alaska Native	
Asian	
Black/African American	
Hawaiian/Pacific Islander	
White	✓
Other (specify):	

Ethnicity: (Select One)

Ethnicity	
Hispanic/Latino	
Non-Hispanic	✓
Other	
Decline to Answer	

Sexual Orientation (Circle One) — Lesbian/Gay, Do Not Know, Other: ______, Straight, Decline to Answer, Bisexual, Queer

Veteran? (Circle One) — Yes **No** (circled)

Migrant Worker? — Yes **No** (circled)

Gender Identity (Circle One) — Male, Trans Male, Decline to Answer, **Female** (circled), Trans Female, Other: ______, Genderqueer/Gender Non-Conforming

Sex Assigned at Birth (Circle One) — Male, Intersex, **Female** (circled), Decline to Answer

Income: $

Circle One: Weekly Bi-Weekly Monthly Yearly

Circle One: Single **Partner** (circled) Married Separate Divorce Widowed

Insurance Information

** If you do not have health insurance, please speak with clinic staff to complete a Discount Sliding Fee Scale Application based on your income and family size.*

Employment Status: Full Time Part Time **I Don't Work** (circled)

Employer:

Housing Works Staff? Yes No

Insurance Plan:	Policy #:	Group #:
Medicaid		

Pharmacy Details

Name	Address	Phone
Taino	2403 2nd Ave	212-289-2000

How Did You Hear About Us? (Referral Source)

Community Partnerships, Retention & Adherence, **Self** (circled), Harm Reduction, OASAS, Other ______

Primary Care

Where do you get your primary medical care?

Name of Clinic/Hospital/Practice: Housing Works

Provider Name: ____________ Phone Number: ____________

I verify that the above information is correct to the best of my knowledge.

Jane Doe (signature) 2/16/23

Patient Signature/Parent Gardian (*If 17 and under*) **Date**

Treatment Philosophy

What is Harm Reduction?

Harm Reduction is a set of ideas and interventions that has a main goal of supporting someone in reducing the harm associated with substance use and other habits. It is based on the idea of acknowledging the power of self-determination that one has in his/her/their treatment and helping to minimize overall negative consequences that impact the community, promote optimal health, and social inclusion.

Person-Centered Care

At Housing Works/Bailey House, we will work with you on your identified goal of reducing use overall and/or working towards abstinence. This also means that you may be in an environment with other people who are at different stages of their own recovery process. We will work with you to develop a treatment plan that includes goals that are achievable and in line with what you want to work on.

I, Jane Doe acknowledge that I understand Housing Works/Bailey House treatment philosophy of working on substance use from the harm reduction lens.

X Jane Doe
Client Signature

2/14/23
Date

X [signature]
Staff Signature

2/14/23
Date

Services offered

Within our clinic, we aim to assist you with your individualized goals. Some of the services that we provide within our OASAS Outpatient clinic:

- Harm reduction and abstinence-based services
- Group counseling with a range of topics including harm reduction, mental health, trauma coping skills
- Individual Counseling
- Sessions completed via telehealth (audio+visual platform)
- Art therapy (Group and Individual)
- Supportive counseling with an RN to assist in addressing medical needs
- Support meeting with a peer for additional support/connections to resources in the community
- Connection to the OASAS LGBTQIA+ liaison, the Director of Clinical Services
- Connection to an on-site MAT/MOUD prescriber (Buprenorphine/Suboxone, etc)
- Supportive counseling with a medical profession to assist in addressing medical needs
- Supported access to psychiatry
- Referral to an on-site mental health therapist, if needed
- Toxicology services
- Coordination with mandated government agencies
- Syringe exchange, Fentanyl test strips and other Harm Reduction access support
- Referrals to case management support
- Connection to medical care
- Referral for HEP C testing and treatment
- Referral for HIV care and preventive care (PrEP and PEP)
- Referral for COVID Support and Vaccination

Program Expectations

Once admitted into the OASAS program, I am expected to:

- Attend groups as scheduled and as discussed with your primary counselor
- Participate in group therapy for the scheduled time
- Attend individual sessions, as scheduled, with your primary counselor or any covering staff
- Be in a space or location that is appropriate for clinical care and confidentiality
- Communicate with staff if I am unable to attend either my group or individual sessions
- Submit a voluntary toxicology test as requested and/or clinically indicated
- When engaging in telehealth, be in a space I feel comfortable having my session
- Provide contact information for anyone that I would like to be involved in my care
- Complete a medical assessment within 30 days of admittance into the program
- Participate in and signing my treatment plans as they are due
- Respect other clients and staff by treating them with respect and honoring confidentiality

When participating in an OASAS group (in person or telehealth), I am asked to:

- Respect all persons in the room
- Be present in the "here and now" as much as possible
- Turn off cell phone or place on vibrate
- Respect boundaries and confidentiality of what is shared in the group
- Be in a space or location that is appropriate for clinical care and confidentiality of self and others
- No sleeping in group
- Not engage in disruptive behavior and seek space/break if needed
- To arrive on time. You will not be admitted to the group 15 minutes after the start time

I, Jane Doe acknowledge that I understand Housing Works'/Bailey House's program expectations of my participation in the OASAS program.

X [signature] X 2/16/23
Client Signature Date

X [signature] X 2/16/23
Staff Signature Date

NOTICE OF PRIVACY PRACTICES

SUBSTANCE USE SERVICES

HOUSING WORKS HEALTH SERVICES III, INC

Housing Works Health Services III, Inc.

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

Housing Works Health Services III, Inc. ("Housing Works") uses your Protected Health Information for your treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are committed to maintaining your confidentiality and protecting your health information. We are required by law to provide you with this Notice, which describes our health information privacy and those of affiliated health care providers.

This Notice applies to all information and records related to your care that our Provider workforce members and Business Associates have received or created. It also applies to health care professionals, such as physicians, and organizations that provide care to you. It informs you about the possible uses and disclosures of your Protected Health Information and describes your rights and our obligations regarding your Protected Health Information.

We are required by law to:

- Maintain the privacy of your Protected Health Information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your Protected Heath Information; and
- Abide by the terms of the Notice that are currently in effect. We reserve the right to change the terms of this Notice, and will notify you or your personal representative if we make any material changes to the Notice.

I. WITH YOUR CONSENT, WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We are required by New York State and Federal Confidentiality Law and to obtain a signed Consent allowing us to use and disclose your Protected Health Information or Private Information to others to provide you with treatment, obtain payment for our services, and run our health care operations. Any such written consent may be revoked by you in writing. (Note: Revoking a consent to disclose information to a court probation department, parole officer, etc. may violate an agreement that you have with that organization. Such violation may result in legal consequences for you.) Without your consent we may not say to a person outside our Organization that you attend the program, nor may we disclose any information identifying you as an alcohol or substance abuser or disclose any other Protected Health Information except as permitted by the

State and Federal laws referenced below. Here are examples of how we may use and disclose your health care information.

FOR TREATMENT: Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. For example, a clinician may consult with another clinician located at another location to determine how to best diagnose and treat you.

FOR PAYMENT: The Provider may use and disclose your Protected Health Information to others in order to bill for your health care services and receive payment. For example, we may include your health information in our claim to Blue Cross/Blue Shield or Medicare in order to receive payment for services provided to you. We may also disclose your health information to other health care providers so that they can receive payment for their services.

FOR HEALTH CARE OPERATIONS: We may use and disclose your Protected Health Information to others for our business operations. For example, we may use Protected Health Information to evaluate the services, including the performance of our staff, and to educate our staff.

II. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES

BUSINESS ASSOCIATES: We may share your Protected Health Information with our vendors and agents who create, receive, maintain or transmit PHI for certain functions or activities on behalf of the Provider. These are called our "Business Associates." To protect and safeguard your health information, we require our Business Associates and subcontractors to appropriately safeguard your information.

FAMILY AND FRIENDS INVOLVED IN YOUR CARE: With your consent, we may disclose your Protected Health Information to a family member or close personal friend, including clergy, who is involved in your care or payment for that care.

PERSONAL REPRESENTATIVE: If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative or to your next of kin, as permitted under state and federal law.

DISASTER RELIEF: We may disclose your Protected Health Information to an organization assisting in a disaster relief effort.

PUBLIC HEALTH ACTIVITIES: We may disclose your Protected Health Information for public health activities including the reporting of infectious disease, illness, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may also disclose your information to notify a person who may have been exposed to a communicable

disease or may otherwise be at risk of contracting or spreading a disease or condition if a law permits us to do so.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your Protected Health Information to health oversight agencies authorized by law to conduct audits, investigations, inspections and licensure actions or other legal proceedings. These agencies provide oversight for the Medicare and Medicaid programs, among others.

REPORTING VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your Protected Health Information to notify a government authority if required or authorized by law, or if you agree to the report.

LAW ENFORCEMENT: We may disclose your Protected Health Information for certain law enforcement purposes or other specialized governmental functions including to report a crime committed on our premises or against our Program Personnel as permitted by law.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose your Protected Health Information in the course of certain judicial or administrative proceedings as permitted by law.

RESEARCH: We will request that you sign a written authorization before using your Protected Health Information or disclosing it to others for research purposes.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTOS, ORGAN PROCUREMENT ORGANIZATIONS: We may release your Protected Health Information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person as permitted by law.

MILITARY AND VETERANS: If you are, or were, a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also use and disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.

WORKERS' COMPENSATION: We may use or disclose your Protected Health Information to comply with laws relating to worker's compensation or similar programs.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES; PROTECTIVE SERVICES: We may disclose Protected Health Information to authorized federal officials who are conducting national security and intelligence activities or as needed to provide protection to the President of the United States, or other important officials.

AS REQUIRED BY LAW: We will disclose your Protected Health Information when required by law to do so.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your authorization to use or disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the appropriate Provider Staff. If you revoke your Authorization, then we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

Fundraising [if applicable].

We may contact you or your personal representative to raise money for our organization. We may also share your demographic information with a charitable foundation that may contact you or your personal representative to raise money on our behalf. In certain circumstances, you must provide us with your written authorization for our use of your information for fundraising and you also have the opportunity to opt out or restrict your receiving future fundraising communications. Your request to opt out of receiving future fundraising communication will revoke any prior authorizations and you will not receive any future communications.

Marketing [if applicable].

In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our individual lists or your health information to a third party without your written authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the appropriate Provider Staff.

RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION: You have the right to request, either orally or in writing to inspect and obtain a copy of your Protected Health Information, subject to some limited exceptions. If available, you have the right to access your information in electronic format. We must allow you to inspect your records within 10 days of your request. We must furnish you copies of alcohol and substance abuse records within 15 days of your request. If you request copies of the records, we must furnish you a copy within 30 days of that request. We may obtain a 30 day extension in certain circumstances. We may charge a reasonable fee for our costs in copying and mailing your requested information or provision of information in electronic format.

In certain limited circumstances, we may deny your request to inspect or receive copies. If we deny access to your Protected Health Information, we will provide you with a summary of the

information, and you have a right to request review of the denial. We will provide you with information on how to request a review of our denial and how to file a complaint with us or the Secretary of the Department of Health and Human Services.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on the way we use and disclose your Protected Health Information for our treatment, payment or health care operations. You also have the right to request restrictions on our disclosures of your Protected Health Information to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction, and in some cases, the law may not permit us to accept your restriction. However, if we do agree to accept your restriction then we will comply with your restriction EXCEPT IF: (1) you are being transferred to another health care institution; (2) the release of records is required by law, or (3) the release of information is needed to provide you emergency treatment. If your restriction applies to disclosure of information to a health plan for payment or health care operations purposes and is not otherwise required by law, and where you paid out of pocket, in full, for items or services, we are required to honor that request.

RIGHT TO RECEIVE NOTICE OF A BREACH: We will notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

In the event the breach involves 10 or more individuals whose contact information is out of date, we will post a notice of the breach on the home page of our web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting" of our disclosures of your Protected Health Information. This is a listing of certain disclosures of your Protected Health Information made by the Provider or by others on our behalf, but does not include disclosures made for treatment, payment and health care operations or certain other purposes unless the records are maintained in an Electronic Health Record. Records maintained in an Electronic Health Record will include disclosures made for treatment, payment, health care operations and other purposes.

You must submit a request in writing, stating a period of time for the accounting that is within six years from the date of your request. Where an Electronic Health Record is used, we will provide you with an accounting of disclosures for a 3 year period. You are entitled to one free accounting within one 12-month period. For additional requests, we may charge you our costs.

We will usually respond to your request within 60 days. Occasionally, we may need additional time to prepare the accounting. If so, we will notify you of our delay, the reason for the delay, and the date when you can expect the accounting.

RIGHT TO REQUEST AMENDMENT: If you think that your Protected Health Information is not accurate or complete, then you have the right to request that the Provider amend such information for as long as the information is kept in our records. Your request must be in writing and state the reason for the requested amendment. We will usually respond within 60 days, but will notify you within 60 days if we need additional time to respond, the reason for the delay and when you can expect our response. We may deny your request for amendment, and if we do so, we will give you a written denial including the reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

RIGHT TO A PAPER COPY OF THIS NOTICE: It is the Provider policy to provide you with a paper copy of this notice.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we speak to you only at certain private locations. We will accommodate your reasonable requests.

V. COMPLAINTS

If you believe that your privacy rights have been violated, then you may file a complaint in writing with Provider or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with the Provider, contact:

Erica Hudson
Vice President for Operations, Compliance Officer
Housing Works, Inc.
81 Willoughby Street, 2nd Floor
Brooklyn, New York 11201
e.hudson@housingworks.org
Phone: (718) 408-6549
Cell: (917) 734-1469

Janell Matthews, MPA
Compliance and Risk Management Coordinator
Housing Works, Inc.
81 Willoughby Street, 2nd Floor
Brooklyn, New York 11201
j.matthews1@housingworks.org
Phone: (718) 408-6500, ext. 6586
Cell: (929) 442-9170

Gillian Saunders
Director of Healthcare Compliance
Housing Works, Inc.
81 Willoughby Street, 2nd Floor
Brooklyn, New York 11201
g.saunders@housingworks.org
Phone: (347) 675-7689

Michelle Kot (340B Compliance)
Healthcare Data and Project Manager
Housing Works Community Healthcare
81 Willoughby Street
Brooklyn, New York 11201
m.kot@housingworks.org
Phone: (718) 408-6500, ext. 6064
Cell: (929) 288-1169

No one will retaliate or take action against you for filing a complaint.

VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by the Provider as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the appropriate Provider Department. In addition, we will provide a copy of the revised Notice to all individuals/consumers.

If you have any questions about this Notice or would like further information concerning your privacy rights, then please contact:

Erica Hudson
Vice President for Operations, Compliance Officer
Housing Works, Inc.
81 Willoughby Street, 2nd Floor
Brooklyn, New York 11201
e.hudson@housingworks.org
Phone: (718) 408-6549
Cell: (917) 734-1469

Janell Matthews, MPA
Compliance and Risk Management Coordinator
Housing Works, Inc.
81 Willoughby Street, 2nd Floor
Brooklyn, New York 11201
j.matthews1@housingworks.org
Phone: (718) 408-6500, ext. 6586
Cell: (929) 442-9170

Gillian Saunders
Director of Healthcare Compliance
Housing Works, Inc.
81 Willoughby Street, 2nd Floor
Brooklyn, New York 11201
g.saunders@housingworks.org
Phone: (347) 675-7689

Michelle Kot (340B Compliance)
Healthcare Data and Project Manager
Housing Works Community Healthcare
81 Willoughby Street
Brooklyn, New York 11201
m.kot@housingworks.org
Phone: (718) 408-6500, ext. 6064
Cell: (929) 288-1169

Consent Form

Patient Name: Jane Doe **Date of Birth:** 1/23/74

Consent for Treatment

By signing below, I consent to treatment and services by Housing Works Community Healthcare including Primary Care, Psychiatry, and/or Psychotherapy, in addition to other specialties. I consent on behalf of myself or the patient, as the patient's parent or legal guardian.

Consent for Picture

Housing Works Community Healthcare takes pictures of clients and retains them in patient charts for purposes of identity confirmation only.

- ☒ Yes, I agree to have my/the patient's picture taken and placed in my/the patient's chart for the purposes of identity confirmation.
- ☐ No, I do not agree to have my/the patient's picture taken and placed in my/the patient's chart.

Consent for Portal Access

Housing Works Community Healthcare offers patients the option to be web-enabled and given access to its patient portal. The patient portal is an interactive website that allows patients to ask questions and access information including lab results and more.

- ☒ Yes, I agree to be web-enabled and given access to the patient portal (interactive website).
- ☐ No, I do not agree to be web-enabled and do not want access to the patient portal (interactive website).

Finance Acknowledgement

By signing below, I agree that payments from my/the patient's insurance company will be made directly to Housing Works Community Healthcare for services received. I understand that there may be services or procedures (including laboratory services provided by LabCorp, Inc.) not covered by my/the patient's insurance that I will be responsible for. I accept responsibility for all charges not covered by my/the patient's insurance, and agree to pay any co-pays and/or balances at the time of service unless other arrangements are made in advance.

Consent to Healthix

I understand that I/the patient has the option to consent to allow Housing Works Community Healthcare to share my/the patient's personal health information via its participation in the Regional Health Information Exchange (Healthix) by selecting "I GIVE CONSENT" or "I DENY CONSENT" on the Healthix Consent Form.

I understand that if I pay for services for myself/the patient fully out of pocket, I have the option to decline to share my/the patient's personal health information related to the particular visit or service by choosing "I DENY CONSENT" on the Healthix Consent Form.

Consent for Pharmacy

For better collaboration of care, by signing below I consent to allowing my/the patient's pharmacy to access my/the patient's medical records on a "need to know" basis to confirm my/the patient's medication history, payment, and to order medications.

Edited 040722

Consent Form

Consent to Release Information

By signing below, I authorize Housing Works Community Healthcare to release all information necessary to complete insurance forms and to secure payment on my/the patient's behalf.

I understand that Housing Works Community Healthcare and its employees and contracted services will have access to my/the patient's personal and medical information as reasonably necessary to carry out treatment plans and recommendations, payment activities, and healthcare operations (including but not limited to quality assurance activities and audits). I authorize Housing Works Community Healthcare to release my/the patient's medical record, including but not limited to records of office visits and treatment rendered, x-rays, x-ray reports, and photographs t other health care professionals or facilities for the purposes of discussing or consulting on my/the patient's condition. I consent to the release of any medical information about me/the patient to any health care providers involved in caring for me/the patient as reasonably necessary to carry out treatment, payment, or health care operations.

Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of Housing Works Community Healthcare's Notice of Privacy Practices.

Below, I make the following request for confidential communication or restriction on use or disclosure of my/the patient's protected health information. [Please state the specific restriction you are requesting and to whom the restriction applies. This written request will be submitted to Housing Works' Privacy Officer for review and you will be notified of our decision.]

I am requesting the following restrictions:

____

____

Patient Signature

2/16/23
Date

____
Signature of Authorized Representative or Parent/Legal Guardian

____
Date

____
Description of Authorized Representative or Parent/Legal Guardian

For Office Use Only:

☐ Check this box if patient refused to sign

Forward any Restriction Requests to Privacy Officer. If approved, enter the Restriction in a Global Alert and Indicate 'DO NOT DELETE' in Alert.

Edited 040722

Client's Rights

As a participant of an OASAS-certified program, you have the right to:

- Be informed of the program's rules and regulations
- Receive considerate and respectful care
- Receive services that are responsive to your individual needs and goals
- Receive services without regard to race, color, ethnicity, age, religion, sex, sexual orientation, gender, gender identity or source of payment
- Receive confidential treatment. Except in the case of a medical emergency, court order, suspected child abuse, or crimes committed on program premises, a program generally cannot release information about your treatment without your written consent
- Receive information about provider services available on site or through referral, and how to access such services
- Receive education, linkage and support with all forms of FDA approved medications that treat substance use disorders
- Receive a prompt and reasonable response to requests for provider services or a stated future time to receive such services in accordance with an individual treatment plan
- Be fully informed of your treatment plan and participate in its development. This includes setting goals and measuring progress with your counselor
- Know the standards that apply to your conduct, to receive timely warnings for conduct that could lead to discharge and to receive incremental interventions for barriers to completion of treatment plan goals
- Voice a grievance, file a complaint, or recommend a change in procedure to service, free from intimidation, reprisal, or threat
- Refuse treatment and be told what effect this could have on your health or status in the program or with mandating parties
- Decline Telehealth services
- Discontinue treatment at any time
- Obtain, in writing, an explanation of the reason(s) for your discharge from treatment and information about the program's appeal process. And, if necessary, receive help obtaining treatment at another program
- Avoid inappropriate personal involvement with counselors, staff or other patients. Patients have the right to be free from sexual harassment and sexual misconduct.

Jane Doe — 2/14/23

Client Signature — Date

[signature] — 2/14/23

Staff Signature — Date

Grievance Procedure

All clients have the right to address complaints or concerns regarding their perceived quality of care. If you have any questions about the treatment services you receive or if you feel your rights have been violated, follow these steps:

- Talk with your counselor. Most problems can be handled by your counselor.
- If matters are not resolved by your counselor, talk with their supervisor who is the Director of Clinical Services, Dara Walker, LCSW at 347-671-4166
- If you still feel that your issue has not been resolved to your satisfaction, you will have the opportunity to meet with the VP of Behavioral Health Integration, the SVP of Health Services Operation and/or the Executive Director.
- After you have utilized the on-site methods of grievance and still feel that your issues/concerns were not resolved, call the OASAS Client Advocacy Unit at (800) 553-5790.

Patient Advocacy Unit

The OASAS Patient Advocacy Unit addresses the questions, concerns, and grievances with licensed OASAS programs. It promotes high quality care by assuring that patients' rights are protected and that services are delivered consistent with regulations and generally accepted treatment practices.

When contacted, the unit staff will attempt to resolve the matter as quickly and fairly as possible.

Report a Complaint:

Program Complaints 1-800-553-5790 — Email: patientadvocacy@oasas.ny.gov

Counselor Complaints 800-482-9564 Option 5 — Email: credentialing@oasas.ny.gov

Housing Works Client Code of Conduct

In keeping with Housing Works' responsibility to maintain a safe and welcoming environment for its clients, staff, volunteers, interns and the larger community in which we live, certain behaviors are expressly prohibited. Prohibited behaviors include:

1. Coming to Housing Works Offices Under the Influence of Illicit Substances or Alcohol: If you come to Housing Works while under the influence of drugs or alcohol to the extent that you are unable to participate in the program or become disruptive, you may be asked to leave and escorted away from the premises. Repeated instances of this behavior can result in suspension or termination from Housing Works.

2. Use of Illicit Substances at or in the Vicinity of Housing Works' Offices is Prohibited: If you are found using substances, such as illegal drugs, alcohol, or drugs that are not prescribed to you, at Housing Works offices, program areas, and/or inclusive of the front of the building, it could lead to suspension or termination from services. Dealing and steering substances/drugs at Housing Works, in any Housing Works apartment, or in the neighborhood of its offices may result in permanent termination from the agency and may result in criminal charges.

3. Verbal Abuse, Weapons, and Physical Violence Are Prohibited: Abusive behavior, including threats and other forms of verbal abuse directed toward staff, volunteers, interns, clients or guests, is prohibited. Weapons, including but not limited to firearms, are not allowed in our facilities. Physical violence of any kind is absolutely prohibited. Persons who engage in abusive or violent behavior will be asked to leave the office, suspended from services, or be permanently terminated from the agency and may face criminal charges. Discrimination, harassment, bullying, or mistreatment based on sex, gender identity, sexual orientation, race, ethnicity, religion, disability, of any kind will result in suspension or termination.

4. Theft of Property is Prohibited: Taking or borrowing anything that does not belong to you without the permission of the person to whom it belongs is theft. Anyone caught stealing from Housing Works, its neighbors, its clients, volunteers, interns or staff will be required to make full restitution as a condition of receipt of any services from the agency. Other penalties for theft may include suspension from services, permanent termination from the agency or criminal charges.

5. Trespassing on the Property of Others is Prohibited: Housing Works clients are welcome in Housing Works' offices and in the building in which Housing Works offices are located only during official business hours. Being in the building or in a Housing Works office which has been closed constitutes trespassing. It is also trespassing to be in areas of the building where you are not authorized to go. Trespassing may result in termination from the agency and may result in criminal charges.

6. Breaches of Confidentiality Are Prohibited: In the course of groups and other services, clients often learn confidential information about other clients, including medical status. You should not share any information, including the identity of a client, with other people without consent from that client.

7. Audio or Video Recording is Prohibited: Recording of Housing Works staff and/or clients both on Housing Works premises or at any offsite sponsored event without the written consent of a member of Housing Works' executive leadership is not allowed. Violation of this policy may result in suspension or termination. Nothing in this policy should be construed to restrict rights protected by applicable local, state and federal law.

8. Compliance with Public Health Regulation is Mandatory: In order to ensure the welfare of our community and to protect from the spread of infectious disease and environmental hazards, staff and clients are required to comply with all public health mandates.

Print Name: Jane Doe

Signature: [signature] Date: 2/14/23

Updated: May 14, 2020

Telehealth Informed Consent

The below pertains to all Telehealth visits including group and individual sessions:

- I understand that the OASAS 822 program will work to assist with my Telehealth care and requests in care treatment provision.
- I understand and agree to be assessed from clinical appropriateness to engage in telehealth services on an as needed basis to support best clinical care possible for me as an individual.
- I understand that it is my obligation to notify my counselor of any other people in the location, either on or off camera, and who can hear or see the session. I understand that I am responsible for ensuring privacy at my location. I will notify my counselor at the outset of each session and am aware that confidential information may be discussed.
- I agree that I will not record, either through audio or video, any of the sessions.
- I understand that the following will be assessed and documented at the time of each telehealth session:
    - Location of the practitioner
    - Your location: at the start of session and if it changes during session
    - Any other persons present
    - What the plan is for if the encounter is disrupted due to equipment failure and for follow up
- I understand there are potential risks to using telehealth technology, including but not limited to interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.
- I consent to the use of DOXY or Zoom as the technology service(s) we will use to conduct telehealth videoconferencing appointments. My Counselor will discuss the use of the platform to determine preferences that support reducing barriers to care. Prior to each session, I will receive a link to enter the "waiting room" or "room" for the session.
- To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.
- I recognize that if it appears my or other peers' confidentiality is at risk, or other code of conduct rules are being violated during a telehealth session, my counselor may end the session or "remove" me from group.
- I recognize my counselor may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my Counselor is concerned that immediate medical attention is needed.
- I understand that either I or my counselor can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

Telehealth Informed Consent

I, Jane Doe acknowledge that I understand Housing Works'/Bailey House's program expectations of my participation in the OASAS program.

X Jane Doe
Client Signature

X 2/14/23
Date

X [signature]
Staff Signature

X 2/14/23
Date

Revoked On: Staff Initials:

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

CONSENT TO THE USE OF TELEPRACTICE IN THE PROVISION OF ADDICTIONS TREATMENT

Patient's Last Name Doe	First Name Jane	M.I.
CASE No. ElCare #		
FACILITY Housing Works Bailey House	UNIT OASAS	

INSTRUCTIONS: GIVE COPY OF FORM TO PATIENT. Keep an original of this consent

TELEPRACTICE INFORMED CONSENT

PURPOSE OR NEED FOR CONSENT: To permit the Substance Use Disorder (SUD) treatment to be provided via Telepractice as specified in OASAS Part 830 Regulations.

EXTENT OR NATURE OF INFORMATION

I Jane Doe provided information and understand the following regarding services delivered via Telepractice:

I. Description:

Telepractice is the delivery of Substance Use Disorder (SUD) treatment services provided by an OASAS certified program who is approved for the provision of Telepractice via Audio/Visual and when approved Telephonic mediums. Telepractice is a method of obtaining treatment and recovery support when in-person methods are not available and is subject to the same regulatory and clinical standards as in-person services. When applicable, reimbursable through both Medicaid and Commercial Insurance Plans.

II. Confidentiality:

Telepractice is subject to the confidentiality requirements of 42 CFR Section and HIPAA for the protection of individual's privacy and confidentiality while providing services via Telepractice. Telepractice should be delivered using telecommunication technology that is compliant with confidentiality standards of state and federal law. Provider using Telepractice will make every reasonable effort to decrease the risks associated with the use of Telepractice. I further understand that my confidential information will not be redisclosed without my consent.

III. Patient Rights:

Telepractice is also subject to the requirements of the OASAS Part 815 Patient Rights Regulations. Concerns regarding my treatment can be sent to PatientAdvocacy@oasas.ny.gov I understand that I can decline services via Telepractice at any time.

I, the undersigned, have read the above and authorize the staff of Housing Works | Bailey House, to provide my SUD treatment services via Telepractice. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it, and that in any event this consent expires automatically as follows:

Jane Doe
(Signature of Patient)

(Signature of Parent/Guardian, when required)

Jane Doe
(Print Name of Patient)

(Print Name of Parent/Guardian)

2/16/23
(Date)

(Date)

Describe authority to sign on behalf of Patient:

TRS-66 (04-20)

Office of Alcoholism and Substance Abuse Services

NYS Office of Alcoholism and Substance Abuse Services
Authorization for Release of Behavioral Health Information

Patient Name: Jane Doe	Date of Birth: 1/23/74	Patient Identification Number: E1 CARE #
Patient Address: 1751 Park Ave NY, NY 10035		

I, or my authorized representative, request that health information regarding my care and treatment may be released and exchanged as set forth on this form. I understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, my federal social security number (for record matching purposes only), any and all information relating to ALCOHOL and DRUG TREATMENT and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

   ________ If you initial this line, HIV-AIDS RELATED information can also be released to OASAS. You do not have to initial this line.

   ________ If you initial this line, your Social Security Number can also be released to OASAS. You do not have to initial this line.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing and Exchanging this Information:

6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged:

   NYS Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, New York 12203

   I authorize the above listed Entity to inform the New York State Office of Alcoholism and Substance Abuse Services (OASAS) of my enrollment in this treatment program so that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and OASAS relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services.

7. The Purpose of this disclosure is to comply with implementation of New York's Medicaid redesign initiative and to comply with mandatory federal reporting requirements. By accepting the information covered by this consent into the NYS OASAS Client Data System, NYS OASAS acknowledges that this information may not be redisclosed per 42 CFR 2.32 – Prohibition on redisclosure.

8. My health information may be disclosed for a period of three (3) years from the last date of service, or until revoked.

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Jane Doe — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

2/16/23 — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

Dave Wal, LCSW — STAFF PERSON'S NAME AND TITLE

Dave Wal, LCSW — SIGNATURE

2/16/23 — DATE

Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

Revoked On: ___________ Staff Initials: ___________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Patient's Last Name	First	M.I.
Doe	Jane	
Case Number: EICARE #		
Facility: Housing Works/ Bailey House	Unit: OASAS	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan ____________________ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

30 Days from discharge

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

Jane Doe
(Signature of Patient)

(Signature of Parent/Guardian)

Jane Doe
(Print Name of Patient)

(Print Name of Parent/Guardian)

2/14/23
(Date)

(Date)

Revoked On: ____________ Staff Initials: ____________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

Patient's Last Name: Doe	First: Jane	M.I.
Case Number: E1CARE #		
Facility: Housing Works Bailey House	Unit: OASAS	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

All information necessary to investigate any alleged incident(s) of abuse or neglect, or other significant incidents, in which I may be named or am otherwise relevant.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

1) I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) including its Bureau of Special Hearings, and the NYS Justice Center for the Protection of People with Special Needs (JC) including its Vulnerable Persons Central Register (VPCR) for the purpose of investigating or making determinations regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

2) If I am a minor (under 18), I additionally consent to this program, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) and the Justice Center for the Protection of Vulnerable Persons (JC) providing notification to my parent or legal guardian regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition extending period specified above: Completion of an investigation by the Justice Center into an allegation of abuse or neglect, or other significant incident, pursuant to Chapter 501 of the Laws of 2012 and determination of a proceeding under NY Social Services Law Article 6, title 6.

30 Days from discharge

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Jane Doe (signature) (Signature of Patient)	(Signature of Parent/Guardian)
Jane Doe (Print Name of Patient)	(Print Name of Parent/Guardian)
2/14/23 (Date)	(Date)

OUTREACH AGREEMENT FORM

I am being asked to read the following material to ensure that I am informed of the peer outreach component of this program.

PURPOSE

As an OASAS funded program, our mission is to improve the lives of all New Yorkers by leading a comprehensive premier system of addiction services for prevention, treatment, and recovery. We are proud to include the implementation of Peer led supports within your treatment. It is of utmost importance that the beneficiaries of our services are well informed of the additional outreach that will be enforced in efforts to better support participants in their recovery process.

PROCEDURE

Outreach will consist of keeping participants motivated, supported, and engaged in services via telephone calls, home visits, on-site check-ins and other various peer delivered services. In addition to the above mentioned, more intensive outreach will be provided to those at higher risk of discharge and/or relapse. The Peer Model was designed for you, the participant, to have access to a more informal and individualized standard of care. All the while, having the lived experience of Recovery Coaches at your fingertips! You have support within your recovery and the Outreach Specialists here at Housing Works hope to serve as reminders of that. Additionally, you can contact the Director of Clinical Services, Dara Walker, LCSW at 347-671-4166 to answer any questions in regards to our outreach initiative.

RISKS

Although the potential risks associated with your participation in this program are minimal, at times you might be encouraged to challenge yourselves in ways that are conducive to your recovery. As the Peer Model emphasizes the importance and effectiveness of a strength-based approach, challenges will look and feel different for different people. Keeping that in mind, we only ask that you check-in with both us and yourselves throughout this process of self-exploration.

BENEFITS

In addition to developing a recovery focused companionship with another peer, you may find that you've adopted a form of support that you never knew could benefit you. Think of Bailey House/ Housing Work's Outreach Specialist as another tool you can use in your recovery. Whether it be emotional support or linkage to supportive or vocational services, an Outreach Specialist is here to help you accomplish your individual recovery goals.

Other services that the Housing Works/Bailey House Outreach Specialists will provide include:

- Assisting peer participants in the development of a personal self-directed recovery plan
- Working with participants to identify strengths
- Linking participants to formal recovery supports
- Providing peer participants with information on existing community supports and services
- Assisting peer participant with applying for benefits
- Accompanying peer participant to medical appointments
- Providing non-clinical crisis support, especially after periods of hospitalization or incarceration
- Accompanying peer participants to court appearances and other appointments
- Identifying and supporting linkages to community resources that support the peer participant's goals and interests

CONFIDENTIALITY

All information shared with an Outreach Specialist is to remain confidential. The only instances in which a participant's information will be disclosed is if some individual expresses harming themselves or others in any way. Also, information might be shared with your OASAS counselor in regards to your treatment. This is important because it ensures that you receive the appropriate care while receiving services.

AUTHORIZATION

Signing this form means that I have read and understand the purpose, procedures, risks, and benefits of peer-delivered services at Housing Works/Bailey House.

☐ I give consent to receive home visits.

☒ I do not give consent to receive home visits.

[signature] 2/16/23

Participant's Signature Date

[signature] 2/16/23

Staff Signature Date

Narcan Overdose Prevention Kit Attestation

I, Jane Doe acknowledge that I have been informed of, have discussed with either my primary counselor, members of the intake department, or other clinical, administrative or medical staff members, that the Housing Works/Bailey House 822-Outpatient program has on site a Narcan (Naloxone) opioid overdose prevention kit. I am also aware that there may be periodic trainings on administration of Narcan that may be held in groups or on site throughout the agency.

☑ I have further been informed of the staff members who have received training on Narcan (Naloxone) administration, its availability, and its purpose, protocols, and means of administration.

☐ I, myself, would like to receive training on Narcan (Naloxone) and its administration.

☐ I would like to receive Narcan (Naloxone) administration training.

☑ I am not interested in receiving Narcan (Naloxone) administration training at this time.

[signature] 2/16/23

Client Signature Date

[signature] 2/16/23

Staff Signature Date

Tobacco Free Agreement

Housing Works/Bailey House is a tobacco free program. Our locations are co-located with Department of Health programs requiring us to maintain a tobacco free environment. Please support our commitment to a healthy environment and strong recovery by refraining from use of tobacco products during your treatment on and around Housing Works/Bailey House grounds;

To support a tobacco free environment, I agree to the following:

1. I will not use any type of tobacco products while on Housing Works/Bailey House premises. I understand this includes inside the program, as well as the sidewalk immediately outside of the building.

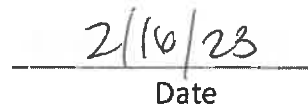
2. As a tobacco user, if it is a part of my recovery plan, I understand treatment goals specific to nicotine dependence may be a part of my recovery plan and I will have the opportunity to engage in groups to aid me if I chose to address my nicotine dependence.

3. In an effort to support peers who have also agreed to this initiative, I agree to take measures to remove the odor or evidence of smoking from my person before entering the program.

4. In the event that I have challenges with the policy, I understand that my case may be reviewed with possible changes to my recovery plan as agreed upon by both me and my counselor.

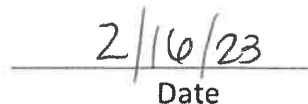
As part of the Housing Works/Bailey House admission process I have been informed of this policy and I agree to abide by it.

Client Signature



Date

Staff Signature



Date

Client Handbook

Please **initial** on the lines below and sign at the bottom.

JD I acknowledge that I have reviewed the client handbook which includes the client rights and responsibilities during my intake process at the OASAS Outpatient Substance Use clinic.

JD I understand my rights and responsibilities as client in the OASAS Outpatient Substance Use clinic.

JD I have been offered a copy of the client handbook in its entirety.

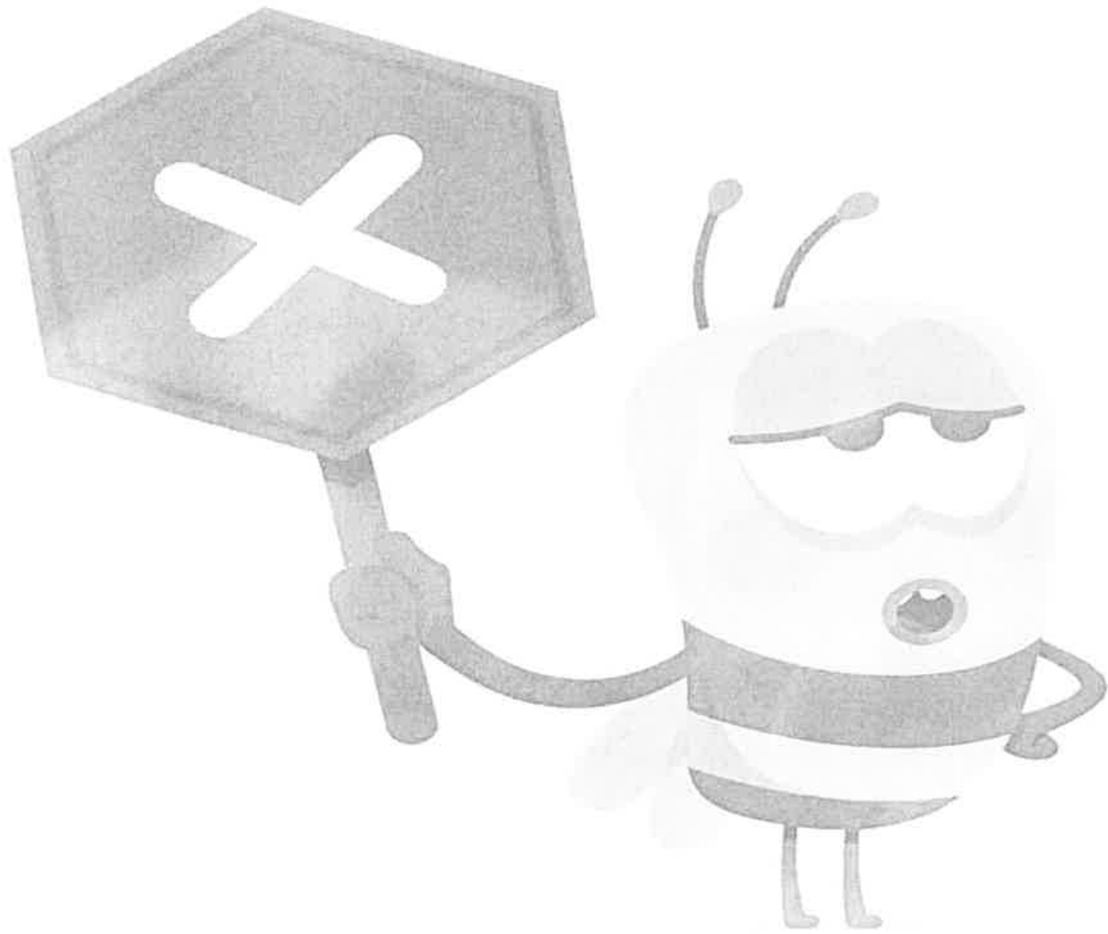
________ I have elected to not take a copy of the handbook.

Jane Doe 2/16/23

Client Signature Date

2/16/23

Staff Signature Date



STOP HERE – THE FOLLOWING CONSENTS WILL BE COMPLETED WITH THE ASSESSMENT COUNSELOR

Housing Works Health Services III, Inc.

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE USE DISORDER PATIENT RECORDS

I, Jane Doe, authorize Housing Works Health Services III,
[Patient's Name]
Inc. to disclose my medical record, as reasonably necessary, for purposes of continuity of care, treatment (including treatment plans and recommendations), payment activities, and health care operations (including but not limited to quality assurance activities and audits), to the following (list name of recipient):

✓ My Insurance Company: Medicaid
✓ My Pharmacy: Taino
___ Other Treatment Providers: ___
✓ Healthix Health Information Exchange (to opt out, please ask to complete a Healthix Authorization Form).

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

30 days after discharge
[Date, event, or condition upon which consent will expire]

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Jane Doe — Signature

2/16/23 — Date

___
Signature of Person Signing Form if Not Patient

Describe Authority to Sign on Behalf of Patient: ___

Date Revoked: ___ **Staff Initials:** ___

Bailey House Park Ave Health Center • Ph#: 718-277-0386 • **Fax:** 929-480-9160
East New York Health Center • Ph#: 718-277-0836 • **Fax:** 929-480-9136

Medical Clearance Form

Dear Primary Care Provider:

I am referring Jane Doe / DOB: 1/23/74 to Bailey House/ Housing Works' OASAS Program. I believe my patient can benefit from the program in one or more of the areas outlined below, which will enhance the quality of my patient's life.

Please check services that apply to your patient:

- Case Management
- Mental Health Services
- Substance Use/Harm Reduction Services

Please list medical condition (s) / History: (*Please attach all recent labs for patient as may pertain to treatment)

____

____

PPD	Date of Last PPD: ________ Result (circle one): Positive / Negative (must be within 1 year) History of PPD+ (circle one): Yes / No
Chest X Ray	If PPD Positive, Date of last XRay ________ (must be within one year) Please attach a copy of the Radiology Report

Hep C: Negative/ Positive Test date:____________ If positive, please provide Viral Load and treatment plan

HIV: Negative/Positive Test date:____________ If positive, please provide Viral Load and CD4.

PCP Name: ________________ NPI#:__________ Circle One: MD / NP / PA

Signature: ________________

PCP Hospital/Clinic: ________________

Address: ________________

____

Phone Number: ________________ Date: ________

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Jane Doe	1/23/74	E1 CARE #
Patient Address		
1751 Park Ave NY NY 10035		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Housing Works** to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Housing Works** to access ALL of my electronic health information through Healthix to provide health care.

☒ **2. I DENY CONSENT** for **Housing Works** to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Jane Doe	2/16/23
Print Name of Legal Representative (if applicable)	**Relationship of Legal Representative to Patient (if applicable)**

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization(s) listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases
    - Medication and Dosages
    - Diagnostic Information
    - Allergies
    - Substance use history summaries
    - Clinical notes
    - Discharge summary
    - Employment Information
    - Living Situation
    - Social Supports
    - Claims Encounter Data
    - Lab Test

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call **Housing Works** at: (718) 277-0386; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.