RACHEL'S HELPING HANDS CANCER FOUNDATION

NOTICE OF PRIVACY PRACTICES

Effective date: 07-06-2015/Version 1

SUMMARY

WHAT IS THE NOTICE FOR? This notice of Privacy Practices (Notice) describes how Rachel's Helping Hands Cancer Foundation (We or US) may use and disclose your medical information that we maintain and how you can get access to this information.

WHO ARE WE? RACHEL'S HELPING HANDS CANCER FOUNDATION is a non-profit organization which provides monies for cancer patients who cannot afford their deductibles.

WHY DO YOU NEED THIS NOTICE? The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, places certain obligations upon us with regard to how we may use and disclose your personal health information **(PHI)**. Your PHI includes medical information about you such as your medical records and the care and services that you have received. We are committed to **maintaining the privacy** of your PHI. When we need to use or disclose it, we will comply with the full terms of this Notice. Anytime we are permitted to or required to share your PHI with others, we only provide the **minimum** amount of data **necessary** to respond to the need or request unless otherwise permitted by law.

WHEN CAN WE USE/DISCLOSE YOUR PHI? There are certain uses and disclosures of your PHI that we may undertake **without your written or other authorization**. These uses and disclosures may be for purposes such as to provide you with treatment, obtain payment for services we have provided, and other health care operations (such as administration, quality improvement, cost studies and other activities designed to improve the service we provide to all our patients). Some other examples include: PHI made known to your relatives, close friends, or caregivers, public health activities and officials, reporting of abuse or neglect as may be required by law, health oversight activities, judicial and administrative proceedings, law enforcement officials, workers' compensation, and other individuals and activities as set forth in this Notice. Individuals who may have access to your information **without your written or other authorization** may include doctors, nurses, health care students, and other hospital staff.

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WE MUST OBTAIN YOUR WRITTEN AUTHORIZATION FOR ANY USE OR DISCLOSURE NOT SET FORTH IN THIS NOTICE. You may revoke this authorization **at any time**. In addition to obtaining your written authorization for uses or disclosures not described in this Notice, we generally will also need to seek your written authorization or approval prior to disclosing the following information:

- HIV/AIDS related information
- Sexually transmitted disease information
- Psychotherapy notes
- Mental health information
- Drug and alcohol information
- Genetic information
- Any information where you, if a minor, sought emancipated treatment (e.g., care related to your pregnancy or child, sexually transmitted diseases, etc.)

We will also seek your **written authorization** for any "marketing" activities we may conduct or where we would receive money for providing a third party with your PHI.

WHAT RIGHTS DO YOU HAVE FOR YOUR PHI? You have the right to ask us to limit certain uses and disclosures of your PHI. We will consider ALL request but may not be required to agree to your requested limitations. You also have the right to inspect and receive copies of your PHI, the right to request a change or amendment be made to your PHI, the right to an accounting (a list) of certain disclosures of your PHI, and the right to revoke any authorization you may have made to the extent we have not yet relied upon it. You also have the right to receive a paper copy of this Notice at any time.

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CAN WE CHANGE THIS NOTICE? We may change this Notice **at any time**. The revised Notice will apply to all PHI that we maintain. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice. You may obtain the new Notice in hard copy as well from our Privacy office.

ADDITIONAL INFORMATION/COMPLAINTS. You may contact our Privacy Office if you wish any additional information or have questions concerning this Notice or your PHI. If you feel that your privacy rights have been violated, you may also contact our Privacy Office and file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. **We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights.**

THE ABOVE IS ONLY A SUMMARY OF THE RIGHTS AND OBLIGATIONS WITHIN THIS NOTICE. PLEASE READ CAREFULLY THE ENTIRE NOTICE THAT FOLLOWS. WE WELCOME ANY QUESTIONS YOU MAY HAVE.

Effective date 07-06-2015 - No revisions

RACHEL'S HELPING HANDS CANCER FOUNDATION

CONFIDENTIAL COMMUNICATION LIST

Patient's Name: ______________________________

Date of Birth: ______________________________

I give my permission for the following person/persons to inquire and receive medical updates regarding my protected health information and billing information.

PRIMARY CONTACT: ______________________________

Home Phone#: ______________________

Cell Phone#: ________________________

Relationship: ______________________

SECONDARY CONTACT: ______________________________

Home Phone#: ____________________________

Cell Phone #: _________________________

Relationship: _________________________

EMERGENCY CONTACT: ____________________________

Home Phone#: ____________________

Cell Phone#: __________________________

Relationship: __________________________

Patient Signature: _______________________ Date: _________________

Patient Representative: ___________________________ Date: _________________

APPLICATION FOR CO-PAYMENT ASSISTANCE

1200 BUSTLETON PIKE SUITE 3 FEASTERVILLE, PA 19053
215-322-2065

STEP 1 - PERSONAL INFORMATION

Patient Name (Please Print Clearly) Today's Date ________________

First Name ______________________________ Last Name ________________________________

Gender 0 Male 0 Female Date of Birth: ________/______/________
Month Day Year

Address ______________________________________ City, State, Zip __________________________

Phone ( ) ________________ Cell ( ) ______________ Email ______________________

Marital Status 0 Married 0 Single 0 Divorced 0 Widow
Disabled 0 Yes 0 No

You **must** be a US Citizen or legal resident to be eligible for assistance.
YOU MUST BE IN **ACTIVE CHEMOTHERAPY OR RADIATION TREATMENT PROGRAM** TO RECEIVE ASSISTANCE! PLEASE CALL THE FOUNDATION AT 215-322-2065 IF YOU HAVE ANY QUESTIONS

STEP 2 - PRESCRIBING PHYSICIAN

Physician's Name ____

STEP 3 - INSURANCE INFORMATION

You **must have Insurance Coverage** in order to be eligible.
Please include a photocopy of your Insurance Card (front & back) for medical assistance.

Insurance Company - Primary
Insurance Company Name ____

Address ______________________________________ City, State, Zip __________________________

Phone ( ) ____________________ Fax ( ) ____________________

Member ID # ____________________ Group # ____________________

What Type of Insurance Plan is this? (Please check all that apply)
0 Medicare A&B 0 Medicare Advantage Does this plan include prescription coverage? **Yes / No**
0 Private Does this plan include prescription coverage? **Yes / No**
0 Cobra Date COBRA coverage ends _____/_____/_______
0 Other ______________________________

STEP 4 - INCOME INFORMATION

Income Sources - YEARLY Gross Income

	Patient	Spouse	Other
Salary (Before Taxes)	________	__________	________
Unemployment Income	________	__________	________
Medicare Wages or Social Security Disability	________	__________	________
Retirement Income	________	__________	________
Non Taxable Income	________	__________	________
Interest/Dividends/Rental Income	________	__________	________
Alimony/Child Support	________	__________	________
Net Business or Other Income	________	__________	________
TOTAL	________	__________	________

STEP 5 - ASSET INFORMATION

Asset Sources

	Patient	Spouse	Other
Cash in Banks	________	__________	________
Marketable Securities	________	__________	________
Real Estate Owned (excluding Primary Residence)	________	__________	________
Other Assets	________	__________	________
TOTAL	________	__________	________

STEP 6 - PROOF OF CO-PAYS OR OUT OF POCKET MEDICAL EXPENSES

Proof of Co-Pays or Out of Pocket Medical Expenses

0 You **must** attach proof of co-pay or medical expenses to be considered for reimbursement.

I hereby acknowledge that the information given herein is true and correct. I authorize **The Rachel Paster Helping Hands Foundation, Inc.** to verify any information contained in this document for the sole purpose of assessing financial need. Application will not be processed if this information is not provided.

______________________________	______________________________
Signature of Person Make Request	Date

______________________________	______________________________
Signature of Spouse/Other	Date

The Rachel Paster Helping Hands Foundation

______________________________	______________________________
Signature	Date

STEP 7 - THE RACHEL PASTER HELPING HANDS CANCER FOUNDATION, INC.

Consent Information

I give The Rachel Paster Helping Hands Cancer Foundation, Inc. permission to:

1 Check my information to make sure it is true and complete
2 Share my information with the people helping with the foundation
3 Contact me by mail or phone about the Foundation and about other programs of service that might interest me.

I promise that:

1 All the information in this application, including all copies of documents providing my income, is true and complete
2 I am authorized to sign this application
3 I will contact the Foundation if any of the information about my prescription drug coverage, insurance status, pharmacy/infusion provider changes and/or my employment or salary changes
4 I do not receive any other financial assistance for the expenses that I have asked the Foundation to cover. This includes Medicaid, state drug assistance programs, and medical flexible spending accounts.
5 I am not receiving other financial assistance from other co-payment assistance programs for the same medical expenses and/or co-pays.

I understand that the Foundation will only use my information to:

1 Decide if I qualify to participate in the Foundation's medical or co-pay assistance program
2 Administer or improve the Foundation

I understand that I can call **215-322-2065** at anytime to:

1 Withdraw from the Foundation
2 Cancel my permission to use my information and withdraw from the program

I understand that:

1 The Foundation can ask for more information from me at any time.
2 The Foundation permission to contact the person named below with follow-up questions about my application (this applies **only** if someone completed this application for you)

If a family member or someone helped you with this application and you want them to answer the questions for you, please provide their name and phone number.

Name ______________________________ Phone ( ) ____________________

Signature of Applicant	**Date**
x ______________________________	____________________