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Application for Services

Today's Date: _____
Client Name_____
Address_____
City _____ State_____ Zip _____
Birthdate _____
Social Security Number _____
Sex: Male _____ or Female_____
Phone Numbers _____
Email: _____
I have No Insurance or any way to pay for counseling - ***statement of need by client or parent for help to cover costs of this counseling.***

The below information will be used anonymously to access grant funding. Sex: _____Male or _____Female
Are you a citizen of the United States of America?____Yes _____No
Circle which Race best describes you.
White / Caucasian African American Latino American Indian
Or Other: or combination of
Client estimated Income from last year _____
Client estimated income for this current year _____

Counselor or Agency Business Name _____
Billing Address _____
City _____ State _____ Zip_____
Business Phone Number _____
Business Email _____
This child or adult needs professional counseling because_____
_____
_____
_____
_____
_____
_____
_____

Brief Statement of what kind of documentation has been shown or stated about some kind of sexual assault. _____
_____
_____
_____
_____

By signing this form below – you confirm that there has been some kind of official documentation of sexual abuse that happened at some time in this person's or child's life.

Client Name (if over 18) _____
Signature _____

Signature of parent or Guardian (if under 18)

_____

Contact information of the person signing this
Name _____
Contact information if different than above_____

_____

_____

Signature of Counselor _____

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
The following individual or organization is authorized to make the disclosure: This information may be disclosed to and used by the following individual or organization.

For the purpose of: _____

Name: Straight Up Sol**G**ier Foundation, Inc. or _____

Address: _____

City: _____ State: _____ Zip: _____

Signature of patient or legal representative Signature of witness

_____ _____

Date: _____ Date: _____

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records, _____ Lab results/X-ray reports, _____ Physical exam
_____ Consultation reports, _____ Immunization record

_____ Other (please specify: _____

3I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). 4. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. 5. *This information may be disclosed to and used by the following individual or organization.*

For the purpose of: _____

6.I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition

_____

7.If I fail to specify an expiration date, event or condition, this authorization will never expire. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

_____

_____ _____

Signature of patient or legal representative Signature of witness
*** If under 18 must be parent or legal guardian**

Date:_____ Date:_____

For Your Information: What is HIPAA?

HIPAA stands for the Health Insurance Portability & Accountability Act of 1996. HIPAA is also known as the Kennedy-Kassebaum Act.

It calls for:

1. Standardization of electronic patient health, administrative and financial data;
2. Unique identifiers for individuals, employers, health plans and health care providers;
3. Security standards protecting the confidentiality and integrity of health information.

Confidentiality of Records and HIPAA Authorization

While we will make every effort to keep information we learn about you private, this cannot be guaranteed. Other people may need to see the information. While they normally protect the privacy of the information, they may not be required to do so by law. Results of the research may be presented at meetings or in publications, but your name will not be used.

Health information means any information, whether oral or recorded in any form or medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected health information means individually identifiable health information transmitted or maintained in any form or medium.

Record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Date: _____ Sign Name:_____

Print Name:_____