Special Diabetes Program Application

Samish Indian Nation Health Department
715 Seafarers Way Suite #100
Anacortes, WA 98221-2257

Date of Application: _____

In order to be considered for services, please fill out this form in its entirety.

To be eligible for services, you must live within our 12-County Service Area. (Clallam, Island, Jefferson, King, Kitsap, Mason, Pierce, San Juan, Skagit, Snohomish, Thurston, or Whatcom County).

Personal Information

Name: _____

Address: _____

Email: _____

Phone Number: _____ Date of Diabetes Diagnosis: _____

Date of Birth: _____ Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Pre-Diabetes

Sex: ☐ Male ☐ Female ☐ Prefer not to say

Signature

Please Initial

_____ By signing this application, I am self-declaring that I have been diagnosed with Type 1 Diabetes, Type 2 Diabetes, or Pre-Diabetic.

_____ I acknowledge under penalties of perjury that the information contained in this application is true and accurate to the best of my knowledge.

_____ I understand that deliberate falsification of information contained in this application for diabetes assistance may result in denial of services.

Applicant Signature: _____ **Date:** _____

OFFICE USE ONLY

Date Application Received: _____ **Application Approved:** ☐ YES ☐ NO

Staff Signature: _____

Thank you for your information. Samish Indian Nation will review your application for assistance. We will reach out to go over any additional information or to obtain necessary documents. If you need assistance filling this application out, please contact us at diabetes@samishtribe.nsn.us or 360-726-3367.

715 Seafarers Way STE 100
Anacortes, WA 98221

Phone: 360-899-5282

RELEASE OF INFORMATION

Client Name:	Client Phone Number:	Client Email Address

CONSENT TO GIVE/EXCHANGE INFORMATION

Release Information From (Client Name): _____

To: Samish Indian Nation Diabetes Program ATTN: Diabetes Program Staff

By signing this form, you are giving permission for the Diabetes Program to the collection and use of confidential information about me within Samish Indian Nation's Diabetes Program in order to plan, provide, and coordinate services, payments, and benefits for me or for other purposes authorized by law.

CLIENTS: I understand that I may cancel this authority at any time, except to the extent that action has already been taken. Unless cancelled earlier by me this release will expire one year from date signed.

Signature of Client: _____ **Date:** _____

SINHD Representative Signature: _____ **Date:** _____

KEEP

Samish Indian Nation Health Department

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY:

We are required by applicable federal, state and tribal law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties to protect your health information, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

- **Healthcare Operations:** We may use and disclose health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities, or for other business and professional purposes.

- **Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us such authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

- **To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extend necessary to help

with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

- **Persons Involved in Care:** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. We will first require proof of their relationship to you. If you are present and able to consent, we will provide you with an opportunity to object to such uses or disclosures prior to use or disclosure of your health information, In the event of your incapacity or emergency circumstances, we will disclose health information based our professional judgment it is necessary and appropriate to disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

- **Required by Law**: We may use or disclose your health information when we are required to do so by applicable law.

- **Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to the authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law

enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

We will not use your health information for marketing communications without your written authorization.

PATIENT RIGHTS

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You submit a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

- **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You

must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

- **Amendment:** You have the right to request that we amend your information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

- **Electronic Notice:** If you receive this Notice on our Website or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

QUESTIONS & COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may submit your concerns or complaints to us using the contact information listed at the end of this Notice.

You also may submit a written complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S.S. Department of Health and Human Services.

Contact Officer:	Sharon Paskewitz, Essential Services Senior Director
Telephone:	(360) 726-3366
Address	715 Seafarers Way, Suite 103, Anacortes, Washington 98221
Email:	spaskewitz@samishtribe.nsn.us

Samish Indian Nation
Health Department

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Samish Indian Nation's Health Department has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact us at (360) 899-5454 to have us send you a current copy of the Notice of Privacy Practices or to ask questions. It is also posted on our website at https://www.samishtribe.nsn.us/departments/health.

By my signature below, I agree that I have received the Notice of Privacy Practices of Samish Indian Nation Health Department.

_____

Printed Name of Client

_____

Client Signature or Legally Authorized Individual Signature Date Time

_____ _____

Printed Name (If signed on behalf of client) Relationship (parent, legal guardian, personal representative)

_____

Minor Client's Signature, if applicable Date Time

FOR OFFICE USE ONLY

Office staff complete below:

I have attempted to obtain the client's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date:_____ Staff Member Initials:_____

Reasons:

_____

_____

_____