Dear KIC Tribal Elder: April 2012

We are planning our Grand Opening for the KIC Elder Meals and Wheels program for May 12, 2012. In order to provide you services through the KIC Elder Meals and Wheels program including Transportation for Elders 60 and older, Home Delivered Meals for 60+ Homebound Elder, or Congregate Meals (Lunch meals for 60+ Elder from 12-1) we need you to complete the attached Release of Information form (highlighted areas below and return it to the KIC Clinic. Turn it in at any reception desk at 2960 Tongass Avenue.

Thanks very much. We look forward to serving you! Sue Pickrell, Elder Services Director

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KIC Tribal Health Clinic

2960 Tongass Avenue ○ Ketchikan, Alaska 99901
(907) 228-4900 Fax (907) 228-4925

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

INFORMATION TO BE RELEASED FROM

I hereby authorize the following organization to release medical information as identified below:

☐ KIC Tribal Health Clinic

☒ Other: **KETCHIKAN SENIOR SERVICES**

Address: 1016 Water Street City: Ketchikan, Alaska 99901

INFORMATION TO BE RELEASED TO

☒ KIC Tribal Health Clinic **KIC ELDER SERVICES PROGRAM (KIC ELDER MEALS & WHEELS)**

Address: 615 Stedman Street City: Ketchikan, State Zip: 99901

Purpose of disclosure: Information regarding services currently being provided by S.E. Senior Services

Date(s) of Health Care information to be released: From _____ to _____

(Limited to 2 years unless otherwise specified)

TYPE OF INFORMATION TO BE RELEASED

☐ Medical records/excluding protected records include:

☐ X-Ray Reports ☐ Lab Results (please specify): _____

☐ Consultations ☐ Itemized Billing ☐ Other (specify): _____

☒ Mutual exchange of verbal or written information between the facilities listed above

INFORMATION PROTECTED BY STATE/FEDERAL LAW

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or HIV/AIDS testing and/or treatment, I agree to its release:

Alcohol or Substance Abuse Disorders/Treatment ☐ Yes ☒ No Initials _____

Mental Health Diagnosis/Treatment ☐ Yes ☒ No Initials _____

Sexually Transmitted Disease diagnosis/counseling (includes AIDS/HIV) ☐ Yes ☒ No Initials _____

TIME LIMIT AND THE RIGHT TO REVOKE THIS AUTHORIZATION

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to facility Privacy Officer at KIC Tribal Health Clinic. Unless revoked, this authorization will expire in 90 days.

RE-DISCLOSURE

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability Accountability Act (HIPAA). The facility, its employees, officers and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

I understand that KIC Tribal Health Clinic may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize KIC Tribal Health Clinic to use and disclose the protected health information as specified above.

_____ _____ _____

Signature of Patient or Legally Responsible Party | Relationship to Patient if not Patient | Date

Affix label here or complete information on right

_____

Patient Name

_____

Patient Address

_____ _____

DOB | Phone

KIC ELDER MEALS AND WHEELS PARTICIPANT REGISTRATION FORM

CONFIDENTIAL

HD meals must include reasons on page 2

907-247-RIDE (7433)

ADA#_____

IDN#_____

LOCATION: KIC – 615 Stedman St Ketchikan, AK 99901 907-228-9203 DATE: _____/_____/_____

NAME (Last, First, Middle Initial): _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

CITY, STATE: ZIP: _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

BIRTHDATE: _____/_____/_____ GENDER: MALE_____ FEMALE _____

****This information below is important for Federal Funding*****

ETHNIC RACE (Check 1 box) ❒ Black/African American ❒ Hispanic origin ❒ Native/American Indian ❒ Native Hawaiian/Other Pacific Islander ❒ Asian ❒ Caucasian/Non-Minority ❒ Other

DO YOU LIVE ALONE? ❒ YES ❒ NO DO YOU HAVE DIABETES? ❒ YES ❒ NO

IS YOUR INCOME ABOVE **($1,133-1 PERSON) OR ($1,532-Couple)** PER MONTH (Not including Senior Benefits Program and Permanent Fund Dividend? ❒ YES ❒ NO

DO YOU HAVE DISABILITY? ❒ YES ❒ NO ARE YOU 80 YRS OF AGE OR OLDER? ❒ YES ❒ NO

EMERGENCY CONTACT: _____ TELEPHONE #_____

QUALIFIED MEAL GUESTS UNDER 55 PLEASE CHECK ☑		SERVICES REQUESTED MANAGER PLEASE CHECK ☑
ARE YOU A MEALTIME VOLUNTEER? ❒ YES ❒ NO		Congregate
IS YOUR SPOUSE OVER 55? ❒ YES ❒ NO		Transportation
DO YOU HAVE A DISABILITY AND LIVE IN LOW INCOME SENIOR HOUSING? ❒ YES ❒ NO		Home-Delivered Meals
		Shopping Assistance
(Please complete the survey on the back)		Homemaker/Chore
		Care Coordination
		Adult Day Program
		Other

For Program Office Use Only:
Class: C S V DE MV Status: O N I R M D V MV NR _____ ADL_____ LADL _____

KIC CONGREGATE AND HOME DELIVERED MEAL CLIENTS COMPLETE QUESTIONS BELOW

Nutritional Risk Questions	(Circle the number if YES)
I have an illness or condition that made me change the kind and/amount of food I eat.	2
I eat fewer than two (2) meals per day.	3
I eat fewer than five (5) servings of fruits & vegetables and 2 milk servings per day.	2
I have three (3) or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three (3) or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained ten (10) pounds in the last six (6) months.	2
I am not always physically able to shop, cook, and/or feed myself.	2
TOTAL NUTRITIONAL SCORE	

Score Guide

0-2 Good! Recheck your nutritional score again in six (6) months.

3-5 You are at **Moderate Nutritional Risk**. See what can be done to improve your eating habits and lifestyle. Your senior nutrition program can help. Recheck your nutritional score again in three (3) months.

6+ **You are at High Nutritional Risk.** Bring this checklist the next time you see your doctor, dietician or other qualified health or social service professional. Talk with them about any problems you have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition.

PARTICIPANTS REQUESTING HOME DELIVERED MEALS, ASSISTED RIDES & HOMEMAKER/CHORE SERVICES COMPLETE BELOW

Do you need assistance with any of the following activities? Please check ☑ the activity:

☐ Eating	☐ Preparing meals
☐ Dressing	☐ Shopping for personal items
☐ Bathing	☐ Medication management
☐ Bathroom	☐ Managing money
☐ Transferring in/out of bed/chair	☐ Using telephone
☐ Walking	☐ Doing heavy housework
Total IADL's	☐ Doing light housework
	☐ Using available transportation
	Total IADL's

Is the participant bedridden? ☐ YES ☐ NO

Indicate if the participant uses a: Walker ☐ YES ☐ NO Cane ☐ YES ☐ NO Wheelchair ☐ YES ☐ NO

***REASONS FOR MEALS AT HOME: _____

_____

_____

ADDITIONAL CONCERNS? _____

REFERRED BY: _____

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