George Junior Republic
IN INDIANA

Acknowledgement of OYS Goals and Expectations

I acknowledge that my OYS worker has reviewed with me the reason for the referral from DCS/probation and has discussed the following:

1. Expectation of the intensity of service
2. Contact information for GJR Older Youth Case Manager
3. Information regarding my potential eligibility for Chafee IL Services, Collaborative Care, and Chafee Voluntary Services.
4. Goals that may be listed on the referral

I understand DCS/Probation expects me to work with my Older Youth Case Manager to develop goals and learn skills that will assist me in achieving successful adulthood. I am expected to participate directly in designing my program activities, accept personal responsibility for achieving interdependence, and have opportunities to learn from both positive and negative experiences.

Goals in the below areas will be developed based on results of the Casey Life Skills Assessment and Learning Plan. This plan will be developed by me with assistance from my Older Youth Case Manager.

Education	Employment
Financial and Asset Management	Physical and Mental Health
Housing	Activities of Daily Living
Youth Engagement	

I understand that DCS/Probation also expects the following assessments/applications to be completed:

Casey Life Skills Assessment	Independent Living Learning Plan
FAFSA	ETV Applications
Emergency Contact List	Credit Check (if over 18yrs old)
Obtaining Vital Documents	21 Century Scholars Application/Scholar Track

Safety Concerns - are there any safety concerns in your home (i.e. weapons, bed-bugs, communicable diseases)?

_____
_____
_____

Are there any cultural/religious considerations you want me to be aware of?

_____
_____
_____
_____

_____ _____
Printed name of client Date

_____ _____
Signature of client Date

_____ _____
GJR Older Youth Case Manager Date

George Junior Republic
IN INDIANA

YOUTH RIGHTS

Each youth receiving services from George Junior Republic in Indiana is entitled to certain rights as defined under the law. Employees of George Junior Republic in Indiana are responsible for ensuring that each youth's rights are respected. At no time is an employee permitted to take any action that violates the rights of a youth and each employee is responsible to read and understand the youth rights statement.

- A youth, the youth's family, and youth's placement may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age or sex.
- A youth has the right to be safe, nurtured and protected from youth abuse and neglect.
- A youth has the right to grow up in a supportive, stable home.
- A youth and their family have the right to be treated with fairness, dignity, and respect.
- A youth and their family have the right to be informed of the guidelines and expectations of the program.
- A youth and their family have the right to practice the religion or faith of choice, or not to practice any religion or faith.
- A youth has the right to appropriate medical, behavioral health and dental treatment.
- A youth has the right to rehabilitation and treatment.
- A youth has the right to an individualized, written treatment plan to be developed promptly after admission.
- A youth has the right to be free from excessive medication.
- A youth may not be subjected to unusual or extreme methods of discipline, which may cause psychological or physical harm to the youth.
- A youth has the right to clean, seasonal clothing that is age and gender appropriate.
- A youth and the youth's family have the right to lodge a grievance with the program *for an alleged violation of specific client or civil rights* without fear of retaliation.
- A youth and their family have the right to confidentiality of records.
- A youth may not be deprived of specific client or civil rights.
- A youth's rights may not be used as a reward or sanction.

We have received and reviewed our rights with the George Junior Republic in Indiana, Inc. staff.

PARENT OR GUARDIAN SIGNATURE _____ DATE _____

YOUTH SIGNATURE (IF APPLICABLE) _____ DATE _____

George Junior Republic
IN INDIANA

CLIENT GRIEVANCE PROCEDURE

Each client, youth and parent or guardian has the right to lodge grievances without the fear of retaliation. The Client Grievance Procedure within George Junior Republic in Indiana is as follows:

1. If a problem, question, issue or situation arises regarding the client, youth and/or family's treatment, it should first be discussed with the client's George Junior Republic in Indiana Social Worker/Case Manager.

2. If a problem, question, issue or situation arises regarding the client, youth and/or family's treatment and cannot be satisfactorily resolved with the program's Social Worker/Case Manager, it should then be discussed with the George Junior Republic in Indiana Regional Supervisor. The Regional Supervisor is a managerial staff person and the direct Supervisor of the Social Worker/Case Manager.

3. If a problem, question, issue or situation arises regarding the client, youth and/or family's treatment and cannot be satisfactorily resolved with the Regional Supervisor, it should then be discussed with the Director of Indiana. The Director is an administrative staff person and the immediate Supervisor of the Regional Supervisor.

4. If a problem, question, issue or situation arises regarding the client, youth and/or family's treatment and cannot be satisfactorily resolved with the George Junior Republic in Indiana Regional Director, it should then be discussed with the Vice President of Human Resources.

5. Also, please keep in mind that at any time, a client, youth, parent or guardian is encouraged to discuss any problems, questions, issues or concerns regarding the George Junior Republic in Indiana Program with the Probation Officer or Caseworker from the referring agency.

_____ _____

CLIENT, PARENT OR GUARDIAN SIGNATURE DATE

_____ _____

YOUTH SIGNATURE (IF APPLICABLE) DATE

(Two originals to be signed; one to be kept at the client/youth's home and one to be placed in the treatment file.)

GEORGE JUNIOR REPUBLIC IN INDIANA
CONSENT TO RECEIVE SERVICES

1. I, as the Patient (the term "I" and "Patient" shall mean the patient receiving the Services or the parent or legal guardian who is executing this Consent on behalf of the patient), understand that George Junior Republic in Indiana ("GJR") provides an array of services, such as home-based and office-based individual, group or family therapy, case-management, group home services, diagnostic and evaluation testing, assessments, random drug screens, independent living as well as other interventions as outlined by referral sources. In-person, virtual, or telephonic services will be utilized when appropriate. I understand that the Patient and/or Patient's family will be provided services on an ongoing basis as defined in the Patient's treatment plan ("Services") and I consent to the provision of Services. I understand such Services will be provided by an appropriate level of direct care worker as defined by Indiana state service standards regarding scope of education, training, and experience.

2. I understand that communication through social media including, but not limited to, Facebook, encrypted email, Skype, oovoo, MySpace, Twitter, Google+ and text messaging may be used and that every attempt will be made to avoid, limit and protect disclosing personal health information [PHI].

3. I understand that the following information has been explained to me before the commencement of Services:
    a. Patient's status giving rise to the proposed Services
    b. Proposed Services to be rendered to the Patient.
    c. Expected outcome of such Services.
    d. Material risks of such Services.
    e. Reasonable alternatives to Services.

4. I understand that I have a right to withdraw this consent for Services at any time by notifying, in writing or verbally, GJR.

5. I understand GJR may terminate services by notifying the Patient verbally or in writing, of the reasons for termination, and that GJR will refer the Patient for alternate treatment services if requested or required.

6. I understand that if emergency medical care or treatment is needed for the Patient I consent to GJR obtaining such emergency medical care or treatment. I understand that I will be

financially responsible for any such emergency medical care or treatment obtained by GJR for the Patient.

7. I have had sufficient opportunity to discuss the Patient's condition with a representative of GJR. I understand the potential benefits of the Services and all of my questions have been answered to my satisfaction.

8. I understand the contents of this consent form. I understand that I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction.

9. I acknowledge that I have adequate knowledge upon which to base an informed consent to the Services.

_____ _____ _____
PATIENT SIGNATURE DATE OF BIRTH DATE SIGNED

_____
Printed Patient Name

_____ _____
PARENT / LEGAL GUARDIAN SIGNATURE DATE SIGNED
(Parent or Legal guardian must sign if Patient is under the age of 18 years)

_____
Printed Name of Parent/Legal Guardian

_____ _____
WITNESS SIGNATURE DATE SIGNED

_____
Printed Name of Witness

George Junior Republic
IN INDIANA

RESPONSIBLE PARTY CONFIRMATION FORM

George Junior Republic of Indiana ("GJR") provides home-based, group home, office-based, and other consultation services to clients of GJR. Due to the nature of GJR's services, there may be times when a person other than client's parent has been assigned responsibility for making health care decisions for a client. Such person may be a guardian, health care representative, or special advocate, appointed by the court, or other person otherwise authorized to make decisions on behalf of the client (the "Responsible Party"). To ensure GJR communicates with and obtains consent from, the proper person regarding the client, this form notifies GJR when a person other than the parent has been established as a Responsible Party.

In addition to completing this form, when there is a Responsible Party, legal documentation confirming the authority of the Responsible Party must be submitted to GJR. An example of such legal documentation is a copy of the court order establishing the guardianship or representation. GJR retains the right to withhold treatment or otherwise withhold communication about the client to the person, unless GJR receives such legal documentation supporting the Responsible Party's authority.

Section 1. Client Information

Name of Client: _____
Date of Birth: _____

Section 2. Confirmation of Responsible Party

Please check the applicable box:

☐ I am the parent of the client and there is <u>not</u> currently a Responsible Party appointed for the client.

If this box is checked, complete Section 3 and Section 5.

☐ I am the parent, but do not have the authority to make health care decisions on behalf of the client due to the appointment of a Responsible Party.

If this box is checked, complete Section 3, Section 4 with information about the Responsible Party, and Section 5.

☐ I am the Responsible Party and have the authority to make health care decisions on behalf of the client due to my appointment as (check the applicable circle):

- o Judicially-appointed guardian
- o Health care representative
- o Court appointed special advocate

- Other person authorized to make health care decisions on behalf of the client. Please describe _____

  If this box is checked, complete Section 4 with your information and Section 5.

Section 3. Parent Information

Mother
Name of Mother: _____
Date of Birth: _____
Home Address: _____
Phone Number (Home): _____
Phone Number (Cell): _____
Name of Employer: _____
Phone Number (Work): _____

Father
Name of Father: _____
Date of Birth: _____
Home Address: _____
Phone Number (Home): _____
Phone Number (Cell): _____
Name of Employer: _____
Phone Number (Work): _____

Section 4. Responsible Party Information

Name of Responsible Party: _____
Date of Birth: _____
Home Address: _____
Phone Number (Home): _____
Phone Number (Cell): _____
Name of Employer: _____
Phone Number (Work): _____
Relationship to Client: _____
Effective Date of Status as Responsible Party: _____
Termination Date/Event of Status as Responsible Party: _____

Please also provide a copy of the legal documentation confirming the authority of the Responsible Party.

Section 5. Attestation and Signature

I have read and understand the above information. By signing this form, I attest that I have completed this form to the best of my knowledge regarding the person who has the legal authority to make decisions on behalf of the client.

Name of Parent/Responsible Party (Print): _____
Signature of Parent/Responsible Party: _____
Date: _____

GJR Staff Signature: _____
Date: _____

GJR Staff Use Only
Legal Documents Supporting Responsible Party Provided? Y / N
Copy of Legal Document Placed in Client Record? Y / N

GJR
George Junior Republic
IN INDIANA

TRANSPORTATION CONSENT AND RELEASE

I, the undersigned, do hereby consent to the transportation of _____ (the "Individual" [s]), by George Junior Republic in Indiana, Inc. ("GJR"), its agents, therapists, employees, and independent contractors (each individually and collectively, "GJR Representatives").

By signing this Form, I hereby release and agree to hold harmless GJR and GJR Representatives, from any and all claim(s) stemming from or in any way relating to the transportation of the Individual, whether the Individual is being transported to or from GJR by a GJR Representative at the time the Individual is allegedly injured as a result of said GJR Representative's alleged negligence or otherwise allegedly tortuous conduct. I understand and acknowledge this Form will be in effect regardless of the nature or seriousness of any and all injuries which may be sustained by the Individual while or as a result of the Individual being transported by a GJR Representative.

Prior to signing this Form, I have had sufficient opportunity to independently consider and/or to consult with an attorney to ask questions regarding the meaning and significance of this Form. I understand and agree to all of the terms of this Form and acknowledge that in so doing I have not relied upon any statement, explanation or promise by any GJR Representative, with regard to the meaning, scope or effect of this Form.

_____
(Printed Name of Individual or Parent/Guardian on behalf of Individual)

_____
(Signature of Individual or Parent/Guardian on behalf of Individual) (Date)

_____
(Printed Name of Witness)

_____
(Signature of Witness) (Date)

George Junior Republic
IN INDIANA

RELEASE FORM - Transportation/Group Activities

I, _____,_____ do hereby consent to
(Name of Client) (Date of Birth)
involvement in group tasks and transportation with other youth in the George Junior Republic programs.

_____ _____
(Signature of Client, Parent, or Guardian) (Date)

_____ _____
(Signature of Witness) (Date)

The Department of Child Services or Juvenile Probation is the guardian of

_____ and consents to this youth participating in groups and/or transportation with other youth involved in the George Junior Republic program.

_____ _____
(Signature of Parent/Guardian/Referral Agency) (Date)

_____ _____
(Signature of Witness) (Date)

George Junior Republic
IN INDIANA

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____

Client Address: _____

Client Date of Birth: _____

I, _____ do hereby consent
(Name)

and authorize unrestricted communications between
_____ (Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

1. Assessment/diagnosis in treatment/counseling
2. Attendance/participation in treatment/counseling
3. Progress and prognosis in treatment/counseling
4. Verbal Communication
5. Progress notes
6. Discharge summary/completion letter
7. Information relevant to facilitation of compliance with GJR Program
8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: _____

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:_____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient

Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

(Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

Signature of Client (if 13 year or older) Date

Signature of Personal Representative* Date

_____

*Nature of Relationship between Personal Representative and Client, where applicable

_____

Signature of Witness Date

_____

Printed Name of Witness

George Junior Republic
IN INDIANA

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____

Client Address: _____

Client Date of Birth: _____

I, _____ do hereby consent
(Name)

and authorize unrestricted communications between
_____ (Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

8. Assessment/diagnosis in treatment/counseling
9. Attendance/participation in treatment/counseling
10. Progress and prognosis in treatment/counseling
11. Verbal Communication
12. Progress notes
13. Discharge summary/completion letter
14. Information relevant to facilitation of compliance with GJR Program

8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: _____

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:_____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient

Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

(Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

Signature of Client (if 13 year or older) Date

Signature of Personal Representative* Date

_____

*Nature of Relationship between Personal Representative and Client, where applicable

_____

Signature of Witness Date

_____

Printed Name of Witness

George Junior Republic
IN INDIANA

Consent for Release of Student Information

George Junior Republic ("GJR") and its affiliates, [GJR in PA, GJR in Indiana, GJR Preventative Aftercare] periodically publish or otherwise make publicly available the names, image, likeness, voice, achievements and/or recognizes or provides similar information about students or their activities at or relating to George Junior Republic ("Personal Information") for the purposes described below. These releases of information include but are not limited to press releases; newsletters; photographs, videos (including voices); recordings, fund raising materials; "broadcasts" or other information dissemination provided as, on or in television, radio, computers, phones, social media, blogs, podcasts, mobile devices or apps, the GJR website, other websites or online services, and other existing or future ways to release information.

Purposes. The releases are made for purposes of supporting, advertising, raising funds, educating, or otherwise promoting or providing information about George Junior Republic or its mission, programs, students, community, activities or outreach efforts. The releases may be provided locally, nationally or internationally and in all possible existing or future media (now known or unknown).

By my signature below, I: (a) certify that I have (or have obtained) all necessary permissions and authority lawfully to provide this consent so that it will be legally binding, and (b) give consent for George Junior Republic (and its representatives, agents and service providers) to publish and/or release the Personal Information about the student identified below for the limited purposes described above, all without payment to the student, me or anyone else. I understand that I may withdraw this consent by writing GJR at 233 George Junior Road, Grove City, PA 16127, but I agree for myself and the student that any withdrawal will not be effective as to anything already published or when GJR has already relied upon this consent.

Name of Student (print)	Date of Student's Birth
Name of Signing Parent/Guardian, Adult Student, or Authorized Representative (print)	Signer's Relationship to Student
SIGNATURE (sign legal name and include any necessary title or authority)	Date of Signature

George Junior Republic
IN INDIANA

I _____ acknowledge that I have received a copy of GEORGE JUNIOR REPUBLIC IN INDIANA'S NOTICE OF PRIVACY PRACTICES and had the opportunity to ask questions.

_____
Name of Client

_____
Signature of the client or the client's personal representative if the client cannot make health care decisions for him/herself.

_____
Witness Signature

_____
Date

_____
Date

George Junior Republic
IN INDIANA

GEORGE JUNIOR REPUBLIC
HOMEBASED PROGRAM
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

If you have any questions regarding this notice, you may contact our privacy officer at:

George Junior Republic in Indiana, P.O. Box 1058 Grove City, PA 16127
Attention: Brandy M. Stark, LCSW – privacy officer.
Telephone: (812) 447-9580
Facsimile: (812) 346-2822

YOUR PROTECTED HEALTH INFORMATION

George Junior Republic is required by the federal privacy rule to maintain the privacy of your health information that is protected by the rule and to provide you with notice of our legal duties and privacy practices with respect to your protected health care information. We are required to abide by the terms of the notice currently in effect.

Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you.

Your medical, psychiatric, counseling, and billing records at George Junior Republic are examples of information that usually will be regarded as your protected health information.

I. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Treatment, payment, and health care operations.

This section describes how we may use and disclose your protected health information for the purposes of treatment, payment, and health care operations. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations purposes will be listed.

1. Treatment

We may use and disclose your protected health information for our treatment purposes as well as the treatment purposes of other health care providers.

Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- While receiving services, George Junior Republic, social workers, counselors, regional supervisors, directors, and other treatment and support staff involved in your care may review your medical, mental and behavioral health records and share and discuss this information with each other.
- We may share and discuss your past, present and future medical, mental and behavioral health information with outside entities to include juvenile probation, children and youth services, human services agencies, medical and mental health providers, and school personnel.
- We may share and discuss your progress within the program with family members and other concerned persons.
- While receiving services, George Junior Republic staff will be meeting with you at school, home and in public community settings.
- While receiving services, your name may appear on our business checking system after earning an allowance or stipend check.
- While receiving services, George Junior Republic staff may escort you to medical or mental health appointments to assist in the assessment and treatment process.

1. Payment

We may use and disclose your protected health information for our payment purposes as well as the payment purposes of other health care providers and health plans. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that you can obtain reimbursement for that care, for example, from your health insurer. Some examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service.
- Submission of a claim form to your health insurer.
- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.
- Sharing your demographic information (for example, your address) with other health care providers who seek this information to obtain payment for health care services provided to you.

- Mailing statements in envelopes with George Junior Republic as the return address. Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.
- Providing medical records and other documentation to your health insurer to support the medical necessity of a health service.
- Allowing your health insurer access to your medical records for a medical necessity or quality review audit.
- Providing consumer-reporting agencies with credit information (your name and address, date of birth, social security number, payment history, account number, and our name and address).
- Providing information to a collection agency for purposes of securing payment of a delinquent account.
- Providing information in a legal action for purposes of securing payment of a delinquent account.
- Providing insurance information with an outside physician, laboratory, pharmacy or other provider for purposes of securing payment.

2. Health care operations

We may use and disclose your protected health information for our health care operation purposes as well as certain health care operation purposes of other health care providers and health plans. Some examples of health care operation purposes include:

- Quality assessment and improvement activities.
- Population based activities relating to improving health or reduction health care costs.
- Reviewing the competence, qualifications, or performance of health care professionals.
- Conducting training programs for medical and other students.
- Accreditation, certification, licensing, and credentialing activities.
- Health care fraud and abuse detection and compliance programs.
- Conducting other medical review, legal services, and auditing functions.
- Business planning and development activities, such as conducting cost management and planning related analyses.
- Other business management and general administrative activities, such as compliance with the federal privacy rule and resolution of client grievances.

B. **Uses and disclosures for other purposes.**

We may use and disclose your protected health information for other purposes. This section generally describes those purposes by category. Each category includes one

or more examples. Not every use or disclosure in a category will be listed. Some examples fall into more than one category – not just the category under which they are listed.

1. Individuals involved in care for payment for care.

We may disclose your protected health information to someone involved in your care or payment for your care, such as probation officer, caseworker, attorney or a family member. For example, if you are injured, we may discuss your injury with a family member.

2. Notification purposes

We may use and disclose your protected health information to notify, or to assist in the notification of, a family member, a personal representative, or another person responsible for your care, regarding your location, general condition, or death. For example, if you are hospitalized, we may notify a family member of the hospital and your general condition. In addition, we may disclose your protected health information to your probation officer involved in your care.

3. Required by law

We may use and disclose protected health information when required by federal, state, or local law. For example, we may disclose protected health information to comply with mandatory reporting requirements involving child abuse, disease prevention and control, vaccine-related injuries, medical device-related injuries, gunshot and other injuries by a deadly weapon or criminal act, driving impairments and blood alcohol testing.

4. Other public health activities

We may use and disclose protected health information for public health activities, including:

- Public health reporting.
- Child abuse and neglect reports.
- FDA-related reports and disclosures, for example, adverse event reports.
- Public health warnings to third parties at risk of a communicable disease of condition.
- Child Welfare reportable incidents.

5. Victims of abuse, neglect or domestic violence

We may use and disclose protected health information for purposes of reporting abuse, neglect or domestic violence in addition to child abuse to the Child Protective Services Agency.

6. Health oversight activities

We may use and disclose protected health information disclosures for purposes of health oversight activities authorized by law. These activities could include audits, inspections, investigations, licensure actions, and legal proceedings.

7. Judicial and administrative proceedings

We may use and disclose protected health information disclosures in judicial and administrative proceedings in response to a court order or subpoena discovery request of other lawful process. For example, we may comply with a court order to testify in a case at which your medical condition is at issue.

8. Law enforcement purposes

We may use and disclose protected health information for certain law enforcement purposes including to:

- Comply with legal process, for example, a search warrant.
- Comply with a legal requirement.
- Respond to a request for information for identification/location purposes.
- Respond to a request for information about a crime victim.
- Report a death suspected to have resulted from criminal activity.
- Provide information regarding a crime on the premises.
- Report a crime in an emergency.
- Report an injury/health condition in an emergency.

9. Coroners and medical examiners

We may use and disclose protected health information for purposes of providing information to a coroner or medical examiner for the purpose of identifying a deceased client, determining a cause of death, of facilitating their performance of other duties required by law.

10. Funeral directors.

We may use and disclose protected health information for purposes of providing information to funeral directors as necessary to carry out their duties.

11. Organ and tissue donation

For purposes of facilitating organ, eye and tissue donation and transplantation, we may use protected health information and disclose protected health information to entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.

12. Threat to public safety

We may use and disclose protected health information for purposes involving a threat to public safety, including protection of a third party from harm and identification and apprehension of a criminal. For example, in certain circumstances, we are required by law to disclose information to protect someone form imminent serious harm.

13. Specialized government functions.

We may use and disclosure protected health information for purposes involving specialized government functions including:

- Military and veterans activities
- National security and intelligence.
- Protective services for the President and others.
- Medical suitability determinations for the Department of State.
- Correctional institutions and other law enforcement custodial situations.

14. Business associates

Certain functions of George Junior Republic are performed by a business associate such as a billing company, an accountant firm, or a law firm. We may disclose protected health information to our business associates and allow them to create and receive protected health information on our behalf. For example, we may share with our billing company information regarding your care and payment for your care so that the company can file health insurance claims and bill the responsible party.

15. Creation of de-identified information

We may use protected health information about you in the process of de-identifying the information.

16. Incidental disclosures

We may disclose protected health information as by-product of an otherwise permitted use of disclosure. For example, while visiting you at school, other students or staff may overhear your name being mentioned as you are asked to report to the office.

Use and disclosures with authorization

For all other purposes which do not fall under a category listed under sections II.A and II.B, we will obtain your written authorization to use or disclose your protected

health information. Your authorization can be revoked at any time except to the extent that we have relied on the authorization.

PATIENT PRIVACY RIGHTS

A. Further restriction on use or disclosure

You have a right to request that we further restrict use and disclosure of your protected health information to carry out treatment, payment, or health care operations, to someone who is involved in your care or the payment for your care, or for notification purposes. We are not required to agree to a request for further restriction.

To request a further restriction, you must submit a written request to our privacy officer. The request must tell use: (a) what information you want restricted; (b) how you want the information restricted; and (c) to whom you want the restriction to apply.

B. Confidential communication

You have a right to request that we communicate your protected health information to you by a certain means or at a certain location. For example, you might request that we only contact you by mail. We are not required to agree to requests for confidential communications that are unreasonable.

To make a request for confidential communications, you must submit a written request to our privacy officer. The request must tell us how and where you want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled.

C. Accounting of disclosures

You have a right to obtain, upon request, an "accounting" of certain disclosures of your protected health information by us (or a business associate for us). This right is limited to disclosures within six years of the request and other limitations. Also, in limited circumstances we may charge you for providing the accounting. To request an accounting, you must submit a written request to our privacy officer. The request should designate the applicable time period.

D. Inspection and copying

You have a right to inspect and obtain a copy of your protected health information that we maintain in a designated record set. Under federal law, however, you may not inspect or copy psychotherapy notes. Information compiled in a reasonable anticipation of, or use in, a civil, or criminal, or administration action or proceeding and protected health information that is subject to law and prohibits accesses.

To exercise your right to access, you must submit a written request to our privacy officer. The request must: (a) describe the health information to which access is requested, (b) state how you want to access the information, such as inspection, pick-up of copy, mailing of copy, (c) specify any requested form or format, such as paper copy or an electronic means, and (d) include the mailing address, if applicable.

E. Right to amendment

You have a right to request that we amend protected health information that we maintain about you in a designated record set if the information is incorrect or incomplete. This right is subject to limitations. To request an amendment, you must submit a written request to our privacy officer. The request must specify each change that you want and provide a reason to support each requested change.

IV. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We further reserve that right to make any change effective for all protected health information that we maintain at the time of the change – including information that we created or received prior to the effective date of the change.

We will make available a copy of our current notice with the program social worker. At any time, clients may review the current notice by requesting a copy from the Preventative Aftercare social worker.

V. COMPLAINTS

If you believe that we have violated your privacy rights, you may submit a complaint to George Junior Republic or to the Secretary of Health and Human Services. To file a complaint with Preventative Aftercare, Inc. submit the complaint in writing to our privacy officer. We will not retaliate against you for filing a complaint.

VI. LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.