Client Registration Form

Personal Information:

Clients Name: _____ Sex: M____ F____
Address: _____
City: _____ County: _____ Zip Code: _____
Date of Birth: _____ SS#: _____
Phone: ____-____-_____ Age: _____
Lives? Alone _____ With Spouse _____ Other_____

Office Use
Agency: Van Wert Council on Aging____
Assessor: _____
Date: _____
Purpose: _X_ Initial Assess ____ Reassess
____ Other ____ Term.
Consent: ____ Yes ____ No

Financial Information:

Income Sources:
____ Social Security
____ SSI
____ Disability
____ Retirement
____ Interest
____ Other

Monthly Income:
____ Below $200
____ $201-$500
____ $501-$700
____ $701-$1000
____ More

Other Assistance
____ Homestead Exemption
____ Golden Buckeye
____ Energy Credit
____ HEAP
____ Weatherization
____ Food Stamps

Medical Insurance
____ Medicare
____ Medicare B
____ Medicaid
____ Health Insurance
____ Other

Medication List (currently taking)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family Physician:

Name: _____
Address: _____
_____
Phone: _____

Medical History:

Do you use assistive devices? ____Yes ___ No
If yes explain_____

Family Contact:

Name: _____
Address: _____
_____
Phone: _____
Relationship: _____

Emergency Contact:

Name: _____
Address: _____
_____
Phone: _____
Relationship: _____

The Van Wert County Council on Aging has permission to share this information with Social Service Agencies, and the following people named below in order to better serve you as the consumer.

_____ _____
_____ _____
_____ _____

X: _____ _____
Client Signature Date

Fill out and return to Van Wert Council on Aging

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date of This Privacy Notice

The effective date of this Privacy Notice is _____October 16, 2003_____.

Changes or Revisions to our Privacy Notice

We reserve the right to change our Privacy Notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our Privacy Notice, we will post a copy of the new or revised notice in our main lobby. You may obtain a copy of the new/revised Privacy Notice from the business office.

X Our Privacy Notice was revised on June , 2012 . ____No changes since the effective date above.

Should you have any questions concerning our privacy practices, obtaining copies of our Privacy Notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclosed concerning your health information, requests to inspect or copy your medical information, requests that we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

Executive Director: Kevin Matthews
Van Wert County Council on Aging
220 Fox Road
Van Wert, Ohio 45891
(419) 238-5011

You May also file complaints with:
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington D.C. 20201
Toll-Free 1-877-696-6755

I certify that I received a copy of the provider's Privacy Notice and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting my health information.

_____

Date Signature of Client Printed Name of Client

_____

Date Signature of Witness Printed Name of Witness

I certify that I am the representative of _____ and that I have received the Privacy Notice on behalf of this individual and that the provider provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting health information.

_____

Date Signature of Representative Printed Name of Representative

Relationship to Client: _____

_____

Date Signature of Witness Printed Name of Witness

Van Wert County Council on Aging

Disclosure Statement

The Client Registration Form was designed to assist the Ohio Department of Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any client information obtained from this form will be kept confidential and no personal identifying information about the client (e.g. name, address, telephone number, ID No., etc.) will be released to the public without the client's prior written consent, or unless otherwise required under federal law.

The data collected (age, sex, race, low income status, ADL's and LADL's) will be forwarded to the Area Agency on Aging and the Ohio Department of Aging and summarized and reported to the Administration on Aging (AOA) in order to keep both state and federal legislators informed on the effectiveness of senior programs (as required by the 1992 Older Americans Act reauthorization). While all clients receiving services under the Older Americans Act are asked to complete the form in full, no client may be denied services for refusing any of the information requested, including social security number.

I hereby authorize the Van Wert County Council on Aging to release pertinent information as needed to other social service agencies, medical service providers, and/or medical insurance companies to effectively accomplish timely and efficient service delivery.

I also confirm that I have received a copy of:

__X__ Client Rights and Responsibilities
__X__ Cost Share Information
__X__ Disclosure Statement
__X__ HIPAA Medical Release
__X__ HIPAA Privacy
__X__ Council on Aging Transportation Service Policies and Procedures

I understand that I may cancel this authorization for the release of information at any time by contacting the office of the Van Wert County Council on Aging at 419-238-5011.

If you have any questions, ask the staff to explain why this release is necessary.

_____ _____
Signature of Client or Person Responsible and Relationship Date

_____ _____
Van Wert County Council on Aging Staff Member Date