YOU FIRST
Screening and support for heart disease, breast and cervical cancer.

You First Membership Application

Please complete and return this signed application and signed Notice of Privacy Practices:
Mail: Vermont Department of Health, You First, 280 State St, Waterbury, VT 05671-8380
Fax: 802-657-4208

For Deaf and hard of hearing individuals, please use Vermont Relay Service 711 and give our number: 1-800-508-2222.
If you have questions or need interpretation services, call 1-800-508-2222. Please state your language and we will connect with an interpreter.
Si vous avez des questions ou besoin de services d'interprétation, composez le 1-800-508-2222.
Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na 1-800-508-2222.
Si usted tiene preguntas o necesita servicios de interpretación, llame al 1-800-508-2222.
Haddii aad su'aalo qabto ama aad u baahan tahay adeeg tarjumaan, wac lambarka hoos ku qoran 1-800-508-2222.
Kama una maswali au unahitaji huduma za tafsiri, piga 1-800-508-2222.
စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-800-508-2222 သို့ဖုန်းဆက်ခေါ်ပါ။
यिद तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-800-508-2222 मा कल गनुहो

Section 1: About You

First Name:

Last Name:

Name you would like You First staff to use:

Date of birth (mm/dd/yyyy):

Social Security number (XXX-XX-XXXX): ☐ I do not have a Social Security number

Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ other (please specify):

Street address: ☐ I do not currently have a permanent address

City/Town: **State:** **Zip Code:**

Mailing address (if different than above):

YOU FIRST
Screening and support for heart disease, breast and cervical cancer.

E-mail address:

Phone number: ☐ Home ☐ Work ☐ Cell

(_____) _____ - _____

Is it ok to leave a message? ☐ Yes ☐ No

How do you prefer to be contacted? ☐ Phone ☐ Email ☐ Mail

Are you of Latino or Hispanic origin? ☐ Yes ☐ No ☐ Prefer not to answer

What race or races do you identify with? (please check all that apply)

- ☐ White
- ☐ Black or African American
- ☐ Asian or Asian American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Indigenous, American Indian, or Alaska Native
- ☐ Don't know/Not sure
- ☐ Prefer not to answer
- ☐ Other (please specify):

What is your preferred language for written and verbal communication?

- ☐ English
- ☐ Spanish
- ☐ Arabic
- ☐ French
- ☐ Nepali
- ☐ Somali
- ☐ Kirundi
- ☐ Other (please specify):

Do you need us to call you with an interpreter? ☐ Yes ☐ No

What is the highest level of education you have completed?

- ☐ Less than 9th grade
- ☐ Some high school
- ☐ High school graduate or equivalent
- ☐ Some college
- ☐ College graduate
- ☐ Don't know/Not sure equivalent
- ☐ Prefer not to answer

Do you identify as an LGBTQ+ person (lesbian, gay, bisexual, transgender, queer)? ☐ Yes ☐ No ☐ Prefer not to answer

Do you have a physical, mental, learning, or emotional health condition or disability? ☐ Yes ☐ No ☐ Prefer not to answer

The You First program asks for personal information about race, ethnicity, education, gender identity, sexuality, disability, and language to ensure we are reaching all program-eligible Vermonters. Your answers are very helpful to our team in our work to reduce preventable differences in health outcomes, but you can choose the 'prefer not to answer' response option.

YOU FIRST
Screening and support for heart disease, breast and cervical cancer.

Section 2: Income

Total household income before taxes: $

☐ each year ☐ each month ☐ each week ☐ every other week

Total number of people who live on this income:

(Include yourself, spouse/partner, children, or others that live on this income)

Section 3: Health Insurance

Do you have health insurance?

☐ Yes, I have health insurance.
☐ No, I do NOT have health insurance right now.

If yes, please fill out below:

Name of insurance company:	Coverage start date:
Policy holder's name:	Policy or ID number:
Group or account number:	

Section 4: Health History

Do you have, or have you had, breasts or a cervix? ☐ Yes ☐ No

Do you have a doctor or health care provider? ☐ Yes ☐ No

If yes:	Office name: Office location (Town/City):

If no, do you need help finding a doctor? ☐ Yes ☐ No

YOU FIRST
Screening and support for heart disease, breast and cervical cancer.

When was your last Pap or HPV test?	☐ Never had a Pap/HPV test	☐ I've had a hysterectomy
Date: Location:		☐ Unsure of date
Do you have any cervical concerns or recent abnormal Pap or HPV tests?	☐ Yes	☐ No
When was your last mammogram?	☐ Never had a mammogram	☐ I've had a mastectomy
Date: Hospital Name:		☐ Unsure of date
Do you have any breast changes, concerns, or a recent abnormal mammogram?	☐ Yes	☐ No
Do you use any type of tobacco products (like cigarettes, cigars, or vaping products)?	☐ Yes	☐ No ☐ Prefer not to answer
If yes, could we make a referral to 802Quits for you? 802Quits will contact you by phone and leave a message if they do not reach you.	☐ Yes	☐ No

How did you find out about You First?

- ☐ I was a member before
- ☐ Friend or relative
- ☐ Online search
- ☐ Online advertising
- ☐ Pride Center of Vermont
- ☐ Doctor, nurse, clinic (specify):
- ☐ Poster or pamphlet
- ☐ Facebook or social media
- ☐ TV or radio
- ☐ Other (specify):

YOU FIRST
Screening and support for heart disease, breast and cervical cancer.

Section 5: Member Consent — Rights and Responsibilities

By signing this application, I am consenting to enroll in the You First program. I agree that I have completed the application with information that is true as far as I know. I authorize You First to access and share my health information.

I authorize my doctor, clinic, hospital, laboratory, and lifestyle programs to share my information with the You First Program, so that they can make sure I receive quality care and so You First can pay my qualifying medical bills.

I authorize You First to share personal health information about breast and cervical cancer screenings, heart disease risk factor screening, and diagnosis and treatment care with my doctor, nurse, hospital, clinics, and health care providers involved in my tests and treatment.

You First is funded by the Centers for Disease Control and Prevention (CDC) which collects information from You First about how that funding is used. I authorize You First to share my deidentified information with the CDC. "Deidentified" means we will protect your privacy by hiding or removing information that would tell people who you are.

I understand that when I enroll in the Vermont Department of Health's You First program, I am giving permission for the program to share information about my eligibility with other Agency of Human Services (AHS) programs to coordinate services.

My personal health information will be kept secure according to the Agency of Human Services (AHS) Privacy Practices and all applicable laws. I have received a copy of the AHS Notice of Privacy Practices.

I understand that I have the right to withdraw from the You First program. If I no longer want to be enrolled in the program, I will send a letter or call You First so that I can be withdrawn. Please send a letter to: Vermont Department of Health, You First, Waterbury, VT 05671-8380 or call our Member Services Coordinator at 800-508-2222.

Signature: _____ Date: _____

Please also sign and submit the attached Agency of Human Services Notice of Privacy Practices.

Digital signatures are not accepted. Please contact the You First program with any questions at 1-800-508-2222.

Acknowledgment*

*Direct Treatment Providers shall make a good faith effort to obtain the individual's written acknowledgment of receipt of this notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.

I hereby acknowledge that I received a copy of this notice.

Dated: _____ _____

(Signature of individual or personal representative)

_____

(Print Name of individual or personal representative)

Agency of Human Services
Notice of Privacy Practices

This notice takes effect as of June 1, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION, AND OTHER INDIVIDUALLY IDENTIFIABLE INFORMATION, ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

FREE INTERPRETER SERVICES ARE AVAILABLE

Please tell us if you need an interpreter or other accommodation in order to read and understand this notice.

"We" are the Agency of Human Services (AHS). AHS includes the Department for Children and Families; the Department of Disabilities, Aging and Independent Living; the Department of Health; the department of Mental Health; the Department of Corrections; and the Department of Vermont Health Access. Our contractors and grantees include service providers throughout Vermont, such as parent-child centers, adult day centers, and community mental health centers.

When we provide you with health and social services, we will obtain individually identifiable information (identifying information), and sometimes health information, about you. Federal and state laws require us to protect this information including the federal Health Insurance Portability and Accountability Act of 1996 known as HIPAA ("Privacy Rule").

This notice tells you about how we may use or share your identifying and/or health information and when we may not do so. It also tells you about your rights. The law requires that we give you this notice. The law requires us to follow the terms of the notice currently in effect.

PRIVACY PRACTICES REGARDING: HEALTH INFORMATION

1. What health information does AHS have about me?

You and others may give us information about your health and health care when you apply for or receive our services. This may include information about your diagnosis, disability or treatment. This may also include financial and billing information.

2. What health information does AHS use and share?

We use and share only the minimum necessary health information that our staff or our contractors need to do their jobs.

3. When does AHS use or share my health information?

We may use and share your health information for treatment, payment, or health care operations which includes service planning and AHS administration.

For example, we may use your information for the following reasons:

- To determine your eligibility for services or benefits
- To create and provide individualized service or treatment plans.
  For example, we may share your information to make a plan for your treatment with nurses, doctors and other health care workers who treat you.
- To remind you of appointments.
- To tell you of other service supports or treatments that may be helpful to you or your family.
- To pay for your services.
  For example, your doctor may send us your health information so that we can pay her. We may also share your health information with contractors so that they can pay your doctor for us.
- To carry out our operations and manage our programs. *For example, we may use and share your health information to make sure people who care for you give you high quality services and are paid promptly and correctly. We may use and share your information to make sure*

you get the right services and to improve the services that you get.

4. Are there other times that AHS uses and shares my health information without my authorization?

There are limited times when we use and share information without your authorization. Sometimes the law allows or requires us to do this.

We may share your information without your authorization for the following personal reasons:

- With a family member or any other person you choose, relevant to their involvement in your care or payment for your care.
- To notify your family or other person responsible for your care of your location, condition or death.
- To a, funeral director, or medical examiner who needs the information to carry out their duties when an individual dies.
- For worker's compensation or other similar programs.

We may share your information without your authorization for the following special reasons:

- For public health activities such as preventing or controlling disease, helping with product recalls, reporting adverse reactions to medications, injury or disability, and for keeping vital records of things such as births and deaths.
- For research purposes, subject to strict legal restrictions.
- With organizations that provide for organ donation and transplants.
- In response to a court or administrative order, subpoena, discovery request, or other process.
- To the police when required by law.
- To report a crime committed on our premises or against our staff.
- To report abuse, neglect, or domestic violence to the appropriate authorities.
- To a health oversight agency for activities when authorized by law such as audits and investigations.
- To the United States Department of Health and Human Services for a compliance review or complaint investigation unless you are an applicant or enrollee of the Immigrant Health Insurance Plan whose information is protected from disclosure under 33 VSA § 2092(c).
- To avoid a serious threat to the health or safety of a person or the public, or to a law enforcement officer for a law enforcement purposes.
- To carry out specialized governmental functions, such as to protect public officials, for national security, for military affairs, and to correctional institutions for certain purposes.
- With health oversight agencies for activities authorized by law.
- With another agency administering a government program providing public benefits, with respect to eligibility or enrollment information, and to better coordinate, administer and manage related government programs.

Except for the reasons stated in this notice, or otherwise permitted by law, we will not use or share your health information without your written authorization.

5. What if someone else needs my health information?

You may ask that we give your information to others, or we may ask your permission to do so. Before we share any information, you will be asked to sign an authorization form. The authorization form tells us what information to share, the purposes for sharing, and the identity of the person(s) with whom we will share. You can cancel your authorization at any time.

6. May I Choose someone to act for Me?

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

7. May I see my health information?

In most cases, you may see your health information. You should ask the Privacy Officer, in writing, to see it or to get a copy of it (see contact information on page 3). We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. You may also request electronic copies of information that we hold electronically. Safety or other legal reasons may limit the information that you see. We may charge a reasonable amount for copying.

8. May I change my health information?

If you think some of your health information in your record is incorrect, you may ask in writing that we correct it or add new information. You may ask that we send the corrected or new information to others who have received your health information from us.

We may not make the changes or additions if in our opinion the information is already accurate and complete or for other reasons. If we do not agree to change your information, we will tell you, inwriting usually within 60 days, why we do not agree. We will also note in your record that you asked us to change your information and that we did not agree to change it.

9. May I ask AHS to restrict how it uses and shares my health information?

You may ask that we restrict how we use and share your health information. Your request must be in writing and tell us what restrictions you want. We will consider your request but are not required to agree with it.

10. May I request that AHS communicate with Me in a confidential way?

You may ask that we communicate with you by reasonable alternative means or at an alternative location. Your request must be in writing and tell us where and how we should contact you. We will try to honor your request.

If you tell us that you need the alternative communication to prevent a disclosure of information that would put you in danger, we will honor your request.

11. May I get a list of when AHS has shared my health information with someone?

You may ask for an accounting of disclosures of your health information by us for six years prior to the date you ask, who we shared it with, and why. You must make your request in writing to the Privacy Officer. The law does not require us to list every situation in which we have shared your information. For example, we do not have to list those times that we shared your information for AHS treatment, payment or health care operations or when we shared your information pursuant to an authorization signed by you.

12. Will I be told if there is a breach of the privacy or security of my health information?

We will notify you in writing if there is a breach of your health information. A breach occurs when someone impermissibly sees, uses or discloses protected health information in a way that compromises the privacy or security of the health information. AHS uses the risk assessment factors set forth in the Privacy Rule to determine whether the information was compromised.

13. What laws does AHS follow that apply to the privacy of my health information?

We follow the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA. We also follow any federal or state laws that give you greater privacy protections than HIPAA, whenever they apply. For example, we follow the federal confidentiality law concerning substance abuse treatment programs, 42 CFR Part 2, state confidentiality laws concerning mental health records, 18 VSA § 7103, and 33 VSA § 2092(c).

14. May I have a copy of this notice?

Yes, you are entitled to a copy of this notice. You may ask us for a paper copy at any time. An electronic version is on our website, www.humanservices.vermont.gov
.

15. Can AHS change its privacy practices?

We reserve the right to change our privacy practices and this notice. Any changes in our practices will apply to information about you that we already have and to information that we receive in the future. We will post a copy of any new notice on our website, www.humanservices.vermont.gov, and provide it to you by mail.

16. Who do I contact if I have questions about this notice?

Please contact the **Privacy Officer** by phone at 802-241-0225, by email at: AHS.PrivacyAndSecurity@vermont.gov, or by mail at:

AHS Privacy Officer
c/o Agency of Human Services
Office of the Secretary
280 State Drive – Center Building
Waterbury VT 05671-1000

17. How do I complain if I believe that my privacy rights have been violated?

You can complain to our Privacy Officer in writing or by phone. You can also complain to the Office for Civil Rights, DHHS, JFK Federal Building Room 1875, Boston, MA 02203, by calling 1-800-537-7697, or visiting:
https://www.hhs.gov/hipaa/filing-a-complaint/index.html

PRIVACY PRACTICES REGARDING: INDIVIDUALLY IDENTIFIABLE INFORMATION

In addition to health information privacy practices, AHS has guidelines concerning the confidentiality of information that identifies the individuals to whom we provide benefits and services.

What is individually identifiable information?

This is information created or received by AHS or its contactors or grantees that identifies, or reasonably could identify, an individual who receives services or benefits from AHS. Examples of identifying information are:

- Name
- Social security number
- Date of birth
- Address
- Phone number

When does AHS share or disclose my identifying information without my permission?

We may share or disclose your identifying information for our own program administration without your permission. Program administration means activities necessary to carry out the operations of AHS and consist of the following:

- Establishing eligibility and scope of services and assistance for which you have applied, including the identification and coordination of these services within AHS and with its contractors and grantees.
- Planning, providing, arranging, funding or paying for services and assistance for individuals and families.
- Coordination of benefits.
- Detecting fraud and abuse.
- Engaging in quality control and improvement activities.
- Emergency response and disaster relief.
- Complying with federal and state legal, reporting, and funding requirements except AHS is prohibited from sharing any information regarding applicants or enrollees of the Immigrant Health Insurance Plan with the United States government.

When does AHS need to have my permission before sharing or disclosing my identifiable information?

We need your written permission to share or disclose your identifying information in order to:

- Consider your eligibility for services other than those for which you have already applied.
- Coordinate your services with your providers who do not have a contract or grant with us.
- Consult with professionals outside of AHS in order to benefit from their expertise.
- Share with the persons of your choice.

If you do not give permission in the above circumstances, we may not be able to provide the full quantity and quality of services that may be available to you.