FRESNO AMERICAN INDIAN HEALTH PROJECT
DOCUMENT CHECKLIST FOR HEALTH RECORDS

Client Name:_____

CHILD REGISTRATION
Check each item that is in the client's records.
Blank spaces indicate that the document is not present or needs to be updated.
Bold items are required in order to complete client registration.

DATE: _____

____ **Informed Consent and Disclosure: (needs to be signed)**

____ **Client Intake Registration Form: (needs to be signed)**

____ **Client's Bill of Rights: (needs to be signed)**

____ **Health History Form: (needs to be signed)**

____ **Notice of Privacy Practices Notification: (needs to be signed)**

____ **Birth Certificate (children)**

____ **Drivers' License or California Identification Card**

____ **Social Security Card**

____ **Tribal Enrollment Letter or Card**

____ **Income Verification** (Last 6 months—i.e. pay stubs, notice of action, food stamp cards)

____ **Immunization Record (children 0-17)**

____ Medi-Cal / Medi-Care Card / Private Insurance Card

____ List of Medications (if client is taking any)

____ DV/IPV Exam Code #34 (results entered into RPMS)

____ Selective Service (males 18-26)

____ **OTHER**_____

INTERNET ACCESS?_____

Registration Complete Staff Initials:_____

FRESNO AMERICAN INDIAN HEALTH PROJECT

1551 E. Shaw Ave., Suite 139 Fresno, CA 93710 • Phone (559) 320-0490 Fax (559) 320-0494

INFORMED CONSENT AND DISCLOSURE OF SERVICES

I understand that the services provided by Fresno American Indian Health Project include direct services as well as referral and linkage services.

FAIHP PROVIDES THE FOLLOWING SERVICES AS APPROPRIATE TO EACH CLIENT:

- ◊ Substance Use/Abuse Services
- ◊ Case Management Services
- ◊ Employment Services
- ◊ Social Services (Housing, Nutrition, Transportation)
- ◊ Senior Activities
- ◊ Cultural/Spiritual Activities
- ◊ Mental Health Services
- ◊ Referral to Medical Services
- ◊ Referral to Dental Services
- ◊ Referral to Residential Treatment/Detox
- ◊ Referral to Sober Living
- ◊ Referral to Traditional Practitioners

The direct services listed above are provided free of charge to all qualified FAIHP Clients. FAIHP staff will work with the clients to secure services and funding available from various resources outside of FAIHP. FAIHP does not guarantee payment for services that are referred to an appropriate health or substance abuse treatment provider.

Initials _____ I understand that this consent acknowledges my participation in the services provided by FAIHP & requires the discussion of my health conditions and health needs with a FAIHP staff member.

Initials _____ I authorize FAIHP Staff to provide the necessary or advisable health screening, assessments and evaluations for the purpose of providing direct services and linkage/referral services for:

[ ] Myself _____ (Print Name)

[ ] My Child _____ (Print Child's Name)

Initials _____ I understand that some or all of my/my child's personal health information may be shared among FAIHP Professional Staff and outside Service Providers in order to link me/my child to the appropriate services and to provide active case management services.

Initials _____ I understand that I will not be charged for Direct Services provided by the FAIHP.

Initials _____ I understand that FAIHP is not responsible for fees to outside service providers unless I obtain a written referral/authorization for payment from my Case Manager prior to service.

Patient Release of Information

I, _____ hereby authorize Fresno American Indian Health Project to request and receive copies of my medical information for any services that I receive from outside service providers. I understand that this information will be used to update my records at the FAIHP and to provide appropriate Case Management follow-up and referral services. I further understand and agree that requests for specific information regarding HIV/AIDS status and/or treatment, treatment for drug, alcohol or substance abuse and information related to the treatment of mental health, developmental or psychiatric conditions require a separate consent.

Signed: _____ Date: _____

Witness/Case Manager: _____ Date: _____

FRESNO AMERICAN INDIAN HEALTH PROJECT
FRESNO, CALIFORNIA

All information provided is Confidential

Client Registration Form **Chart ID#**

_____ Initial _____ Update Today's Date _____

Client Name _____ Other Name(s) used _____

Date of Birth _____ Age _____ Soc Sec # _____

Sex Male___ Female___ T/G___ Place of Birth (City and State) _____

Present Address _____
Street City State Zip Code How long at this address?

Home Phone # _____ Office / Mobile Phone # _____

Tribal Affiliation _____ _____
(Reservation, Rancheria, Native Corp., Public Law Land)

Blood Quantum _____ American Indian Verification
(i.e.. Full, 3/4 1/2 1/4 1/8 etc)

- ☐ CDIB Obtained
- ☐ CDIB Pending
- ☐ No CDIB Available
- ☐ Letter of Descendent

Race/Ethnicity (if other than Am. Indian) _____

Emergency Contact _____ Relationship to Client _____

Address _____ Phone # _____

_____ Phone # _____

	Name	Relationship to Client	Sex	AI/AN	DOB	Occupation / Source of Income	Monthly Income
1	Client	Self					
2							
3							
4							
5							
6							
Continue on back if additional space is needed							
Total # in Household _____						**Total Monthly Income**	

Health Care Information (UAll Staff will need to get a copy or your health care card)

___ Medicare ___ Medi-Cal ___ CMS ___ CHAM ___ Veteran ___ Railroad Retirement ____ Private

Is the client claimed as a dependant or married, or do parents of spouse have health care coverage? ___ Yes ___ No

If yes, please specify: _____

My signature is a statement that the information provided is truthful and accurate

_____ _____

Client Signature (or Parent/Legal Guardian if applicable) **Date** **Reviewed by: FAIHP Staff**

For Official Use Only: Initial Registration conducted through which department of FAIHP

___ FAIHP ____ OTHER (Please specify):_____

Revised 08/13/2007 11:12AM

Fresno American Indian Health Project

Client's Bill of Rights

The client has the right to receive services and to exercise the following rights without regard to gender, culture, ethnic group identification, economic status, education level, disability, age, creed, religion or sexual orientation. This statement shall not preclude FAIHP from emphasizing services for the American Indian/Alaska Native community:

- The client has the right to receive considerate and respectful care and to be accorded dignity in contact with staff, volunteers, board members, and other persons.
- The client has the right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- The client has the right to expect that all communications and records pertaining to his/her care be treated as **confidential** except in cases of threat to self or others, child abuse, elder or dependent adult abuse or court order. The client's written permission shall be obtained before their records can be made available to anyone not directly concerned with their care. FAIHP shall assure confidentiality in accordance with Title 42, Code of Federal Regulation, Part 2.
- The client has the right to know the name of the provider who has primary responsibility for coordinating their care and the names and professional relationships of other providers who will see them.
- The client has the right to obtain complete and current information concerning their diagnosis, treatment, and prognosis in terms that the client can be reasonably expected to understand.
- The client has the right to participate in decisions regarding their care unless the health or safety of self or others is being compromised or the client is in an altered state.
- The client has the right to refuse treatment to the extent permitted by law, and to be informed of the health care consequences of the action.
- The client has the right to be accorded access to his or her file.
- The client has the right to leave the premises even against the advice of their providers.
- The client has the right to expect that Fresno American Indian Health Project will make reasonable response to all requests for services and provide clear explanations for any services that cannot be provided.
- The client has the right to expect reasonable continuity of care and to know in advance the time and location of appointments.
- The client has the right to know what the program rules and regulations are that apply to his/her participation in the program.
- The client has the right to be advised if the provider proposes to engage in research or perform experimentation that in any way affects their care. The Client has the Right to Refuse participation in Experimental Research.

Revised July, 2007

CLIENT COPY

Fresno American Indian Health Project

- The client has the right to be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- The client's rights will be extended to and apply to any person who is identified to have legal responsibility to make decisions regarding the care of the client.
- The client has the right to appeal a discharge or file a complaint with the Program Director according to the grievance procedure. This information is available at the front desk.

CLIENTS HAVE THE RESPONSIBILTY TO:

- Provide accurate and complete information concerning your health history, financial status and/or any other information that is required by FAIHP in order to provide services.
- Inform Fresno American Indian Health Project and/or referring facilities if you are not able to keep any appointments 24 hours prior to the scheduled appointment.
- Request further information concerning anything you do not understand.
- Speak with the Program Director if you are having difficulty with any staff member.
- Treat the staff and other clients in a respectful and courteous manner.
- Follow all rules and guidelines for program participation and use of the FAIHP facilities.

FAIHP HAS THE RIGHT TO:

- Refuse service to any client who is verbally or physically abusive or threatening to any staff member or other client (on the phone or in person).
- Refuse service to any client who is under the influence of alcohol, drugs or other substance.
- Suspend or terminate services of any client who does not comply with the guidelines or rules that are outlined for use of FAIHP programs or facilities.

I have reviewed the Client's Bill of Rights and understand what my rights and responsibilities are as described above. Furthermore, I understand that I may file a grievance using FAIHP procedures* if I feel these rights have been violated.

Signature of Client _____ **Date** _____

Signature of FAIHP Staff _____ **Date** _____

*The Grievance Policy and Comment Forms are available at the front desk upon request.

Revised July, 2007

MAKE A COPY FOR CLIENT

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When	_____
Frequent ear infections	☐ Yes	☐ No	Explain	_____
Problems with ears or hearing	☐ Yes	☐ No	Explain	_____
Nasal allergies	☐ Yes	☐ No	Explain	_____
Problems with eyes or vision	☐ Yes	☐ No	Explain	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain	_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain	_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain	_____
Blood transfusion	☐ Yes	☐ No	Explain	_____
Frequent abdominal pain	☐ Yes	☐ No	Explain	_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain	_____
Bladder or kidney infection	☐ Yes	☐ No	Explain	_____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain	_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When	_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain	_____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain	_____
Frequent headaches	☐ Yes	☐ No	Explain	_____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain	_____
Diabetes	☐ Yes	☐ No	Explain	_____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain	_____
Any other significant problem	☐ Yes	☐ No	Explain	_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain	_____

FRESNO AMERICAN INDIAN HEALTH PROJECT.
Notice of Privacy Practices

This notice summarizes how medical information about you may be used and disclosed and how you can get access to this information.

Your provider will discuss this information with you and you will be given a copy of the complete Privacy Notice. Please ask your provider any questions you have or if you do not understand your privacy rights.

PLEASE REVIEW IT CAREFULLY.

Fresno American Indian Health Project
1551 E. Shaw Ave., Suite 139
Fresno, CA 93710

SUMMARY OF YOUR PRIVACY RIGHTS

I. Understanding Your Health Record Information

Each time you visit a Fresno American Indian Health Project facility for services, a record of your visit is made. If you are referred by FAIHP through the Contract Health Service (CHS) program, FAIHP also keeps a record of your CHS visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health record, serves as a:

- Plan for your care and treatment
- Communication source between health care professionals
- Tool with which we can check results and continually work to improve the care we provide
- Means used by Medicare, Medicaid, private insurance or FAIHP can verify the services billed.
- Tool for education of health care professionals
- Source of data for medical research, facility and program planning
- Legal document that describes the care you receive

Understanding your health record and how the information is used helps you to:

- Ensure its accuracy
- Better understand why others may review your health information
- Make an informed decision when authorizing disclosures

II. Your Health Information Rights

Although your health record is the physical property of the Fresno American Indian Health Project the information belongs to you.

You have the right to:

- **Inspect and receive a copy of your health record**
- **Request a restriction** on certain uses and disclosures of your health information. If FAIHP is agrees to your request, we will comply with your request unless the information is needed to provide you with emergency services.
- **Request a correction/amendment to your health record**
- **Request confidential communications about your health information.** You may ask that we communicate with you at a location other than your home.
- **Receive a listing of certain disclosures FAIHP has made** of your health information upon request.
- **Revoke your written authorization to use or disclose health information**. This does not apply to health information already disclosed or used or in circumstances where we have taken action on your prior authorization.

III. FAIHP Responsibilities

Fresno American Indian Health Project is required by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices regarding health information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Honor the terms of this notice or any subsequent revisions of this notice.

FAIHP reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. If FAIHP makes any significant changes to this Notice, we will make the notice of change public. FAIHP also will post any revised Notice of Privacy Practices at public places in its health care facilities and on its web site at www.uaii.org or you may also request a copy of the notice be sent to you. FAIHP understands that health information about you is personal and is committed to protecting your health information. **FAIHP will not use or disclose your health information without your permission, except as described in this notice and as permitted by the Privacy Act.**

IV. How FAIHP may use and disclose health information about you.

The following categories describe how we may use and disclose health information about you.

- **In order to provide your treatment.**
- **For the payment of services you receive.**
- **For normal health care operations and conducting routine business**
- **To Business Associates /MOU Providers so they my provide you services**
- **Notification/Communication with Family** if they are responsible for your treatment
- **Research** that has been approved and there are established protocols to ensure the privacy of your health information.
- **Uses and Disclosures about the Deceased**
- **To notify you of Treatment Alternatives and Other Health Benefits and Services**
- **To contact you for Appointment Reminders**
- **Food and Drug Administration (FDA)** in connection with an FDA-regulated product.
- **Workers Compensation** if required by law
- **Public Health:** FAIHP may use or disclose your health information to public health or other appropriate government authorities as follows:
  (1) FAIHP may use or disclose your health information to government authorities that are authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations, and interventions;
  (2) FAIHP may disclose your health information to government authorities that are authorized by law to receive reports of child abuse or neglect, and
  (3) FAIHP may disclose your health information to government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic violence as required by law, or as authorized by law if FAIHP believes it is necessary to prevent serious harm. Where authorized by law, FAIHP may disclose your health information if you who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- **Correctional Institution** health information necessary for your health
- **Law Enforcement** as authorized by law or in response to a court order
- **Health Oversight Authorities:** These oversight activities include: investigations, audits, inspections and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance.
- **Compelling Circumstances** affecting the health or safety of an individual.

- where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness or missing person;

Non-Violation of this Notice: **FAIHP is not in violation of this Notice** or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) discloses protected health information under the following circumstances:

- **Disclosures by Whistleblowers:** If a FAIHP employee or contractor (business associate) in good faith believes that FAIHP has engaged in conduct that is unlawful or otherwise violates clinical and professional standards or that the care or services provided by FAIHP has the potential of endangering one or more patients or members of the workplace or the public and discloses such information.
- **Disclosures by Workforce Member Crime Victims:** Under certain circumstances, a FAIHP workforce member (either an employee or contractor) who is a victim of a crime on or off the facility premises may disclose information about the suspect to law enforcement official provided that:
  a. The information disclosed is about the suspect who committed the criminal act.
  b. The information disclosed is limited to identifying and locating the suspect.

Any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing at any time.

To Exercise Your Rights
To exercise your rights under this Notice, to ask for more information, or to report a problem regarding your Privacy Rights, contact the Services Program Director or Executive Director at Fresno American Indian Health Project.

You may request copies of the full Privacy Notice and the procedures and forms to exercise your rights under the HIPAA Privacy Act at the front desk of any FAIHP Department.

If you believe your privacy rights have been violated,
You may file a written complaint with:

The California Area Office of Indian Health Service
650 Capitol Mall
Sacramento, CA 95814

or

The Secretary of Health and Human Services
U.S. Department of Health and Human Services
Washington, D.C. 20201.

There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of FAIHP Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Fresno American Indian Health Project. (FAIHP) Notice of Privacy Practices at the following department:

- ❑ The Fresno American Indian Health Project.

_____	_____	_____
Print Name of Client	Client Signature	Date

Or

_____	_____	_____
Print Name of Client Representative	Representative's Signature	Date

_____	_____	_____
Print Name of FAIHP Staff	Staff Signature	Date

_____

Staff Member's Position/Title

If Client is Unable to Acknowledge Receipt of Privacy Notice

I hereby certify that the client was unable to acknowledge receipt of the FAIHP Notice of Privacy Practices because:

_____

_____

_____	_____	_____
Print Name of FAIHP Staff	Staff Signature	Date

FAIHP

Fresno American Indian Health Project

Office Location:
1551 E. Shaw Ave. Ste. 139
Fresno, CA 93710

Office Hours:
Monday - Friday
8:00am - 5:00pm

Phone:
(559) 320-0490
Fax: (559)320-0494

Should you need medical attention during the hours that we are closed please go to your nearest emergency room.