Pinellas County
HUMAN SERVICES

Dear Applicant:

The Department of Human Services looks forward to providing you professional, quality services, delivered in a timely and accurate manner. To process your application we will need the following items:

☐ Complete Pinellas County Human Services Application Packet

☐ Proof of Pinellas County Residency such as :
- copy of your drivers license
- car registration
- utility bill

☐ Current proof of income for the past month and/or Support Statement from anyone helping you

☐ If you are self-employed:
- proof of income and business expenses for the past three months

☐ Proof of any assets such as:
- bank statements
- trust fund
- stocks
- IRA's
- Non-Homestead properties
- Automobiles

☐ Proof of identity such as:
- Social Security Card
- Birth Certificate
- U. S. Passport

☐ If not a US Citizenship born in the United States:
- Proof of U.S Citizenship/resident/asylee status

Sincerely,

Human Services Staff
(727)582-7709

Official Use Only: Time In:_____ Time Back: _____

Pinellas County Human Services Application

I. Applicant Information

First Name: _____ Middle Name: _____ Last Name:_____

Social Security Number:_____ Date of Birth:_____

Home Phone Number:_____ Cell Phone:_____ Work Phone:_____Ext:___

Your email address: _____

Physical Address:_____ Apt/Lot Number:_____

City:_____State:_____ Zip Code:_____ County:_____

Mailing Address:_____ Apt /Lot Number:_____

City:_____ State:_____ Zip Code:_____ County:_____

Emergency Contact Name: _____ Relationship to you:_____ _____

Physical Address:_____ Apt/Lot Number:_____

City:_____State:_____ Zip Code:_____ County:_____

Phone Number_____ Cell Phone:_____ Work Phone:_____ Ext:_____

Emergency Contact email address: _____

II. Reason for Visit

What brought you in today? ☐ Health Care ☐ Veterans Services ☐ Disability Services ☐ Housing
☐ Other/ Notes: _____

III. Demographic Information

(1) Gender: ☐Male ☐Female

(2) Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

(3) Race (check all that apply):☐White/Caucasian ☐Black/African American ☐ American Indian/Alaska Native ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐ More than one Race

(4) Are you Hispanic/Latino/ Latina: ☐ Yes ☐No

(5) Citizenship Status: ☐ Born in the U.S. or U.S. territory ☐Naturalized Citizen ☐Born outside U.S. to U.S. Citizen ☐Non-sponsored Legal Permanent Resident ☐ Sponsored Legal Permanent Resident ☐Refugee/Asylee ☐ Undocumented ☐Other _____

(6) Is English Your Primary Language? ☐Yes ☐No **If no, preferred language**:_____

(7) Veteran: ☐Yes ☐No **Spouse of a Veteran**: ☐Yes ☐No **Child of a Veteran**: ☐Yes ☐No

(8) Disabled: ☐Yes ☐No

(9) Housing: ☐ Couch Homeless ☐ Emergency Shelter/Safe House ☐ Group Home ☐ Homeless ☐ Institution ☐Living with family/ friends ☐Motel ☐ Shelter ☐Owned by Client ☐ Public Housing ☐Rental by Client ☐Transitional ☐Other_____

(**10) Highest Level of Education:** ☐ Less than High School ☐ GED ☐ H.S. Diploma ☐Technical School ☐ Some college ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate ☐Other_____

IV. Family / Household Information

Family / Household Members' Names	Relationship to You	DOB	Do they live with you?

V. Assistance **Do you currently receive any type of assistance?** ☐Yes ☐No

If so, please identify the type of assistance you receive:

☐Food Assistance (SNAP) $ _____ ☐Medicare ☐Women, Infants, and Children (WIC)
☐Medicaid ☐Medically Needy Share of Cost (MNSOC) $ _____ ☐Section 8 Housing $ _____
☐Temporary Cash Assistance (TCA/ TANF) $ _____ ☐Other:_____

Continued ➡

Applicant Name: _____ DOB: _____ Date: _____

VI. Household Income (Including Spouse)

Are you currently employed? ☐ Yes ☐ No
If Yes: Name of Employer:_____
If Yes: ☐ Full Time ☐ Part Time
Are you self-employed ☐ Yes ☐ No
If yes to either, how much do you make:$ _____
Paid: ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly

Do you have more than one job? ☐ Yes ☐ No
If Yes: Name of Other Employer:_____
If Yes: ☐ Full Time ☐ Part Time
If yes to either, how much do you make:$ _____
Paid: ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly

Is anyone else in your household employed?
☐ Yes ☐ No
If yes, who: _____
If Yes: Name of Employer:_____
If Yes: ☐ Full Time ☐ Part Time
Are they self-employed? ☐ Yes ☐ No
If yes to either, how much do they make:$ _____
Paid: ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly

Does anyone else in your household have more than one job? ☐ Yes ☐ No
If yes, who:_____
If Yes: Name of Employer:_____
If Yes: ☐ Full Time ☐ Part Time
Are they self-employed? ☐ Yes ☐ No
If yes to either, how much do they make:$ _____
Paid: ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly

☐ Unemployment Compensation
Bi-weekly Amount: ☐
Start Date: _____ Projected End Date: _____

☐ Do you have an **active** application for Social Security benefits? ☐Yes ☐ No
If **no**, have you **applied** for any Social Security Benefits ☐Yes ☐ No
☐ Social Security Retirement
☐ Social Security Disability
☐ Supplemental Social Security Income
☐ Social Security Survivors (Widow) Benefits
Monthly Amount: ☐
Start Date:_____ Projected End Date: _____

☐ Child Support/Alimony
Monthly Amount: ☐
Start Date: _____ Projected End Date: _____

☐ Pension or Retirement Income
Monthly Amount: ☐
Start Date: _____ Projected End Date:_____

☐ Are you a student? ☐Yes ☐ No
☐ Do you receive financial aid or assistance? ☐Yes ☐ No
Monthly Amount: ☐
Start Date: _____ Projected End Date: _____

☐Workers' Compensation
Monthly Amount: ☐
Start Date: _____ Projected End Date:_____

☐ Veteran Disability Benefits
Monthly Amount: ☐
Start Date: _____ Projected End Date: _____

Other sources of income such as:
☐ Contributions/Gifts/Credit Card Advances
☐ Estate & Trust Income
☐ Home Equity Line
☐ Interest
☐ Rental Income
☐ Other Income, type:_____
Monthly Amount: ☐
Start Date: _____ Projected End Date:_____

Applicant Name: _____ DOB: _____ Date: _____

VII. Lawsuit Information

☐ Do you have a pending lawsuit? ☐ Yes ☐ No

☐ Have you received a lawsuit settlement within the past year? ☐ Yes ☐ No

If yes, how much did you receive? $_____ Date Received: _____

VIII. Assets

1. Do you own a home? ☐ Yes ☐ No Monthly mortgage payment:$ _____

Are you behind on your mortgage? ☐ Yes ☐ No If yes, how many months are you behind? _____

2. Do you have any other properties? ☐ Yes ☐ No If yes, where is it located? _____

3. Do you own a car(s)? ☐ Yes ☐ No If yes, how many _____ Current Market Value $_____

4. Do you have life insurance with cash value? ☐ Yes ☐ No If yes, current value:_____

5. Do you have an account? ☐ Checking ☐ Savings ☐ Money Market Acct ☐ CD ☐ None ☐ IRA/401K

If you have an account, please provide the following information

Type of Account	Current Balance/Estimated Value	Bank Name

IX. Monthly Expenses (Please fill out your monthly expenses for each of the following categories):

Category	Monthly Cost	Are you behind?
Housing		☐ Yes ☐ No
Phone		☐ Yes ☐ No
Cable/Internet		☐ Yes ☐ No
Electric		☐ Yes ☐ No
Water		☐ Yes ☐ No
Natural Gas		☐ Yes ☐ No
Garbage/Sewer		☐ Yes ☐ No
Food		☐ Yes ☐ No
Gasoline		☐ Yes ☐ No
Car Payment		☐ Yes ☐ No
Insurance		☐ Yes ☐ No
Prescriptions		☐ Yes ☐ No
Child Care		☐ Yes ☐ No
Other, Specify:_____		☐ Yes ☐ No

X. Applicant Declaration

By my signature, I certify that the information I have provided on this application is true and correct. I understand that there is a presumption that any false information provided in this application was done so knowingly and with the intent to improperly obtain benefits from Pinellas County. I understand that failure to provide accurate information on this application will constitute an act of fraud which may result in my eligibility for services being rescinded immediately and disqualify me for future services for a period of three years. I will also be subject to appropriate civil penalties and can be referred to the appropriate law enforcement agency for possible criminal investigation and prosecution. The Pinellas County Department of Human Services collects my social security number in order to process billing and payments on my behalf as a client of the Department. My social security number is also used as a unique numeric identifier and may be used for search purposes. This notice is provided pursuant to Section 119.071(5) Florida Statutes (2007).

Applicant Name (Print)_____Signature_____ Date___/___/_____

NOTICE OF PRIVACY PRACTICES
OF PINELLAS COUNTY DEPARTMENT OF HUMAN SERVICES

Pinellas County Health Services ___ Mobile Medical Unit ___

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

Your health information is personal, and we are committed to protecting it. Your health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice applies to all records about your care that occurs at our facility. (Your physician may have different policies and a different notice regarding your health information).

I. We Are Legally Required to Safeguard Your Protected Health Information.

We are required by law to:

A. maintain the privacy of your health information, also known as "protected health information" or "PHI;"
B. provide you with this Notice, and
C. comply with this Notice.

II. Future Changes to Our Practices and This Notice.

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting the HIPAA Privacy Officer at 647 1st Ave. N., St. Petersburg, FL 33701. We will also make any revised Notice available in our reception area and on our website at **http://www.pinellascounty.org/HumanServices/**

III. How We May Use and Disclose Your Protected Health Information.

The law requires us to have your consent to some uses and disclosures. In other circumstances, the law allows us to use or disclose PHI without your authorization. This Section (III) gives examples of each of these circumstances.

A. Uses and Disclosures that do not Require Your Authorization. We may use or disclose your PHI **to provide treatment** to you or in order for **others to provide treatment** to you. For example, we may disclose your PHI to physicians, nurses, and other health care personnel who are involved in your care.

We may also use and disclose your PHI to contact you to remind you about appointments for treatment at our facility, to tell you about or recommend possible treatment options or alternatives, or about health-related benefits or services that may interest you. With your consent, we may also use or disclose your PHI to your insurance carrier in order **to get paid for treatment** provided to you. For example, we may use your PHI to create the bills that we submit to the insurance company, or we may disclose certain portions of your PHI to our business associates who perform billing and claims processing or other services for us.

With our consent, we may also use or disclose your PHI **for our operations related to health care.** For example, we may use your PHI to evaluate the quality of care you received from us, or to evaluate the performance of those involved with your care. We may also provide your PHI to our attorneys, accountants and other consultants to make sure we are complying with the laws that affect us.

The law makes some exceptions to the consent requirement for treatment, payment and health care operations, uses, and disclosures. For example, your consent is not required if you need emergency treatment, as long as we try to get your consent later. We may also use your PHI to treat you if we try to get consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) and we think you would consent if you were able to do so.

B. Uses and Disclosures That Require Us to Give You the Opportunity to Object If you do not object, we may provide relevant portions of your PHI **to a family member, friend or other person you indicate** is involved in your health care or in helping you get insurance coverage or otherwise provide for payment for your health care. We may use or disclose your PHI to notify your family or personal representative of your location or condition. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends if possible. Unless you object, we may also disclose your PHI to persons performing disaster relief activities.

C. Certain Uses and Disclosures Do Not Require Your Authorization. The law allows us to disclose PHI without your authorization in the following circumstances:

(1) When Required by Law. We disclose PHI when we are required to do so by federal, state or local law.

(2) For Public Health Activities. For example, we disclose PHI when we report adverse reactions to a drug or medical device, or to notify a person who may have been exposed to a disease in compliance with applicable law. We may also use and disclose your PHI as necessary to comply with federal and state laws that govern workplace safety.

(3) For Reports about Victims of Abuse, Neglect or Domestic Violence. We will disclose your PHI in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

(4) To Health Oversight Agencies. We will provide PHI as requested to government agencies who have authority to audit or investigate our operations.

(5) For Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a subpoena or other lawful request, or upon court or administrative order.

(6) To Law Enforcement. We may release PHI as permitted by law if asked to do so by a law enforcement official, in the following circumstances: (a) in response to a court order issued by a court in the county where the records are located, grand-jury subpoena, court-ordered warrant, administrative request or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be due to criminal conduct; (e) about criminal conduct at our facility; and (f) in emergency circumstances, to report a crime, its location or victims, or the identity, description or location of the person who committed the crime.

(7) To Coroners, Medical Examiners and Funeral Directors. We may disclose PHI to facilitate the duties of these individuals.

(8) To Organ Procurement Organizations. We may disclose PHI to facilitate organ donation and transplantation.

(9) For Medical Research. We may disclose your PHI without your consent to medical researchers who request it for approved medical research projects: however, with very limited exceptions such disclosures must be cleared through a special approval process before any PHI is disclosed to the researchers, who will be required to safeguard the PHI they receive.

(10) To Avert a Serious Threat to Health or Safety. We may disclose your PHI to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the public.

(11) For Specialized Government Functions. For example, we may disclose your PHI to authorized federal officials for intelligence and national security activities that are authorized by law, or so that they may provide protective services to the President or foreign heads of state or conduct special investigations authorized by law.

(12) To Workers' Compensation or Similar Programs. We may provide your PHI to these programs in order for you to obtain benefits for work-related injuries or illness.

IV. Other Uses and Disclosures of Your Protected Health Information.

Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclosure your PHI for the purposes specified in the written authorization, except that we are unable to take back any disclosures we have already made with your permission. In addition, we can use or disclose your PHI after you have revoked your authorization for actions we have already taken in reliance on your authorization. We are also required to retain certain records of the uses and disclosures made when the authorization was in effect.

V. Your Rights Related to Your Protected Health Information.

You have the following rights:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI, as long as you are not asking us to limit uses and disclosures that we are required or authorized to make to the Secretary of the Department of Health and Community Services, related to our facility's patient directory, or the disclosures described in Section III, above. Any such request must be submitted in writing to our Privacy Officer. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment.

B. The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to our Privacy Officer.

C. The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI that may be used to make decisions about your care if you ask in writing to do so. Any such request must be addressed to our Privacy Officer who will respond to your request within 30 days (or 60 days if the extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If you ask us to copy your PHI, we will charge you $.25 for each page. Alternatively, we may provide you with a summary or explanation of your PHI, as long as you agree to that and to the cost, in advance.

D. The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to our Privacy Officer and must tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask you whom else you would like us to notify of the amendment.

We may deny your request if you ask us to amend information that:
(1) was not created by us, unless the person who created the information is no longer available to make the amendment;
(2) is not part of the PHI we keep about you;
(3) is not part of the PHI that you would be allowed to see or copy; or
(4) is determined by us to be accurate and complete.
If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

E. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include disclosures we have made for treatment, payment and health care operations purposes, those made directly to you or your family or friends or through our facility directory, or for disaster relief purposes. Neither will the list include disclosures we have made for national security purposes or to law enforcement personnel, or disclosures made before April 14, 2003.

Your request for a list of disclosures must be made in writing and be addressed to our Privacy Officer. The list we provide will include disclosures made within the last six years (except not for those made prior to April 14, 2003) unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

F. The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive the Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy of this Notice by contacting The HIPAA Privacy Officer at 647 1st Ave. N., St. Petersburg, FL 33701. The Notice is also available in our reception area and on our website **http://www.pinellascounty.org/HumanServices/**

VI. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Community Services. To file a complaint with us, put your complaint in writing and address it to our Privacy Officer AT 647 1ST Ave. N., St. Petersburg, FL 33701. **We will not retaliate against you for filing a complaint.**
You may also contact our Privacy Officer if you have questions or comments about our privacy practices.
I hereby acknowledge that I received from Pinellas County Department of Human Services a copy of its Notice of Privacy Practices.

Signature: _____ Print Name: _____ Date: _____

RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS:

1 -- To request assistance promptly and have a determination of eligibility made without discrimination because of race, color, age, gender, handicap, religion, national origin or political belief.

2 -- To be referred to other agencies that may be able to provide additional assistance as needed.

3 -- To obtain complete information concerning eligibility requirements for Department programs.

4 -- To request a reconsideration for a denial, suspension or termination of services within 30 days from the date of denial if you think that the determination was not correct and you have documentation to substantiate your claim.

CLIENT RESPONSIBILITIES:

1 -- To provide the Department with complete and accurate information necessary to determine initial and ongoing eligibility. This includes not altering information, having others give false information for my benefit, or altering agreements or referral forms once assistance is granted.

2 -- To provide verification as requested and sign a release of information authorizing the Department to obtain information needed to determine eligibility.

3 -- To promptly notify the Department of any changes in my income, assets, lawsuits, living arrangement, marital status, child custody, medical condition or any other circumstances that may affect eligibility.

4 -- To comply with all recommendations and referrals for services that will help me achieve self-sufficiency.

5 -- To repay the Department for any benefits received for which I am not eligible.

6 --To repay the Department after a favorable lawsuit, settlement or disability outcome for any assistance received from the Department while pending a lawsuit or disability claim from Social Security Administration.

7 -- To schedule appointments for further services and reschedule my appointment if I arrive more than ten (10) minutes late.

8 -- To voluntarily disclose my Social Security Number to Pinellas County and authorize the use of that number as data to be programmed into the County computer system for purposes of identification, pursuant to Section 102-26, Pinellas County Code.

9 -- To not engage in disruptive/abusive behavior toward staff or any behavior that generates risk to others or constitutes illegal activity.

INFORMED CONSENT AND WAIVER:

If approved for services, I agree to be bound by the following conditions:

1 -- I understand that failure to comply with the client responsibilities outlined in this agreement may result in the suspension or termination of my benefits and subject me to a criminal investigation and possible prosecution. If my program benefits are suspended or terminated, reenrollment is not guaranteed and is subject to any limitations that may be in place when reinstated.

2 -- If I am found potentially eligible for a housing program or disability advocacy assistance, I will be sent for a consultative exam (CE) by an independent physician as well as a drug/alcohol screening test. I understand that my request for assistance will be terminated if I fail to keep my appointment for a consultative exam, if tested positive for drug/alcohol abuse or if the independent physician determines that I am not totally disabled per Social Security Administration criteria.

I understand that if I drop my SSI claim and continue my SSDI claim and am approved for benefits, I will be responsible for repaying the amount of financial assistance provided to me.

This document remains in effect for the duration of my assistance from Pinellas County Human Services.

By signing below, I hereby certify that I have had the information in this document explained to me and that I understand and will fulfill my obligation in this regard.

(Client Signature) (Social Security Number)

(Staff Signature) (Date)

Revised 01-06-2015

Pinellas County
HUMAN SERVICES

Settlement Withholding Form

- 2189 Cleveland St, Ste 230, Clearwater, FL 33765 Phone: (727) 464-8400
- 647 First Ave N, St. Petersburg, FL 33701 Phone: (727) 582-7781

_____
Date

_____

_____

_____

_____

Gentlemen/Ladies:

I, _____, sign and execute this Settlement Withholding Form in order to authorize Pinellas County Human Services to withhold or receive reimbursement from any settlement or award I may obtain for damages resulting from any currently pending or future civil legal action undertaken on my behalf. The amount withheld or reimbursed shall be a sum sufficient to repay all costs incurred by Pinellas County Human Services for any assistance advanced on my behalf unless a lesser amount is agreed to between the Parties.

** I understand that this repayment agreement remains in effect even if I change attorneys.

Attorney/Insurance Company: Please advise agency if you cease to represent this person.

For pay-off information, contact Accounts Receivable Accounting Clerk at 464-8400.

Your signature is required prior to receiving benefits.

_____
Client Signature

Witness:

_____ _____
Signature Print Client Name

_____ _____
Print Name & Title Social Security Number

ES9- Settlement Withholding Form

Serves to advise that a client has entered into a subrogation agreement with the department by which the client agrees to repay the department for the cost of services provided pending settlement or award of claims for damages. This notice is routed to the attorney who represents the client in his civil suit or the insurer who may be responsible for paying third party benefits.

Pinellas County Health Program (PCHP)

BEHAVIOR CONTRACT

Primary care will be provided exclusively in your selected medical home. The providers in your medical home will help you with your basic health care needs. Some screenings, lab work, and prescriptions are part of this basic care. When covered, these services are free. Specialty services are more advanced treatments that can not be done by your provider in your medical home. Some limited specialty services may be provided as part of this program. However, there are many services the program does not cover.

Emergency room services and transportation to the emergency room are <u>not</u> part of this program. If you go to the emergency room, this program will not pay for your visit. Therefore you may receive a bill for emergency room services. Additionally, if you do not use the laboratory providers specified in the Pinellas County Health Program Handbook, you may receive a bill for these services.

Health care is an agreement between you and your provider. This means:

- You will keep your appointment(s), or call 24 hours in advance to reschedule.
- You will respect medical home, specialist, and Pinellas County staff, treating them politely and courteously at all times.

Clients enrolled in PCHP/MMU are expected to behave in a responsible and mature manner in all facilities, offices, pharmacies, and other locations associated with the health program.

Examples of behaviors which may result in immediate termination from PCHP/MMU include (but are not limited to):

- Rude, disruptive or abusive behavior in any health care related or County facility, including but not limited to medical, dental, laboratory and pharmaceutical settings.
- Appearing to be under the influence of alcohol or drugs when receiving any service.
- Failure to follow your provider's recommended plan of care.
- Failure to inform your provider of any treatment or medications prescribed.
- Repeated failure to keep scheduled appointments.
- Abuse of medical identification card, including misrepresentation to secure pharmaceutical drugs. This includes attempts to secure excessive or inappropriate amounts of controlled substances or other medications.
- Any activity that physically harms or poses potential harm to self or others.
- Any activity that indicates fraud, forgery, or theft.

You must comply with the patient rights and responsibilities of your medical home. **You can only change medical homes once within an enrollment period. Your program enrollment ceases once you turn 65.**

I acknowledge that I am voluntarily disclosing my social security number to Pinellas County and authorize use of that number as data to be entered into the County's electronic systems for identification, according to Section 102-26, Pinellas County Code. I also acknowledge my photograph will be saved into the County's electronic system strictly for identification purposes; this image may also be used on my health program participant identification card. I also acknowledge that the Pinellas County Health Program uses a secure community portal for health services outside of the medical home. Only those in our network of doctors, facilities and hospitals may access my health information**.** The Pinellas County Department of Human Services collects my social security number in order to process billing and payments on my behalf as a client of the Department, and to periodically verify my continued eligibility for services. My social security number is also used as a unique numeric identifier and may be used for search purposes. This notice is provided pursuant to Section 119.071(50 Florida Statutes (2007).

Printed Name | Social Security Number | Date

Client Signature

Pinellas County
HUMAN SERVICES

SUPPORT STATEMENT

To be completed by the individual providing support to the applicant.

Applicant's Name: _____

Applicant's Social Security Number: _____

Applicant's Address: _____

I, _____, hereby certify that I provide the following support to the above named applicant:

❑ Place to stay	❑ Utilities	❑ Rental assistance	❑ Transportation	❑ Car insurance
❑ Car payment	❑ Gas	❑ Cigarettes	❑ Toiletries	❑ Laundry
❑ Household items	❑ Food	❑ Place to shower	❑ Cell phone	❑ Storage unit

❑ Other (please explain) _____

I assist by:
- ❑ Giving cash to the client, approximately $_____/month
- ❑ Paying bills directly
- ❑ Taking client shopping and/or purchasing needed items

I estimate the total cost of the monthly assistance I provided at $_____/month.

This assistance is:
- ❑ Ongoing from _____ to _____
- ❑ One time only
- ❑ Occurred in the past from _____ to _____

I am _____ (indicate relationship to client)

I understand that I will be asked to verify this information regularly while the client receives services from Pinellas County Department of Human Services and that I may be asked to provide proof of payments/assistance listed above. By signing below, I certify that this information is truthful.

Signature _____ Date _____

Address _____ Phone _____

_____

Release of Social & Financial Information

Attention: _____ Date: _____

_____

_____

_____

We are requesting financial information concerning the applicant (named below) who is requesting assistance from the Department.

Name: _____ Social Security #: _____

Street Address: _____ Date of Birth: _____

City, State & Zip Code: _____

Below is a release for social and financial information signed by the client.

AUTHORIZATION TO RELEASE SOCIAL & FINANCIAL INFORMATION:

I hereby grant permission and authorize any bank, building association, insurance company, real estate company, employer, United States Postal Service, Social Security Administration, Veteran's Administration, Internal Revenue Service, or any financial or social institution of any kind or character to disclose to any accredited agent of the Pinellas County Department of Human Services or partners full information as to my past, present, or future records; insurance policies; property; and financial accounts.

_____ _____ _____

Print Name Signature Date

Information Requested:

☐ Checking balance as of _____ $_____ ☐ Other: _____

☐ Savings balance as of _____ $_____ _____

☐ Gross monthly earnings $_____

☐ IRS Information from Internal Revenue Service: Literal transcript for the year(s) _____

☐ Current credit report _____

We will maintain all records presently provided by law to be confidential in a manner complying with such law, and will use the information solely for consideration in providing assistance to the applicant.

Please send the requested information to the attention of _____ at the address checked below.

❑ 2189 Cleveland Street, Suite 266, Clearwater FL 33765 Phone: (727) 464-8400 Fax:(727) 464-8428

❑ 647 1st Avenue North, St. Petersburg, FL 33701 Phone: (727) 582-7781 Fax:(727) 582-7912