Presbyterian Hospitality House
**TIP APPLICATION PACKET**

Administrative Center
209 Forty Mile Avenue, Suite 100
Fairbanks, Alaska 99701
907-456-6445 – 907-456-6402 (FAX)

Mat-Su Regional Office
1365 Parks Highway, Suite 101
Wasilla, Alaska 99654
907-357-6445 – 907-376-6402 (FAX)

# TIP APPLICATION

## TRANSITION TO INDEPENDENCE PROCESS

Thank you for your interest in the TIP Program. Enclosed in this packet is the TIP Handbook, which includes the TIP Program Description and TIP Program Rules. You are encouraged to read over the handbook before applying so you have accurate expectations of the program. **Please be aware that we are currently updating our handbook so rules and procedures might change.


Once you have read over the handbook please complete:

- ☐ TIP Admission Form (pg 2)
- ☐ Resident Questionnaire (pgs 3 and 4)
- ☐ Health Insurance Information Form (pg 5)
- ☐ Notice of PHH Policies and Practices to Protect the Privacy of Your Health Information (pg 6 - 10)

Please send the completed documents and any additional collateral information to:

**Attn: Dameka Moss**
209 Forty Mile Ave.
Fairbanks, AK 99701
Fax: (907)456-6402
Phone: (907) 456-6445
Email: aarondruyvestein @phhalaska.org

Once your paperwork is reviewed:

- You will be called to schedule an assessment with the TIP Clinician.
- The TIP Clinician, TIP Case Manager, TIP Program Director, and TIP Resident Assistants will review all information and decide if the TIP program is a good fit for you.
- If so, you will be contacted to set up the date and time when you will move in, and an appointment to complete the remaining intake paperwork.

Presbyterian Hospitality House

Administrative Center
209 Forty Mile Avenue, Suite 100
Fairbanks, Alaska 99701
907-456-6445 – 907-456-6402 (FAX)

Mat-Su Regional Office
1365 Parks Highway, Suite 101
Wasilla, Alaska 99654
907-357-6445 – 907-376-6402 (FAX)

# TIP ADMISSION FORM

TIP ADMISSION FORM

Name:_____ Date:_____ Time: _____

Date of Birth:_____ Social Security #: _____

Race: _____ Male ☐ Female ☐ Medicaid #_____

Resident's

Address:_____

Phone: _____ Email: _____

Family Contact 1: _____ Relationship: _____ Phone: _____

Address: _____

Family Contact 2: _____ Relationship: _____ Phone: _____

Address: _____

Referring Agency:_____ Phone: _____ Fax: _____

Address: _____

Reason for placement: _____

_____

Medical needs/health problems, if known:_____

_____

Prescription medication currently taking and why:_____

_____

Drug, food or other allergies, if known: _____

_____

Special dietary needs, if known: _____

_____

Education/employment plan: _____

_____

Allowed contact with relatives & other individuals: _____

_____

Restricted contact with relatives & other individuals:_____

_____

Anticipated discharge date:_____

I answered the above questions based on the information that was available to me at the time of placement. Any additional information that pertains to my placement will be made available to the facility.

Resident Signature:_____ Date: _____

Placement Staff Signature: _____ Date: _____

Facility Staff Signature: _____ Date: _____

Administrative Center
209 Forty Mile Avenue, Suite 100
Fairbanks, Alaska 99701
907-456-6445 – 907-456-6402 (FAX)

Mat-Su Regional Office
1365 Parks Highway, Suite 101
Wasilla, Alaska 99654
907-357-6445 – 907-376-6402 (FAX)

# RESIDENT QUESTIONNAIRE

1. When would you like to move into the TIP Program?

2. Why do you feel you need the TIP program?

3. What are three goals you have for yourself while in the TIP program?

4. What specific skills do you hope to learn through the TIP program?

5. What do you want to do when you leave the TIP program?

6. What are your expectations of the TIP program?

7. What do you think are reasonable responsibilities for being a resident in the TIP Program?

8. What do you think are reasonable privileges for a resident in the TIP Program?

9. How long do you think you will be in the TIP Program?

10. Where do you think you will live after you leave the TIP Program?

Presbyterian Hospitality House

Administrative Center
209 Forty Mile Avenue, Suite 100
Fairbanks, Alaska 99701
907-456-6445 – 907-456-6402 (FAX)

Mat-Su Regional Office
1365 Parks Highway, Suite 101
Wasilla, Alaska 99654
907-357-6445 – 907-376-6402 (FAX)

# RESIDENT QUESTIONNAIRE

## RESIDENT QUESTIONNAIRE cont.

**11. Please circle the areas below that you need assistance with:**

- Housing
- Budgeting/savings
- Legal concerns
- H.S Diploma/GED
- Job Corp
- Social Security Benefits ( SSI/SSD)
- Food Stamps
- College
- Exploring Skills Training such as Carpentry/ Pipefitting/ Welding /Electrician

| Please check **Yes** or **No:** | Yes | No |
|---|---|---|
| 1. Do you have a state I. D? | ☐ | ☐ |
| 2. Do you have a B.I.A card? | ☐ | ☐ |
| 3. Do you have a drivers permit? | ☐ | ☐ |
| 4. Do you have a driver's license? | ☐ | ☐ |
| 5. Do you have a social security supplemental insurance (SSI)? | ☐ | ☐ |
| a. Have you applied? | ☐ | ☐ |
| 6. Do you have food stamps? | ☐ | ☐ |
| 7. Do you have social security disability (SSD)? | ☐ | ☐ |
| a. Have you applied? | ☐ | ☐ |
| b. If you have SSD, have you applied for disabled housing? | ☐ | ☐ |
| 8. Do you have a H.S diploma? | ☐ | ☐ |
| 9. Do you have a G.E.D? | ☐ | ☐ |
| 10. Are you taking college courses? | ☐ | ☐ |
| 11. Are you interested in going to college? | ☐ | ☐ |
| 12. Do you have a savings account? | ☐ | ☐ |
| a. Checking account? | ☐ | ☐ |
| b. Debit account? | ☐ | ☐ |
| c. Debit Card? | ☐ | ☐ |
| d. Credit card? | | |

Presbyterian Hospitality House

Administrative Center
209 Forty Mile Avenue, Suite 100
Fairbanks, Alaska 99701
907-456-6445 – 907-456-6402 (FAX)

Mat-Su Regional Office
1365 Parks Highway, Suite 101
Wasilla, Alaska 99654
907-357-6445 – 907-376-6402 (FAX)

# HEALTH INSURANCE FORM

**YOUNG ADULT'S NAME:** _____

**BIRTH DATE:** ____/____/____ **SEX: MALE** ☐ **FEMALE** ☐

**SOCIAL SECURITY NUMBER:** ____-____-____

**Primary Insurance**: **If you have any private insurance please make that insurance your Primary Insurance.*

NAME OF POLICY HOLDER**:** _____

*Name of Policy*_____

RELATION TO YOUTH:_____

EMPLOYER:_____

SOCIAL SECURITY #:____-____-____ BIRTH DATE: ____/____/____

POLICY/I.D. # :_____ GROUP #: _____

Insurance Co. & mailing address: _____

_____

**SECONDARY INSURANCE**: NAME OF POLICY HOLDER **:**_____

RELATION TO YOUTH:_____

EMPLOYER:_____

SOCIAL SECURITY #:____-____-____ BIRTH DATE: ____/____/____

POLICY/I.D. # :_____ GROUP #: _____

Insurance Co. & mailing address: _____

_____

**DOES THIS YOUTH HAVE MEDICAID?** YES ☐ NO ☐**MEDICAID #** _____

IF NO, HAS MEDICAID BEEN APPLIED FOR? YES ☐ NO ☐

**I authorize the release of any medical information to process claims for the above named youth. I request payment of government benefits be made either to Presbyterian Hospitality House, or whomever accepts assignment. I understand that I am responsible for payment of services that either my insurance or Medicaid will not cover.**

_____ _____

**Parent/Guardian** **Date**

Presbyterian Hospitality House

Administrative Center
209 Forty Mile Avenue, Suite 100
Fairbanks, Alaska 99701
907-456-6445 – 907-456-6402 (FAX)

Mat-Su Regional Office
1365 Parks Highway, Suite 101
Wasilla, Alaska 99654
907-357-6445 – 907-376-6402 (FAX)

# Notice of PHH Policies and Practices to Protect the Privacy of Your Health Information

**This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information ---- Please read it carefully.**

Presbyterian Hospitality House (PHH) is committed to preserving the privacy and confidentiality of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPPA), Alaska State laws and regulations, and ethical guidelines provide for your privacy. Federal health information privacy rules require us to give you notice of our privacy practices. This document is our notice. We will abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law.

_____

Protected Health Information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We understand that your PHI is personal. We are committed to protecting your PHI and to sharing the minimum necessary required to accomplish the purpose. We create a record of the care and services you receive through PHH. This notice applies to all of the Protected Health Information compiled about you while you are receiving services at PHH.

This Notice of Privacy Practices describes how we use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law (see in the body of this Notice). It also describes your rights to access and control your protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. Whenever there is a material change to the uses and disclosures of protected health information, we will make this revised Notice available for your review.

## A. Uses and Disclosures of Protected Health Information

When you come to PHH, there are many forms that you will need to complete and data that you will provide. We are required to compile much of this information by our payers. Your protected health information may be used and disclosed by our agency, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing services to you.

Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of PHH.

Following, are examples of the types of uses and disclosures of your protected health care information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by PHH.

A. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care services. We will share information that you provide with staff members or our clinical team members so that they can assist in determining the best course of care and services for you.

B. Payment: Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain activities that your health insurance plan or other payer may request before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, or undertaking utilization review activities (review of your care on an ongoing basis). For example, obtaining approval for an admission may require that your relevant PHI be disclosed to the health plan/payer to obtain approval for the admission. We may also disclose your information to another provider involved in your care as part of ensuring your eligibility for services.

C. Healthcare Operations: We may use or disclose, as needed, your PHI for our own health care operations in order to provide quality care to all consumers, to assess staff training needs, or to ensure the efficiency of program operations. Health care operations include such activities as:

- Quality assessment and improvement activities,
- Employee review activities,
- Accreditation, certification, licensing, or credentialing activities,
- Review and auditing, including compliance reviews, record reviews, legal services and maintaining compliance programs, or
- Business management and general administrative activities.

In certain situations, we may also disclose PHI to another provider or health plan for their health care operations.

D. Other Uses and Disclosures: As part of treatment, payment, and health care operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment,
- To inform you of potential treatment alternatives or options,
- To inform you of health related benefits or services that may be of interest to you.

**B. Other Permitted Uses and Disclosures**

A. Others Involved in Your Healthcare: We may use or disclose PHI to your guardian or personal representative or any other person that is legally responsible for your care. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

B. Communication Barriers: We may use and disclose your PHI if we attempt to obtain an authorization from you but are unable to do so due to substantial communication barriers. These barriers would only be ones that we cannot overcome and that we determine, using professional judgment, that you intend to provide authorization to share information.

## C. Other Required Uses and Disclosures

We may use or disclose your PHI in the following situations without your authorization. These situations include:

A. In Connection With Judicial and Administrative Proceedings: We may disclose your PHI in the course of any judicial or administrative proceedings in response to an order of a court or magistrate as expressly authorized by such order or in response to a signed authorization.
B. To a Designated Hospital for Emergency Services (Involuntary Commitment): We may disclose protected health information to assure continuity of care.
C. To Report Abuse, Neglect or Domestic Violence: We may notify government authorities if we believe that a youth is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required by law or when the youth agrees to the disclosure.
D. Health Oversight Activities: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.
E. In a Medical or Psychological Emergency: We may disclose protected health information to direct medical service or mental health personnel if a medical or psychological emergency arises.
F. For Research Purposes: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information. At this time, PHH does not maintain an institutional review board, and does not participate in research as defined in this manner.
G. When Legally Required: We will disclose your protected health information when we are required to do so by any Federal, State or local law.
H. Imminent Threat to Health or Safety: Consistent with applicable Federal and State laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.
I. To Division of Mental Health and Developmental Disabilities in accordance with 7ACC 71.400 – 7 ACC 71.449 (Required Data Submission). We will disclose protected health information to DMHDD for health oversight activities specificalluy identified in Alaska law.

J. Release of Information: For all other disclosures of your PHI we must obtain a written authorization for release of information from you. This authorization must include:
- Specific person to whom the information is being released
- Purpose of the release
- Date of the release -time frame
- Specific information or documents that are being released
- Opportunity to revoke consent.

## D. Your Rights Regarding Protected Health Information

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

A. Right to Inspect and Copy: You have the right to inspect and receive a copy of your PHI. We may have to charge you for copying. This means you may inspect and obtain a copy of PHI about you that is contained in a Designated Record Set. A "Designated Record Set" contains PHI in your clinical record and billing records that we use for making decisions about you. If we perceive that providing you access to your record constitutes a danger to self or a danger to others, we can use our professional judgment regarding access.

B. Right to Request Restrictions: You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your record not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

C. Right to Request Confidential Communications: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make this request in writing. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. We are not required to honor your request, but if we do not do so, we will explain in writing.

D. Right to Amend: You may have the right to amend your case record. This means you may request an amendment of the information in your record for as long as we maintain this information. This request must be in writing and provide a reason for the amendment. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, we will do so in writing. You have the right to file a statement of disagreement with us and we may prepare a

rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact your provider if you request an amendment.

E. Right to an Accounting of Disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. By law it excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. On your request, we will discuss with you the details of the accounting process.

F. Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

## E. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing, with PHH by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (907) 456-6445 for further information about the complaint process.

## F. Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will provide you with the revised notice when you are next seen at our agency, following such a revision.

By signing this form you are acknowledging that you have read and understand our Notice of Privacy. If you have a question regarding the Notice of Privacy, please ask someone in our agency before signing this form.

I have been given a copy of PHH's Notice of Privacy Policies and Practices. I have read and understand the Notice I have received.

_____
Resident's Name Printed

_____ _____
Resident's Signature Date:

_____ _____
Parent/Guardian (if applicable) Date:
(Received Copy if involved and with consent of resident)

_____ _____
Witness/PHH Staff Date: