Mansfield Kaseman Health Clinic, LLC
A subsidiary of Community Reach of Montgomery County
9420 Key West Avenue, Suite 400, Rockville, MD 20850

First Name _____ Last Name _____

Address_____

Home Phone Number _____ Cell Phone Number _____

Social Security Number: _____ Date of Birth: _____

Sex: M ☐ F ☐ Marital Status: Married ☐ Single ☐

EMERGENCY CONTACT _____

RELATIONSHIP TO PATIENT: _____ PHONE NUMBER: _____

HOUSING
Shelter ☐
Homeless ☐
Transition Program ☐
House ☐

CURRENT OCUPACION
Employed ☐
Retired ☐
Unemployed ☐

ETNIC GROUP
Hispanic or Latino ☐
Not Hispanic ☐

RACE
American Indian ☐
Alaska Native ☐
Asian ☐
African American ☐
Native to Hawaii/Other Pacific Island ☐
White ☐
Other ☐

RELIGION _____ LANGUAGE _____ COUNTRY OF ORIGIN _____

ENGLISH SPEAKING ABILITY
Proficient ☐
Limited English ☐
Cannot speak English ☐

Employment Information:
Name and address of **EMPLOYER**: _____
EDUCATION level: _____
Number of adults and children (under 18) who depend on your income: _____
E-mail: _____
PHARMACY near your home (name and street) _____
Referred by: _____
SPECIAL NEEDS: Would you like to be referred for any of the following services?

Food ☐ **Clothes** ☐ **Dentist** ☐ **Vision** ☐

Montgomery Cares Program
Montgomery Cares Eligibility Documentation Form

To be enrolled in Montgomery Cares you must:

- Be a resident of Montgomery County; and
- Be 18 years old or older; and
- With no health insurance – including Medicaid, PAC, or Medicare
- Low or no income

PROOF OF RESIDENCY IN MONTGOMERY COUNTY:

- Mortgage or lease
- Property tax bill
- Utility bill with complete name and address (cell phone bills are not accepted).
- School records
- Driver's license with current address
- Maryland State ID card
- Signed Feral Tax Return/W2 (Current Year)
- Recent pay stubs with name and address
- Voter registration card
- Written statement on letterhead from home-visiting provider or homeless shelter
- Official County or State correspondence on letterhead
- Letter from landlord/third party host with host's proof of residency

Sign here to certify that you reside at the following address, but do not have any of the above documentation:

Name: _____

Address: _____

City: _____ Zip Code: _____

Signature: _____ Date: _____

PROOF OF AGE:

Sign here to certify that you have the following date of birth:

Date of birth: _____

Signature: _____ Date: _____

PROOF OF INCOME:

- Employment income: *Pay stubs, Federal Tax Return – most recent, signed, Letter from employer stating gross income per week or month*
- Disability or Unemployment income: *Disability statement/unemployment statement*
- Social Security Income: Social Security/SSI award letter
- Income from Alimony or Child Support: Court statements about alimony or child support
- Help from a friend or relative: Letter from relative or friend that states the amount of support provided to patient.
- No income:

Sign below to certify that you have the following income, but do not have any of the above documentation:

INCOME	AMOUNT	CIRCLE ONE
Employment income (for example: childcare, construction) _____		
Other income (please list):		
No income ☐		
TOTAL		

Signature: _____ **Date**: _____

PROOF OF INSURANCE:

- ☐ Health insurance from work
- ☐ Medicaid (Maryland Medical Assistance)
- ☐ Medicare
- ☐ PAC (Primary Adult Care)
- ☐ Privately purchased insurance
- ☐ Other: _____

Sign here to certify that you do not have health insurance

Signature: _____ **Date:** _____

MONTGOMERY COUNTY SAFETY-NET PROGRAMS APPLICATION

COUNTY OFFICIAL USE ONLY:

eICM Contact ID: _____

Case Number: _____

Head of Household Name (Last, First, Middle)	Home Telephone	Work Telephone	Cell Telephone

Where Do You Live? (Number and Street)	Apt. #	City	State	Zip Code

Mailing Address (If different from home address)

What language do you speak? ☐ **English** ☐ **Spanish** ☐ **Amharic** ☐ **French** ☐ **Korean** ☐ **Mandarin** ☐ **Vietnamese** ☐ **Other** _____

Are you or anyone in your household pregnant? ☐ **Yes** ☐ **No** **If yes, who?** _____ **Due Date** _____

Have you ever received a county health program benefit program? ☐**Yes** ☐**No** Under what name? _____

SECTION A. HOUSEHOLD MEMBERS

Fill in the blanks for all the people in your household. Check **YES** for each person you are applying for. Check **NO** for each person you are not applying for. Check services you are requesting.

Please complete for each person who has a Social Security number

APPLYING FOR	NAME (Last, First, Middle)	RELATION TO YOU:	DATE OF BIRTH (MM/DD/YY)	GENDER	MARITAL STATUS	*RACE (Indicate below for each person)	*ETHNICITY	SOCIAL SECURITY NUMBER (SSN)
☐ MONTGOMERY CARES ☐ CARE FOR KIDS ☐ SENIOR DENTAL				**M** =Male **F**= Female **NB=**Nonbinary **GQ** = Genderqueer/ Genderfluid **MTF** = Transwoman/ woman of transgender experience **FTM** = Transman/ man of transgender experience	**M** = Married **S** = Single **D** = Divorced **P** = Separated **W** = Widowed	A = Asian B = Black/African American C = White N = American Indian or Alaska Native P = Native Hawaiian or Pacific Islander (You may select more than one code) MENA = Middle Eastern or North African	H/L = Hispanic/ Latino N/L = Non-Hispanic/ Non-Latino	
☐ Yes ☐ No		SELF					☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	

***You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.**

SECTION B. ADDITIONAL INFORMATION

Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based

SECTION C. EARNED INCOME

Does anyone in your household receive any income from employment? ☐ Yes ☐ No If yes, list all gross income (from full or part-time employment, self-employment, babysitting, odd jobs, day work, roomer/boarder payments)

NAME (Last, First, Middle)	EMPLOYER	RATE OF PAY (HOURLY)	NUMBER OF HOURS WORKED	GROSS AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED WE = Weekly BW = Bi-weekly MO = Monthly	JOB START DATE (MM/DD/YY)	JOB END DATE (MM/DD/YY)	STUDENT STATUS (Full or Part-time)

SECTION D. UNEARNED AND OTHER INCOME

List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others, and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

PERSON RECEIVING INCOME	TYPE (For benefits, Include Claimant ID#)	GROSS AMOUNT RECEIVED	HOW MANY TIMES A YEAR?

SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for Montgomery County to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that I do not have health insurance coverage and the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date

H-1

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

Montgomery County Department of Health and Human Services

Please print all information. Use a separate form for each person or agency with which information may be shared.

Client Last Name	First Name	Middle Initial	Date of Birth	Sex/Gender

The **Montgomery Cares** program has my permission to:

☐ **send to** ☐ **receive from** ☐ **verbally discuss the information I provide with:**

The Office of Eligibility and Support Services – Montgomery County Department of Health and Human Services
1401 Rockville Pike, Rockville, MD 20852.

Items covered by this release.

☐ Proof of age ☐ Proof of income
☐ Proof of identity ☐ Proof you live in Montgomery County

Reason this information is being shared: To determine my eligibility for the Montgomery Cares program

This authorization is valid (*Check only one. Not to exceed one year*)

☐ until_____(date) ☐ for 90 days ☐ until these conditions are met: _____

_____

I understand that if I am deemed eligible for the Montgomery Cares program, I will be immediately enrolled in the program. I understand that my information will not be shared without proper written authorization.

I understand I can revoke this authorization at any time by submitting a request in writing to DHHS program staff. The revocation will become effective on the date DHHS receives it. The revocation will not apply to information that has already been used or disclosed through this authorization.

DHHS may not condition treatment, payment, enrollment or eligibility for services/ benefits based on whether I sign this authorization, unless authorization is required to determine eligibility for services/benefits.

I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to federal or State privacy laws, this information may no longer be protected and could be disclosed.

I understand that if this authorization pertains to alcohol or other drug treatment records protected by federal regulations at 42 C.F.R. Part 2, I can orally revoke this authorization, and my records may not be redisclosed without my written consent or as permitted by the regulations.

_____ _____

Signature of client **Date**

_____ _____

Signature of parent, guardian, or other authorized person **Date**

If signed by other authorized person, please describe authority to act on behalf of the client (*Please Print)*

_____

_____ ☐

Signature of DHHS staff member **Date**

Original: external agency; 2nd copy: client; 3rd copy: HHS/Chart DHHS – HIPAA 07/19

Montgomery County Department of Health and Human Services

Notice of Privacy Practices Summary and Signature Page

What is the Notice of Privacy Practices?

We are required by law to provide you with a notice of our privacy practices. Our complete *Notice of Privacy Practices* is attached. The purpose of the *Notice* is to inform you about:

- Our legal obligation to protect your information.
- How we will share your information without your written permission.
- Rights that you have related to your information.
- Who you can contact to ask questions, make a request, or file a complaint.

How will we share your information?

Our Department provides a variety of health, income support and social services. To provide these services, we must ask you for personal information that may contain health, financial and other information that identifies you. We will keep your information safe and will only share it when the law permits us or requires us to do so. We will share your information as necessary to:

- Provide you with high quality and coordinated treatment and services. Example: Communicating information between programs to make referrals, determine eligibility or develop a care plan;
- Obtain payment for services. Example: Billing Medicaid;
- Manage our services and programs. Example: Reviewing the quality of the services you receive.

The attached *Notice* lists other reasons why we may share your information. If we need to share your information for reasons that are **not** listed, we will ask for your written permission. You have other rights related to your information that are listed on page 4 of the *Notice.*

Contact Information:

If you have questions about our privacy practices, want to make a request related to your information, or have a privacy concern, contact the staff person who is working with you, or our Privacy Official at 240 777- 1295. Additional contact information is provided at the end of the *Notice.*

Acknowledgement of receipt of the complete *Notice*:

_____ _____

Client or Authorized Representative (Sign your name) Date

_____

Print your name

_____ _____

Signature of DHHS representative Signature of interpreter/translator if applicable

If unable to get acknowledgement, specify why: _____

Authorization for Use and Disclosure of Medical Information for Community HealthLink and MeDHIX

I _____, a Patient at Mansfield Kaseman Health Clinic, ("My Clinic") understand that Community HealthLink is a computer-based health information exchange comprised of member healthcare providers like My Clinic (members of Community HealthLink are called "CHL Members") whose purpose is to provide improved health care to individuals like me by allowing providers who treat me to have access to my medical records. I further understand that Community HealthLink participates in a larger health information exchange called MeDHIX, which is comprised of other health care providers (members of MeDHIX are called "MeDHIX Members"). I understand that unless I notify My Clinic that my medical information may no longer be shared with Community HealthLink and MeDHIX, my medical information (as defined below) will be provided to Community HealthLink and will be available to CHL members and MeDHIX members for purposes of providing me with health care services as further described below, and as otherwise may be permitted by law. I understand that even if I notify My Clinic that my medical information no longer can be shared, my medical information will continue to be available to CHL Members and MeDHIX Members through Community HealthLink and MeDHIX in certain limited situations as permitted by law (for example, to avert a serious threat to the health and safety of myself or others).

- ***Purpose of use or disclosure of my medical information.*** I am authorizing the sharing of my medical information with Community HealthLink and MeDHIX, which allows CHL Members and MeDHIX Members to more easily share my medical information, as defined below, for the purpose of providing me with health care services.
- ***Information that is covered by this Authorization.*** This authorization covers information about me that is created or received by My Clinic, as well as other CHL Members and MeDHIX Members, in the course of providing health care services to me, including but not limited to medical, personal and family household information (together called "my medical information"). This authorization also covers medical information that CHL Members and meDGIX Members receive from other providers.
- ***Who may receive, use, or disclose my medical information.*** I authorize Community HealthLink and MeDHIX to receive, use and disclose my medical information among CHL Members and MeDHIX Members, including their staff. This authorization does not allow the disclosure of my medical information to individuals or entities other than Community HealthLink, CHL Members, and MeDHIX Members, except as otherwise permitted or required under federal or state law.
- ***Term of Authorization.*** This authorization will remain in effect, unless revoked by me, for a period of TEN (10) years from the date I sign this authorization or any shorter period that may be required by law.

I understand that I may, at any time make a written request to Community Health Link to inspect or obtain a copy of my medical information and that Community Health Link will within thirty days of receiving the written request, either schedule a time to inspect or copy my medical information or provide me with a copy or summary of my medical information.
I understand that once information covered by this authorization has been disclosed redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.
I understand that I may refuse to sign this authorization for any reason and that my refusal to sign this authorization will not affect the commencement, continuation, or quality of my treatment by members of Community Health Link.
I understand that members of Community Health Link and MeDHIXwill not sell or receive compensation for the use or disclosure of my medical information.
I understand that I may revoke this authorization at any time and that such revocation will not affect the commencement, continuation, or quality of my treatment by Community Health Link. To revoke this authorization, I should submit a request to revoke, in writing, to any Community Health Link member. This revocation will be effective immediately upon receipt by the member of the written request revoke.
I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of medical information. Accordingly, I knowingly and voluntarily authorize members of Community Health Link to use or disclose me medical information in the manner described above.

_____ _____

Signature Date

Mansfield Kaseman Health Clinic, LLC
A subsidiary of Community Reach of Montgomery County
Patient Consent Form

Name_____ **Date of Birth** _____
CHL#_____

1. **Consent for Treatment**: I wish to receive medical care from Clinic Mansfield Kaseman. I understand that the doctors, nurse practitioners, nurses, and other healthcare professionals who will treat me may determine that certain tests, treatments, and consultations deemed necessary or appropriate for my care by my doctor or their assistants. I understand that, as part of my comprehensive medical care, I may be subjected to tests to detect drug use or sexually transmitted diseases, including HIV. If I have concerns about the tests, I will discuss them with my healthcare provider.
2. **Authorization to Disclose Information to Healthcare Centers/Providers**: I authorize Kaseman Clinic to provide information about the care I receive and my health records to other healthcare providers in accordance with the HIPAA forms I have signed.
3. **Public Health Reporting**: I am aware that the law requires Kaseman Clinic to provide the names of patients infected with tuberculosis, HIV, or other sexually transmitted diseases, and certain conditions including infectious diseases and animal bites, to the local public health department.
4. **Opportunity to Ask Questions**: I have had the opportunity to ask questions about this consent form and my questions have been answered to my satisfaction.
5. **Authorization to Release Information to Another Person**: I authorize Kaseman Clinic to share my medical information with the individuals named below.

Name of Authorized person _____ Relationship to patient _____

Name of Authorized person _____ Relationship to patient_____

Name of Authorized person _____ Relationship to patient_____

I do NOT authorize anyone to receive my medical information Patient Initials_____

Signature of Patient _____ Date _____
Witness _____ Date _____

CRISP CONSENT

ENGLISH

I have read the attached information about Maryland's Health Information Exchange, which is known as the CRISP network. I understand that if I sign this consent, I am allowing my health care provider to have access to my medical information that is held by another health care provider in Maryland. I understand that if my health care provider has access to my medical information, it will help him or her make better recommendations about my health care.

I further understand that I have the right to refuse to allow my health care provider to access my information.

I do consent to my health care providers being able to access my medical information on the CRISP network.

Signature: _____ **Date:** _____

ESPAÑOL

He leído la información adjunta respecto al Intercambio de Salud Médica de Maryland, conocido como la red *Chesapeake Regional Information System for our Patients, Inc.,* or CRISP, por sus siglas en inglés. Comprendo que si firmo este formulario de consentimiento, le estoy permitiendo a mi proveedor de salud tener acceso a mi información médica, la cual se encuentra en manos de otro proveedor de salud en el Estado de Maryland. Comprendo que si mi proveedor de atención de salud tiene acceso a mi información médica, esto le ayudará a él o a ella a hacer mejores recomendaciones con respecto a mi salud.

Además, entiendo que tengo el derecho de negarme a permitir que mi proveedor de salud tenga acceso a mi información médica.

Doy mi consentimiento a mi proveedor de atención de salud para obtener acceso a mi información médica mantenida en la red CRISP.

Firma del paciente: _____ **Fecha:** _____

FRANCAIS

J'ai pris connaissance des informations ci-jointes relatives à l'échange d'informations médicales dans l'État du Maryland, également connu sous le nom de reseau CRISP. Je comprends que si je signe ce formulaire de consentement, je permets à mon fournisseur de soins médicaux d'avoir accès aux informations médicales me concernant détenues par d'autres fournisseurs de soins médicaux dans le Maryland. Je comprends que si mon fournisseur de soins médicaux a accés aux informations me concernant, il ou elle sera en mesure de me faire de meilleures recommendations pour mes soins médicaux.

Je comprends également que j'ai le droit de refuser de permettre à mon fournisseur de soins médicaux d'avoir accès à ces informations.

Je donne son consentement pour mon fournisseur de soins de santé d'avoir accès à mes informations médicales continues le réseau CRISP.

Signature: _____ **Date:** _____

Mansfield Kaseman
HEALTH CLINIC
A SUBSIDIARY OF COMMUNITY REACH OF MONTGOMERY COUNTY

Patient's Responsibility Agreement

Acuerdo de responsabilidad del paciente

1. I understand that once my appointment is scheduled it is my responsibility to remember the **date and time**, and I **must** keep the appointment.
   *Entiendo que una vez programada mi cita es mi responsabilidad recordar **la fecha y hora, y debo** acudir a la cita.*

2. I understand that I must call the Mansfield Kaseman Health Clinic **within 48 hours to cancel or reschedule** my appointment at **301-917-6800 or via email frontdesk@cmrocks.org**
   Entiendo que debo llamar a Mansfield Kaseman Health Clinic dentro de las 48 horas para cancelar o reprogramar mi cita al 301-917-6800 o por correo electrónico a frontdesk@cmrocks.org

3. I understand failure to notify the Mansfield Kaseman Health Clinic to cancel or reschedule my appointment will result in a **$50 No-Show Fee** for the missed appointment.
   Entiendo que si no notifico a la Clínica de Salud Mansfield Kaseman para cancelar o reprogramar mi cita, se cobrará una tarifa de $50 por no presentarse por la cita perdida.

4. I understand I **must call-in a week in advance** to refill my medication(s).
   Entiendo que debo llamar con una semana de anticipación para renovar/pedir mis medicamentos.

5. Please note that abnormal labs may result in additional charges that I will be responsible to pay.
   Tenga en cuenta que los laboratorios anormales pueden generar cargos adicionales que debo pagar.

I am signing to confirm that I read and understood the four statements above and I am responsible for the charges.
Firmo para confirmar que leí y entendí las cuatro declaraciones anteriores y que soy responsable de los cargos.

Patient Name// Nombre _____

Patient Signature// Firma _____

Today's Date// Fecha _____

Mansfield Kaseman
HEALTH CLINIC
A SUBSIDIARY OF COMMUNITY REACH OF MONTGOMERY COUNTY

9420 Key West Avenue
Suite 400
Rockville, MD 20850
Phone: 301-917-6800
Fax: 301-917-6810
CMRocks.org

Date: _____

Patient Acknowledgment of Information Provided

I, the undersigned, acknowledge that I have received all necessary information from Mansfield Kaseman Health Clinic regarding making appointments and following up with a doctor for the health concerns identified during my visits.

I understand that it is my responsibility to schedule any follow-up appointments and ensure that any recommended care is continued or pursued. I have been informed of the steps to take to address the identified health issues, including the process for making appointments, scheduling follow-ups, and obtaining further clarification if needed.

Please note that upon receiving abnormal results or regarding a critical referral, our clinic will attempt to follow up with the patient three times. If the patient is unable to be contacted after three attempts, the clinic cannot be held liable for further follow-up actions.

By signing below, I acknowledge that the information provided has been clear, and I accept the responsibility of following through with the necessary appointments and healthcare actions as instructed.

Patient name: _____

Patient signature: _____

Thank you for choosing Mansfield Kaseman Health Clinic for your healthcare needs. Please contact us at the clinic if you have any questions or need assistance with scheduling your appointments.

Clinic staff signature: _____

Mansfield Kaseman
HEALTH CLINIC
A SUBSIDIARY OF COMMUNITY REACH OF MONTGOMERY COUNTY

9420 Key West Avenue
Suite 400
Rockville, MD 20850
Phone: 301-917-6800
Fax: 301-917-6810
CMRocks.org

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

Address: _____ City: _____ State _____ Zip _____

Patient's DOB: _____ Phone # _____

I authorize the Mansfield Kaseman Health Clinic (CM) to take the following action:
☐ **Send my medical records to: OR** ☐ **Obtain my medical records from:**

Name: _____
(*Please print name and full address)*

Address: _____
City *State* *Zip*

Phone # _____ Fax # _____

☐ Include all medical records. **DO** release HIV/AIDS and/or sexually transmitted disease-related and/or psychological or psychiatric treatment and/or drug/alcohol abuse or treatment information, if applicable. I understand that this is a dual release inclusive of sensitive medical information, including HIV.

☐ Include all medical records, except for the following selected items:

☐ Send/obtain only the following selected items:

Note to other medical facilities: If the request for records is to be sent to the < >, we would appreciate a summary of diagnostic studies, laboratory report, x-rays and any other pertinent data.

I understand that my authorization to release/obtain information will expire in one (1) year. I understand that I may withdraw this authorization in writing at any time.

Signed: _____ Date _____

Witness _____ Title _____ Date _____