Privacy Act Notice for the Accountable Health Communities (AHC) Model

Privacy Act Notice – effective 5/22/2018

Your Provider participates in the **Accountable Health Communities Model**, a program that connects you with community and social service programs in addition to the health services you get from your health care provider. This includes programs that can help with housing, food, utilities, violence or transportation. We need to collect information about you to connect you with the right programs. Information we collect includes your name, Medicare and/or Medicaid identification numbers, and contact information.

Sharing information is your choice

Sharing your information is your choice, and won't affect the services you get from your health care provider. If you decide not to provide your information, your provider may not be able to connect you with community and social services through this program. Information you give will never be used for immigration enforcement.

How your information is used

You provider will share your information with the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Accountable Health Communities Model. CMS may need to share your information with others, including:

1. Other federal, state and local government agencies (such as the Department of Justice);

2. Your authorized representative, if you have one;

3. A person or company hired by CMS to do official work; and

4. Anyone else as required or allowed by law.

You can learn more about how CMS handles your information at: www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Privacy-Policy.html.

CMS is authorized to collect your information under Section 3021 of the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152). The Privacy Act System of Records Notice associated with this collection is the Master Demonstration, Evaluation, and Research Studies (DERS) for the Office of Research, Development and Information (ORDI), CMS System No. 09-70-0591, as amended, 72 Federal Register, 19705, Apr. 19, 2007. This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)).

Accountable Health Communities Model Screening Tool

*Our goal is to connect you to the community resources you need to be healthy. This health care provider participates in the Accountable Health Communities (AHC) program funded by the Centers for Medicare and Medicaid Services. This program can help connect you to services in your community that may improve your health. By answering these questions we may be able to provide you with connections to services or programs that may help you. Your information will be kept confidential. The information that you provide will not impact your Medicare or Medicaid eligibility status. You should answer the questions in your own way. There are no right or wrong answers. Questions labeled with * are required.*

1. *Complete the following statement. I am answering this survey about …

□ Myself □ My child □ Another adult for whom I provide care

□ Other *(please describe your relationship to this person)* _____

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

Phone (home):_____ Phone (cell): _____

Email Address: _____ *Date of Birth:_____

*What is your sex?

□ Male □ Female □ Other

What is your preferred language? _____

Are you Hispanic, Latino/a, or of Spanish origin? *Choose all that apply*

□ No, not of Hispanic, Latino, or Spanish origin

□ Yes, Mexican, Mexican American, Chicano

□ Yes, Puerto Rican

□ Yes, Cuban

□ Yes, another Hispanic, Latino, or Spanish origin

Which one or more of the following would you say is your race? *Choose all that apply*

□ American Indian/Alaska Native □ Asian

□ Black or African American □ White

□ Native Hawaiian/Other Pacific Islander □ Other (specify)_____

What is the highest grade or year of school you completed?

□ Never attended school or only attended kindergarten

□ Grades 1 through 8 *(Elementary)*

□ Grades 9 through 11 *(Some high school)*

□ Grade 12 or GED *(High school graduate, diploma, or alternative credential)*

□ College 1 year to 3 years *(, Associate's degree, trade, vocational, or technical school)*

□ College 4 years or more *(College graduate)*

*Address 1_____ Address 2 _____

Street address, P.O. box, c/o (Optional) Apartment, suite, unit, building, etc.

*City:_____ *County:_____

*State:_____ *Zip Code:_____ *Country:_____

Insurance Coverage (Insurance Coverage (Medicare, Medicaid, HICN)

*Health Coverage Type:
Medicaid#:_____ Medicare#:_____
Commercial/Uninsured/Other:_____
(check if applicable)

Information

2. *How many times have you received care in an emergency room (ER) over the last 12 months?

If you are in the ER now, please count your current visit. Please do not count urgent care visits.

□ 0 times □ 1 time □ 2 or more times

3. *Do you live in any of the following locations?

- I live in an **assisted living facility** I live in a **nursing home**
- I live in a **rehabilitation center** or **skilled nursing facility**
- I live in an **in-patient recovery program** for a drug or alcohol problem
- I live in a **psychiatric facility**
- I live in a **correctional facility**

□ Yes □ No

Living Situation

4. What is your living situation today?

□ I have a steady place to live
□ I have a place to live today, but I am worried about losing it in the future
□ I do not have a steady place to live *(I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building)*

5. Think about the place you live. Do you have problems with any of the following?

□ Pests such as bugs, ants, or mice
□ Smoke detectors missing or not working
□ Oven or stove not working
□ Mold
□ Lead paint or pipes
□ Lack of heat
□ Water leaks
□ None of the above

Food

6. Within the past 12 months, you worried that your food would run out before you got money to buy more.

□ Often true □ Sometimes true □ Never true

7. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

□ Often true □ Sometimes true □ Never true

Transportation

8. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

□ Yes □ No

Utilities

9. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

□ Yes □ No □ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. (Please circle appropriate answer.)

10. How often does anyone, including family and friends, physically hurt you?

1 Never 2 Rarely 3 Sometimes 4 Fairly often 5 Frequently

11. How often does anyone, including family and friends, insult or talk down to you?

1 Never 2 Rarely 3 Sometimes 4 Fairly often 5 Frequently

12. How often does anyone, including family and friends, threaten you with harm?

1 Never 2 Rarely 3 Sometimes 4 Fairly often 5 Frequently

13. How often does anyone, including family and friends, scream or curse at you?

1 Never 2 Rarely 3 Sometimes 4 Fairly often 5 Frequently

Family and Community Support

14. How often do you feel lonely or isolated from those around you?

□ Never □ Rarely □ Sometimes □ Fairly often □ Frequently

Background.

19. How many people do you currently live with?

Please count yourself, your spouse/partner, your children, and any other dependents. If you live alone, put 1.

☐☐ number of people

20. What is your annual household income from all sources?

Please include your income as well as the income for everyone you counted above in your household.

□ Less than $10,000
□ $10,000 to less than $15,000
□ $15,000 to less than $20,000
□ $20,000 to less than $25,000
□ $25,000 to less than $35,000
□ $35,000 to less than $50,000
□ $50,000 to less than $75,000
□ $75,000 or more

21. What is the number of children in your household? _____

22. If you have children how many are in each age group?

0-3 _____ 4-6 _____ 7-12 _____ 13-18 _____ 19-21 _____

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Is the patient on Medicare and/or Medicaid ____Yes ____No
Has the patient been to the ER 2 or more times in the last 12 months? ____Yes ____No
Did the patient answer "No" to "Do you live in any of the following locations" ____Yes ____No
Needs identified:

_____Housing _____Utilities
_____Food _____Safety (score first)
_____Transportation _____Isolation

(To score the Safety questions add together the numbers of each answer. If it totals 11 or more, the answer is positive.)

***If all of the above are 'yes' and at least one need is identified, this patient is eligible for Navigation.**

Does the patient want navigation? ____Yes ____No
What is the preferred phone number to contact the patient? _____
Were resource lists provided? ____Yes ____No