Bering Omega Community Services

P.O. Box 540517
Houston, Texas 77254-0517
Teléfono: 713-529-6071 / Fax: 713-341-3758

HOUSING ASSISTANCE -TBRA 2010

Dear Client:

Welcome to the Bering Omega Housing Assistance Program. Our services are reserved exclusively for individuals with HIV/AIDS. Our mission is to improve the quality of life for those with critical needs by providing physical, emotional, and spiritual assistance to the patients who receive our care. Part of the goal of the Housing Assistance Program is to create a safe and pleasant environment in which you, our client, receive services. Your privacy and confidentiality shall always be protected.

Becoming A TBRA Client

The following will explain the steps to become a client at Bering Omega Housing Assistance and other information you will need to know.

In order to serve you according to federal regulations, we ask you to supply several different types of documents. Please read the list carefully and arrive prepared and on time for your appointment.

You will need to bring following documents with you at the time of your scheduled appointment. You or your case manager may fax these documents to us

1. **Doctor Statement**. Document must contain the diagnosis of HIV or AIDS.

2. **Proof of Identity**. Texas I.D. card, Texas Driver's License, school or state I.D. I.D. **MUST** have picture. ***This must be submitted for ALL household Members.***

3. **Proof of Residency**. A current lease in your name **PLUS** last month's rent receipt.

4. **Proof of Income**. ***This must be submitted for ALL household members.***
   This can include Social Security and/or SSI award letter, TANF award letters, Food Stamp Certification letter, 6 most recent pay stubs, pension awards, etc., for you and all members of your household.

5. **Childcare or adult care receipts.** If anyone in your household pays for childcare or adult care, so that another member can work outside the home, proof of payment for the childcare or adult care.

6. **Notices** for all utility bills (electricity, gas, water, telephone), and expenses, whether in your name or not.

Please make sure that you complete (In blue or black ink) all of the attached forms ***prior*** to your intake. Be sure to sign and date everything.

Please ***do not mail or fax*** your completed application. Make sure that you have it with you on the day of your intake appointment. **please make sure you have all documents as requested with you on the day of your intake appointment.**

By applying to our program you are agreeing to the following:

- To keep all appointments with the Housing counselor or call to cancel at least 24 hours in advance.
- To keep the Housing counselor informed of any changes in my health or living situation.
- To refrain from using insulting, foul or abusive language, or from yelling or raising my voice while in your offices.
- To not come to our offices under the influence of any alcohol or illegal drugs.

Please understand that if you violate any of the above conditions you will no longer be eligible for services.

- **PLEASE NOTE THAT FAXED APPLICATIONS ARE NOT ACCEPTED**

- **ALL APPLICATIONS LEFT AFTER 6 MONTHS WILL BE SHREDDED**

Bering Omega Community Services – Housing Assistance Program
1429 Hawthorne Street
Houston, Texas 77006
Phone: 713-529-6071
Fax: 713-341-3758

Your appointment has been scheduled for:

_____@_____AM/PM

At: _____

FREE CHILDCARE

Do you have children that need to be supervised while you are visiting the Bering Omega Community Services? **Please note: children under 12 years of age cannot be left unsupervised in the waiting area.**

People With AIDS Coalition (**PWA**) has set up a volunteer children's nursery at the Church next door. The hours are Monday through Friday from 8:00 AM – 5:00 PM. This service is FREE and only available to clients of the Bering Dental Clinic, Housing Assistance, and The Care Center Programs.

Please note: You must register with PWA one time **BEFORE** they will be able to watch your children. **After you register,** you **MUST** be here at least 1 hour before your appointment to give the childcare provider time to get the nursery set up.

To qualify, the following documents are required:

- Proof of HIV status (child or caregiver)
- Proof of residency
- Proof of income
- Valid Identification

PLEASE NOTE: YOU MUST CONTACT THE SITTERS 24 HOURS PRIOR TO YOUR APPOINTMENT TO RESERVE A SPACE FOR YOUR CHILD.

For Further Information call
Adriana Marroquin
713-873-4162

Bering Omega Community Services

INTAKE ASSESSMENT FORM

PLEASE *PRINT* THE ANSWERS TO THE FOLLOWING QUESTIONS:

Date: _____DOB: _____ Social Security #: _____

Last Name: _____ First: _____ Middle: _____

Address: _____ City, State, Zip: _____

County: _____ Home Phone #: _____ Other #: _____

First 3 letters of Mother's Maiden Name: _____

PLEASE CHECK ONE IN EACH CATEGORY:

REFERRAL SOURCE
_____ Physician/Clinic: _____
_____ Case Manager: _____
_____ Friend
_____ Home Health/Social Worker
_____ Other Service Agency _____

SPECIAL NEEDS (May Check More Than One)
_____ Veteran(s)
_____ Chronically Homeless
_____ Domestic Violence Survivor(s)

MARITAL STATUS
_____ Single
_____ Married
_____ Divorce
_____ Widowed

HIV INFECTION CATEGORY
_____ Homosexual/Bisexual contact
_____ Homosexual/Bisexual contact & IV drug use
_____ Transfusion/blood products/tissue
_____ Heterosexual contact only
_____ Heterosexual contact and IV drug use recipient
_____ Other/undetermined

RACE
_____ American Indian/Alaskan Native
_____ Asian
_____ Black/African American
_____ Native Hawaiian/Other Pacific Islander
_____ White
_____ American Indian/Alaskan Native & White
_____Asian & White
_____ Black/African American and White
_____ American Indian/Alaskan Native & Black/African American
_____ Hispanic/Latin
_____ Other Multi-Racial

GENDER
_____ Male
_____ Female

PRIMARY LANGUAGE
_____ English
_____ Spanish
_____ American Sign Language
_____ Other: _____

PLEASE CHECK ONE IN EACH CATEGORY:

HIV STATUS
_____ HIV+ with no related illness
_____ HIV+ with related illness
_____ AIDS Diagnosis

Monthly Income: $_____
Monthly Rent: $_____
Number of rooms in apt/home_____

Diagnosis Date: _____

PRIOR LIVING SITUATION
_____ Place not meant for human habitation
(such as a vehicle, abandoned building, bus/train/airport, or outside)
_____ Emergency shelter
(including hotel, motel, or campground paid for with emergency shelter voucher)
_____ Transitional housing for homeless persons
_____ Permanent housing for formerly homeless persons
(such as Shelter Plus Care, SHP, or SRO Mod Rehab)
_____ Psychiatric hospital or other psychiatric facility
_____ Substance abuse treatment facility or detox center
_____ Hospital (non-psychiatric facility)
_____ Foster care home or foster care group home
_____ Jail, prison or juvenile detention facility
_____ Rented room, apartment, or house
_____ House you own
_____ Staying or living in someone else's room, apartment, or house
(family and friends)
_____ Hotel or motel paid for without emergency shelter voucher
_____ Other:_____
_____ Don't Know or Refused

ACCESS TO CARE AND SUPPORT
_____ Had contact with a case manager/benefit counselor at least once in the last three months
(or consistent with the schedule specified in their individualized service plan)
_____ Had contact with a primary health care provider at least once in the last three months
(or consistent with the schedule specified in their individualized service plan)
_____ Has medical insurance coverage or medical assistance

Do you use Bering Dental Clinic: YES_____ NO _____
If yes, Date of Last appointment: _____
Date of next appointment: _____
If no, would you like an application sent to you: YES_____ NO _____

Do you use Bering Adult Day Care: YES_____ NO _____
If yes, Date last attended: _____
Date you plant to return: _____
If no, Would you like an application sent to you: YES_____ NO _____

Do you use Legacy (The Assistance Fund): YES_____ NO _____

Do you have Medicaid: YES _____ NO_____

Bering Omega Community Services

INTAKE ASSESSMENT FORM

Household Members

(List the Head of Household and all other members / occupants who will be living in the unit. Give the relationship of each family member or occupant to the head of household.)

Household Member's full Name	Relationship	Date of Birth	Race **See Race Codes below**	Sex	Income Amount/Source
	Head of Household				

Race Codes

(When listing race for household members please use codes listed below)

American Indian/Alaskan Native
Asian
Black/African American
Native Hawaiian/Other Pacific slander
White
American Indian/Alaskan Native &
Asian & White
Black/African American and White
American Indian/Alaskan Native &
Black/African American
Hispanic/Latin
Other Multi-Racial

HOUSING PROGRAM
Tenant Based Rental Assistance - TBRA

Program Rules and Responsibilities during the Term of Assistance

1. **TBRA** clients are required to comply with the following Program rules and responsibilities as a condition of receiving Housing Assistance through HOPWA – TBRA assistance

2. **TBRA** clients must read and sign a copy of the Program Rules and Responsibilities during the Term of Assistance prior to receiving assistance.

3. **TBRA** clients cannot be living in any HUD/HOPWA assisted facility, a reduced rent facility, or be receiving any HUD or Section 8 rental subsidy.

4. **TBRA** clients must provide all requested documentation by stated deadlines made by the TBRA Housing Assistance staff throughout their term on the TBRA Program. Failure to provide documentation by deadline may constitute grounds for termination from the program.

5. **TBRA** clients must submit all required documentation prior to receiving assistance. Participants who falsify any documents or provide inaccurate information of any kind including, but not limited to, medical information, household size, composition, or income are subject to termination from the TBRA program.

6. **TBRA** client residence's must have a HUD Housing Quality Standards (24 CFR § 574.320 HQS) inspection, conducted prior to program participation and applicable to standards set forth on CFR §574.320 and subsequent HQS inspections for any move during the TBRA program.

7. **TBRA** clients understand that all housing assisted under 24 CFR § 574.300 (b) (3), (4), (5), and (8), including the HOPWA Rental Assistance Program , must provide a safe housing environment which includes a **Smoke Detector** that is incompliance with the Texas Property Code – Chapter 92.

8. **TBRA** clients must provide six months of income documentation and or an Employer Verification form.

9. **TBRA** rent assistance amount is determined by using the HUD calculation form. Once the amount is determined, a check will be sent directly to the landlord on a monthly basis during the term of participation in the TBRA program. Participants must pay their portion of the rent to the landlord. Failure to pay your portion of the rent may constitute grounds for termination from the program.

10. **TBRA** clients must ensure that all utility accounts are paid in a timely manner. Electricity, water/sewer, or gas utility accounts that are suspended or terminated due to non-payment by the participant may constitute grounds for termination from the program. Participants must also provide copies of utility bills every two months.

11. **TBRA** clients understand and agree to an interim evaluation every four (4) months during the term of assistance and program participation.

12. **TBRA** clients must abide by all provisions in their lease. Clients who break their lease or violate its provisions are subject to termination from the program. Clients who are evicted by their landlord for violation of lease provisions are subject to termination from the program.

13. **TBRA** clients must notify the TBRA Assistance staff in **writing** of any change in household size, composition, or income within ten (10) days of the change. Failure to report changes may constitute grounds for termination from the program.

14. **TBRA** clients are required to establish a Housing Plan, addressing issues such as, financial independence, medical and mental health care, transportation, and discharge planning needs with the TBRA Housing Assistance staff at the initiation of services. The Housing Plan must be reviewed during a client's participation in the program and prior to exit of the program. Failure to comply with the Housing Plan may constitute grounds for termination from the program.

15. A **TBRA** client who wishes to move, in compliance with their lease must give the Housing Assistance staff written notice at least thirty (30) days prior to their move. Failure to give a thirty (30) day written notice may constitute grounds for suspension of assistance and/ or termination from the program.

16. **TBRA** clients must notify the Housing Assistance staff if they will be away from their home for more than thirty days. If Housing Assistance staff is unable to contact a client by a minimum of three (3) telephone calls and one (1) letter within a thirty (30) day period, the client may constitute grounds for termination from the program.

17. **TBRA** clients understand that Housing Assistance payments are based on HOPWA funding and should funding cease, The Housing Assistance staff will give clients a thirty (30) day written notice of termination of assistance.

By my signature below I hereby verify that I understand and agree to abide by the Program Rules and Responsibilities during the term of Assistance.

_____ _____

Client Signature **Date**

_____ _____

Staff Signature **Date**

Bering Omega Community Services

Housing Assistance Program – TBRA Pre-Application

Applicant Name: _____

Current Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Household Members
(List the Head of Household and all other members / occupants who will be living in the unit. Give the relationship of each family member or occupant to the head of household.)

Household Member's full Name	Relationship	Date of Birth	Age	Sex	Social Security Number
	Self				

Are you currently working? ☐ Yes ☐ No

If currently working, Date of hire _____

Name of Employer:

_____

Address of Employer: _____
City State Zip Code

I authorize the Housing Assistance staff to verify all information provided on this application.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

Bering Omega Community Services

APPLICATION FOR HOUSING ASSISTANCE TBRA

MONTH: _____ YEAR_____

Please Print

Last Name:	**First Name:**	**DOB:**
Street:	**City:**	**Zip Code:**
Home Phone:	**Cell Phone:**	**SS#**

I am requesting TBRA assistance through The Bering Omega Community Services, Housing Assistance Program.

I certify that the following bills are either in my name or my legal spouse's name:

Rent ☐ Yes ☐ No	**Electricity ☐ Yes ☐ No**	**Water ☐ Yes ☐ No**	**Gas ☐ Yes ☐ No**

I agree to keep confidential the identity, name, or any other information about any other clients I may come in contact with while at Bering Omega Community Services.

I certify that I am not on Section 8 housing. I also certify that I am not receiving, have not applied, nor will I apply for STRMU or TBRA assistance with any other housing agency for the same month in which I have applied for assistance through Bering Omega Community Services – Housing Assistance Program. I understand that if I apply or have applied for assistance for the same month, then I will be terminated from receiving services from Bering Omega.

I understand that any housing assistance I receive through Bering Omega Community Services can only be used for a residence with smoke detectors.

I confirm that all the information I have provided on this form, is true to the best of my knowledge.

Client Signature:	**Date:**

For Office Use Only

Client ID_____

Rent	**Vendor**	**Account #**	**Amount**	**Date**	**Date**
				_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____

Bering Omega Community Services

CONSENT FOR THE RELEASE/EXCHANGE OF INFORMATION

I, _____, _____, authorize personnel of Bering Omega
Print Client's Name Date of Birth

Community Services, to exchange information with the agencies and/or individuals identified below. This is to access community resources and/or services regarding any or all of the following:

_____ Proof of Identity

_____ HIV status

_____ Eligibility documents: _____

_____ Medical records: _____

_____ Other: _____

This consent may be revoked in writing by the undersigned at any time except to the extent that action may already have been taken on it.

A photocopy of this form shall be considered as effective and valid as the original.

NAME	RELATIONSHIP	PHONE NUMBER

I UNDERSTAND THAT THIS CONSENT SHALL EXPIRE ONE YEAR FROM DATE SIGNED. THIS FORM WAS:
_____ EXPLAINED TO ME or _____ READ BY ME
AND I UNDERSTAND IT'S MEANING. ALL THE BLANKS WERE FILLED IN BEFORE THE FORM WAS SIGNED BY ME.

_____ _____
Client Signature or mark (if of legal age and legally competent) date

_____ _____
Parent/Guardian/Power of Attorney date

_____ _____
Printed Name of Witness**/ Bering Omega Staff Signature** date

_____ _____
Signature of Witness/ **Bering Omega Staff Signature** date

Bering Omega Community Services

CLIENT APPEALS/GRIEVANCE PROCEDURES

Bering Omega Community Services desires to foster the prompt and orderly consideration and resolution of client questions, complaints, conflicts, etc.

For the purposes of this document, "client" refers to any individual receiving services through Bering Omega programs.

PROCEDURE

The following process is designed to resolve all client questions, complaints, conflicts, etc. that may arise during the client/Bering Omega relationship in a fair and efficient manner.

1. Initial Discussion:
   Where the questions, complaints, conflicts, etc. are not resolved after initial discussions, the client should address their issues to the **Program Manager or Program Director**. Program Managers should listen to the questions, complaints, conflicts, etc. and resolve such issues as best as they can, communicating their decisions to the clients in a timely manner.

2. Vice President of Operations Mediation and Response: If clients are dissatisfied after their initial discussions with a Program Manager, the client should next address their issues to the **Vice President of Operations**. The Vice President of Operations should investigate the situations, discuss the issues with the client, and respond to the client within one (1) week after the discussion.

3. President Review: If clients are dissatisfied with the response of the Vice President of Operations, the client should next address their issues **in writing** to the **President**. The President is expected to review the situations, make a decision, and contact the client within two (2) weeks of the review to discuss the decision. The decision of the President will be considered final and will end the internal review of the clients' issues.

4. If any issues concern the President, and if any clients are dissatisfied after their initial discussions with the President, the client should address their issues, **in writing**, to the **Chair of the Board of Trustees**. The Chair should investigate the situations and respond with his/her decision, in writing, to the client within thirty (30) days of the investigation. The decision of the Chair will be considered final and will end the Bering Omega review of the clients' issues.

I. EXTERNAL DUE PROCESS

Should the client be dissatisfied with the decision of Bering Omega Community Services regarding the grievance/complaint, the client has the right to pursue an external due process.
ANY CLIENT HAS A RIGHT TO FILE A COMPLAINT WITH THE TEXAS DEPARTMENT OF HUMAN SERVICES (512) 834-6788, P.O. BOX 149030, AUSTIN, TEXAS 78714-9030; HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, 500 LOVETT BLVD, SUITE 100, HOUSTON, TEXAS 77006, (713) 526-1016; OR HOUSTON/HARRIS COUNTY (RYAN WHITE) PLANNING COUNCIL, 2223 WEST LOOP SOUTH, SUITE 417, HOUSTON, TEXAS 77027, (713) 439-6090.

IN THE OPERATION OF THE SPECIAL NUTRITION PROGRAMS, PARTICIPANTS ARE NOT DISCRIMINATED AGAINST BECAUSE OF RACE, SEX, COLOR, NATIONAL ORIGIN, AGE, POLITICAL BELIEF, RELIGION OR DISABLIITY, IF YOU BELIEVE YOU HAVE BEEN DISCRIMINATED AGAINST, WRITE IMMEDIATELY TO:

Director: Civil Rights Department
701 W. 51st Street (78751)
P.O. Box 149030 (78714-9030)
Mail Code W-106
Austin, Texas

voice – 512-438-3630
TDD – 512-438-4313
Fax – 512-438-4748

And/or you may contact the Secretary of Agriculture, Washington, D.C. 20250

I HAVE READ AND UNDERSTAND THE GRIEVANCE PROCEDURES CONTAINED HEREIN, AND HAVE RECEIVED A COPY OF THIS PROCEDURE.

_____ _____
CLIENT SIGNATURE DATE

_____ _____
GUARDIAN SIGNATURE DATE

_____ _____
BERING OMEGA STAFF SIGNATURE DATE

Bering Omega Community Services

CLIENT ELIGIBILITY FORM

The Housing Assistance program is for persons who are HIV positive.

Criteria for entry into the Housing Assistance program are:

- Person who are HIV infected
- Persons who are unable to pay their monthly rent, mortgage or utility due to an unforeseen circumstance.
- Persons who are minimally dysfunctional and need only minimal assistance in ambulation.
- Persons who exhibit behaviors which are NOT HARMFUL to themselves, or to other clients and/or staff. Persons who demonstrate violence, threats of violence, use of illegal substances, use of alcohol during their visit,, abusive language, theft, and/or behavior considered inappropriate, are subject to immediate dismissal.
- Persons who agree to comply with the policies and procedures of Bering Omega Community Services.
- Persons who are, in the evaluation of the admitting staff worker, sufficiently stable, emotionally, mentally, and physically appropriate for interaction with other clients and staff.

CLIENT BILL OF RIGHTS FOR HIV SERVICES

Each person that is receiving care under the Texas Department of Health (TDH) Services Program has a right to:

- Not be physically or mentally abused or exploited;
- Be treated with respect, consideration, and recognition of his or her dignity and individuality; (The client must also render the same to the provider to receive personal care and treatment in safe, clean surroundings);
- Appropriate care regardless of his/her race, religious practice, color, national origin, sex, age, handicap, marital status, or sexual orientation;
- Communicate in a culturally sensitive manner to address the client's needs for the purpose of getting any type of treatment, care, or services;
- Receive services, care, and treatment regardless of any disability;
- Present grievances to Bering Omega Staff , state agencies, or other persons without fear of denial of services; The grievances policy/procedure, as set by the administrative agency must be presented and explained to the client by any service provider; (In the event that this procedure cannot be followed because of direct conflict with the administrative agency or subcontractor, the grievance will be submitted to the consortium);
- Have local confidential records which cannot be released without his/her written permission; (A client may inspect his/her personal records that are maintained by the agency providing the services);
- Be given the opportunity to actively participate in the planning of his/her service plan.
- Refuse treatment;
- Participate in an annual needs assessment survey.

I HAVE READ, UNDERSTAND, AND AGREED TO THE CLIENT ELIGIBILITY REQUIREMENTS AND THE CLIENT BILL OF RIGHTS FOR HIV SERVICES.

_____ _____

CLIENT/GUARDIAN SIGNATURE DATE

_____ _____

BERING OMEGA STAFF SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES
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

1. **Purpose:** Bering Omega Community Services is committed to providing services designated to meet your needs. We are equally committed to respecting your privacy and protecting the information about you that we may receive. We have prepared this Notice to advise you of what information we collect and how we protect it. Bering Omega Community Services (referred to herein as Bering Omega) and its professional staff, employees, and volunteers follows the privacy practices described in this Notice. We are required by law to maintain the privacy of your health information, whether in paper or electronic records, and to protect the integrity, confidentiality, and availability of your electronic health information when it is collected, maintained, used or transmitted by Bering Omega. However, we must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, Bering Omega must share your medical information as necessary for treatment, payment and health care operations.

2. **What Information We Collect:** As an essential part of our business, we obtain certain personal information about you in order to provide a service to you. Some of the information comes directly from you, on applications or other forms, and may include information you provide during visits to our agency or while speaking with our staff. We may also receive information from physicians and other health providers or agencies. The types of information we receive may include addresses, a social security number, family information, current and past clinical history, and financial information.

3. **What are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your nurse may disclose information about your condition with a pharmacist or an outside physician to discuss appropriate medications. Bering Omega may also disclose your medical information as required by Medicaid or another entity, such as a health plan, for that entity's determinations concerning, for example, medical necessity or the entity's payment responsibility. We may also use and disclose your medical information to improve the quality of care at Bering Omega, for example, for review and training purposes.

4. **How Will Bering Omega Use My Medical Information?** Your medical information may be used or disclosed, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

    - Family members or close friends who may consent to your treatment consistent with state and federal law.
    - As required by law.
    - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required or authorized by law).
    - Health oversight activities, *e.g.*, audits, inspections, investigations, and licensure.
    - Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)

- Law enforcement (*e.g.*, in response to a court order or subpoena).
- To coroners and medical examiners.
- Certain research projects approved by an Institutional Review Board.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces.
- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- Workers' Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
- To carry out treatment, payment, and health care operations functions through business associates, *e.g.*, to install a new computer system.

Certain types of information may be subject to additional restrictions on disclosure, such as AIDS or HIV test results, status or other related information and psychotherapy notes.

5. **Other Ways Bering Omega May Use My Medical Information**. In addition, Bering Omega may contact you to provide appointment reminders and to inform you of treatment alternatives or benefits or services related to your health that may be of interest to you. (You will have the opportunity to refuse to receive this information.)

6. **Your authorization is Required for Other Disclosures**. Except as described above, we will not use or disclose your medical information unless you authorize Bering Omega in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

7. **You have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by Bering Omega:

    - **Right to request restriction.** You may request limitations on your medical information we use or disclose for health treatment, payment or operations, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
    - Right to confidential communications**.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
    - **Right to inspect and copy.** You have the right to inspect and copy your medical information regarding decisions about your care. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; in some cases you may request review of the denial by another licensed health care professional chosen by Bering Omega. Bering Omega will comply with the outcome of the review.
    - **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by Bering Omega, which requires certain specific information. Bering Omega is not required to accept the amendment.
    - **Right to accounting of disclosures.** You may request a list of the disclosures of your medical information that have been made to persons or entities in the past six years, but not prior to April 14, 2003 (such list will not include disclosures made pursuant to an authorization or for treatment, payment, and health care operations). After the first request, there may be a charge.

- **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site, www.beringomega.org.

8. **Requirements Regarding This Notice.** Bering Omega is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. Bering Omega may change this Notice, and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you visit Bering Omega for health care services, you may receive a copy of the Notice in effect at the time.

9. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with Bering Omega or with the Secretary of the United States Department of Health and Human Services. *You will not be penalized or retaliated against in any way for making a complaint to Bering Omega or the Department of Health and Human Services.*

Contact: Call Ann Reed, Vice President of Operations at 713-341-3777 if:

- **you have a complaint;**
- **you have any questions about this Notice;**
- **you wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or**
- **you wish to obtain a form to exercise your individual rights described in paragraph 6.**

_____

Signature Print Name Date