



## Eligibility Requirements

Caregivers often find the task of caring for another person to be overwhelming. The challenges of caregiving can even lead to development of stress-related illnesses. An occasional break from caregiving can enable a weary caregiver to regroup both physically and emotionally. Both the National Family Caregiver Support Program and the Connecticut Statewide Respite Care Program are designed to assist you in your caregiving journey.

**Who are “caregivers”?** The term ‘caregiver’ means an adult relative or non- relative, or another individual who is an informal provider of in-home and community care. Only caregivers who provide care to the care-recipient, and who meet the eligibility requirements listed on the following pages, may receive services under these programs. To be eligible for assistance a caregiver must meet specific requirements for program participation as stated in state regulations. **Care recipients (person requiring care) must have an identified caregiver in order to receive services.**

**RESPITE CARE:** Respite care is a short term option designed to provide a break from the physical and emotional stress of caregiving. Respite care services include, but are not limited to: adult day care, home health aides, homemakers, companions, skilled nursing care, or short term assisted living or nursing home care. Funds may be used for day or night respite. Services are available through the **National Family Caregiver Support Program (NFCSP)** or the **Connecticut Statewide Respite Care Program (CSRCP)**. An assessment from a Case Manager is required before respite services are provided.

**SUPPLEMENTAL SERVICES:** Supplemental services are for purchasing items or services, mostly health-related, when there is a justified need and no other way to obtain the service or item. Supplemental services help improve quality of life for the care recipient and therefore alleviate strain on the caregiver. These services are available through the **National Family Caregiver Support Program only** and are determined in collaboration with the Case Manager.

**PROGRAM DESCRIPTION:** Programs to assist caregivers are described on the next two pages. The best program for you will depend on your fit with the eligibility requirements. Both programs are contingent upon available funding, and available services. **All care recipients must have an identified caregiver in order to receive services.**

## The National Family Caregiver Support Program

The **National Family Caregiver Support Program** (NFCSP) is funded by the federal Administration for Community Living, and is operated in partnership with the State of Connecticut Unit on Aging and the Connecticut Area Agencies on Aging. **This program requests a cost share contribution toward the cost of services received based on the care recipient's monthly income as listed below. Donations are accepted for care recipients under 100% of the poverty level:**

Percentage of Federal Poverty Level	Individual 's Monthly Income	Cost Share Amount
0-100%	0 to \$1,041	donations accepted
150%	\$1,042-\$1,562	5%
200%	\$1,562-2,082	10%
250%	\$2,083-\$2,603	20%
300%	\$2,603-\$3,123	40%
350%	\$3,124-\$3,644	60%
400%	\$3,644-\$4,164	80%
Over 400%	\$4,165+	100%

To be eligible, the **CAREGIVER** must:

- be age 18 or over and caring for a person aged 60 years or older, OR
- as in the case of a child, be an older relative caregiver, age 55 or older, who is the grandparent, step grandparent, or other relative, caring full-time for a child age up to age 18, OR
- be an older relative caregiver (including a parent) age 55 and over, caring for an adult child age 18-59 with disabilities.

To be eligible, the **CARE RECIPIENT** must:

- be at risk for institutional placement which means, with respect to an older individual, that individual is unable to perform at least 2 activities of daily living tasks without substantial assistance (including verbal reminding, physical cueing, or supervision). ADLs include bathing, dressing, toileting, eating, walking without human assistance, OR
- have a cognitive or other mental impairment that requires substantial supervision, OR
- person who has Alzheimer's or a related condition regardless of age, OR
- an adult child age 18-59 with disabilities, OR
- a child under age 18 in the care of a relative caregiver (not a parent).

Priority will be given to older individuals with the greatest social and economic need, with particular attention to low-income older adults; or older individuals providing full-time care and support to adults with severe disabilities.

## The Connecticut Statewide Respite Care Program

The **Connecticut Statewide Respite Care Program** (CSRCP) is funded by the State of Connecticut Department on Aging, and is operated in partnership with the Alzheimer's Association, Connecticut Chapter, and the Connecticut Area Agencies on Aging. **This program has a mandatory 20% co-payment toward the cost of services.** Due to financial hardship, a waiver request may be submitted.

To be eligible, the person receiving care must:

1. Have Alzheimer's disease or an irreversible dementia such as that which may result from: Multi infarct dementia, Parkinson's disease, Lewy Body Dementia, Huntington's disease, Normal Pressure Hydrocephalus, or Pick's disease. (The applicant or authorized agent must provide a completed "Physician Statement" from a physician stating that the patient has been diagnosed with dementia.)
2. The person with the diagnosis must not have an income of more than **\$51,114** a year, or have liquid assets of more than **\$ 135,892**. As these levels are subject to change each year, please check with your local Area Agency on Aging for updated figures.

### Two options of care are available for CSRCP and NFCSP:

1. **Traditional Respite Services** – A Care Manager will order and monitor services through a licensed service provider such as a skilled or non-skilled service agency.
2. **Self- Directed Care** – The caregiver will select, hire, and supervise individuals (cannot be a spouse or conservator) to provide respite care. This option provides more flexibility in the selection and delivery of respite services.

**Please keep these pages for your records.**







**FAMILY CAREGIVER INFORMATION**

**Caregiver's Name:** \_\_\_\_\_

**Gender:**  Male  Female  Non-Binary  Other

**Marital Status:**  Never married  Married  Widowed  Separated  Divorced

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO/DAY/YR

**Social Security Number:** XXX-XX-\_\_\_\_\_  
(Last four digits only)

**Address including PO Box's:** \_\_\_\_\_  
(Street and PO Box) City/ST/Zip

**E-mail address:** \_\_\_\_\_

**Telephone – Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Caregiver's Relationship to Care Recipient:**

- |  |                                       |  |   |                                  |
|--|---------------------------------------|--|---|----------------------------------|
| <input type="checkbox"/> Brother       | <input type="checkbox"/> Daughter     | <input type="checkbox"/> Daughter-in-Law | <input type="checkbox"/> Domestic Partner | <input type="checkbox"/> Father  |
| <input type="checkbox"/> Granddaughter | <input type="checkbox"/> Grandfather  | <input type="checkbox"/> Grandmother     | <input type="checkbox"/> Grandson         | <input type="checkbox"/> Husband |
| <input type="checkbox"/> Mother        | <input type="checkbox"/> Non-Relative | <input type="checkbox"/> Other Relative  | <input type="checkbox"/> Sister           | <input type="checkbox"/> Son     |
| <input type="checkbox"/> Son-in-Law    | <input type="checkbox"/> Wife         |  |   |                                  |

**Primary Language Spoken at Home:**

- |   |   |  |                                     |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Arabic         | <input type="checkbox"/> Cambodian (Khmer) | <input type="checkbox"/> Chinese    |
| <input type="checkbox"/> English                | <input type="checkbox"/> French         | <input type="checkbox"/> German            | <input type="checkbox"/> Greek      |
| <input type="checkbox"/> Gujarati               | <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Italian           | <input type="checkbox"/> Korean     |
| <input type="checkbox"/> Polish                 | <input type="checkbox"/> Portuguese     | <input type="checkbox"/> Russian           | <input type="checkbox"/> Spanish    |
| <input type="checkbox"/> Tactical Sign Language | <input type="checkbox"/> Turkish        | <input type="checkbox"/> Urdu              | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Other: _____           |   |  |                                     |

**Speaks English:**  Very Well  Well  Not Well  Not at All

**Ethnicity:**  Not Hispanic/Latino  Hispanic/Latino

**Race:**  American Indian/Alaskan Native  Asian/Asian American  Black/African American  
 Native Hawaiian/Pacific Islander  White

***I live alone or with someone other than a spouse and MY income is about:***

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> At or below \$1,215 (100%) | <input type="checkbox"/> \$1,216 - \$1,519 (125%) | <input type="checkbox"/> \$1,520 - \$1,823 (150%)    |
| <input type="checkbox"/> \$1,824 - \$2,126 (175%)   | <input type="checkbox"/> \$2,127 - \$2,430 (200%) | <input type="checkbox"/> \$2,431 or over (over 200%) |

***I live with my spouse and OUR income is about:***

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> At or below \$1,643 (100%) | <input type="checkbox"/> \$1,644 - \$2,054 (125%) | <input type="checkbox"/> \$2,055 - \$2,465 (150%)    |
| <input type="checkbox"/> \$2,466 - \$2,876 (175%)   | <input type="checkbox"/> \$2,877 - \$3,287 (200%) | <input type="checkbox"/> \$3,288 or over (over 200%) |

**How did you hear about the Program? (Check all that apply)**

- |   |  |   |                             |
|---|--|---|-----------------------------|
| <input type="checkbox"/> Newspaper                      | <input type="checkbox"/> From a Friend | <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> TV |
| <input type="checkbox"/> Radio                          | <input type="checkbox"/> Internet      |   |                             |
| <input type="checkbox"/> Other* (please describe) _____ |  |   |                             |

**\* If agency, please write the agency name and number of person making referral.**

**Income / Asset Statement**

(This information applies to both programs)

Please list care recipient's sources of income. The following are considered income: Social Security (minus Medicare Part B and Part D Premiums), Supplemental Security, Railroad Retirement Income, Pensions, Wages, Interest and Dividends, Net Rental Income, Veteran's Benefits, and any other payments received on a one-time recurring basis.

Please indicate liquid assets of the care recipient and his or her spouse. Liquid assets are defined as an asset that can be converted into cash within twenty working days. List account balances for all liquid assets, including checking accounts, certificates of deposit, savings accounts, individual retirement accounts, stocks, bonds, and all life insurance policies. Include all accounts in the applicant's name as well as those in both the applicant's and their spouse's name. If the income is from a jointly held asset, indicate so by writing "yes" in the appropriate column.

	<b><u>Monthly Income</u></b>	
	<b>Care Recipient</b>	<b>Spouse</b>
1. Social Security (minus Medicare Premiums), SSI, and Railroad Retirement	\$ _____	\$ _____
2. Pensions, Retirement Income, Annuities	\$ _____	\$ _____
3. Veteran's Benefits	\$ _____	\$ _____
4. Interest and Dividends	\$ _____	\$ _____
5. Other Income (wages, net rental income, non-taxable income)	\$ _____	\$ _____
<b>TOTAL AMOUNT OF INCOME</b>	\$ _____	\$ _____

**\*Spousal income information is used to identify other sources of support and is not a determining factor of eligibility.**

<b>Liquid Assets</b>	<b>Amount</b>	<b>Joint?</b>
_____	\$ _____	_____ With Whom?
_____	\$ _____	_____ With Whom?
_____	\$ _____	_____ With Whom?
_____	\$ _____	_____ With Whom?
<b>TOTAL AMOUNT OF LIQUID ASSETS</b>	\$ _____	_____ With Whom?



**CERTIFICATION AND AUTHORIZATION**  
(This information applies to both programs)

I certify that the information on this form is true, accurate, and complete.

I further authorize any health care provider to release any medical records to ensure that appropriate services are provided by the program.

***If an individual is authorized to act as legal representative for the care recipient, please provide documentation of such power (e.g. power of attorney, appointment of conservatorship through Probate Court.)***

---

SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT

DATE

**COST SHARE AGREEMENT**

(For the National Family Caregiver Support Program only)

I am applying for services for: \_\_\_\_\_  
Name of Care Recipient

I understand that as the caregiver and as the person requesting respite services, I may be asked to make a cost share contribution for the cost of the services received. This determination is based upon a sliding fee scale and the individual's income as compared to the most recent US Poverty Guidelines (see attachment to this application for the scale). The Area Agency on Aging shall determine whether the participant qualifies to participate in cost-sharing for this program. The cost share shall be used to replenish program funds and therefore assist other caregiving families, and shall be made directly to Senior Resources Agency on Aging.

\_\_\_\_\_  
Signature of Caregiver Date

I understand that if I have questions I can call:

**Senior Resources Agency on Aging**  
**19 Ohio Avenue, Norwich, CT 06360**  
**Phone: 860-887-3561**  
**Email: SeniorInfo@SeniorResourcesEC.org**

**CO-PAYMENT AGREEMENT**

(For the Connecticut Statewide Respite Care Program only)

I am applying for services for: \_\_\_\_\_  
Name of Care Recipient

I understand that as the caregiver and as the person requesting respite services, I will be asked to make a co-payment for a portion of the cost of the services received.

The Statewide Respite Care Program requires that participants pay a 20% co-payment of the cost of the services received. This co-payment may be waived based upon demonstrated financial hardship and is determined by the Agency. I understand that if I have an emergency that makes me unable to pay my fee that I must contact the Area Agency as soon as possible, and a special payment schedule may be arranged.

I understand that the amount of my payment could change if the services I receive are modified. If this occurs, I understand that I will be notified.

The co-payment shall be used to replenish program funds and therefore assist other caregiving families. The co-payment shall be made directly to Senior Resources Agency on Aging.

\_\_\_\_\_  
Signature of Caregiver

\_\_\_\_\_  
Date

I understand that if I have questions I can call:

**Senior Resources Agency on Aging**  
**19 Ohio Avenue, Norwich, CT 06360**  
**Phone: 860-887-3561**  
**Email: SeniorInfo@SeniorResourcesEC.org**

**\*PHYSICIAN STATEMENT**

(\*A physician's statement must be obtained for care recipients under the age of 60 who have irreversible or deteriorating dementia or is seeking help only from the Connecticut Statewide Respite Care program.)

An application has been made to Senior Resources – Agency on Aging for the individual named below. In order to evaluate the application, information is needed regarding the disability, health and medical problems, and the level of care of the individual. Please answer the following questions.

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

---

***For Physician use only:***

**Does this patient have irreversible and deteriorating dementia?**

**Yes**                       **No**

\_\_\_\_\_  
**SIGNATURE OF PHYSICIAN**

\_\_\_\_\_  
**DATE**

Name of Physician (Please Print): \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**Please return form to:**      **Senior Resources Agency on Aging**  
   **19 Ohio Avenue, Norwich, CT 06360**  
   **Phone: 860-887-3561 • Fax: 860-886-4736**  
   **Email: SeniorInfo@SeniorResourcesEC.org**

**PERMISSION FOR RELEASE OF MEDICAL INFORMATION**

**CAREGIVER OR AUTHORIZED AGENT: Please complete this page and send it, along with the physician's statement, to your physician.**

I agree to the release of medical information on:

---

Name of Patient

---

Address

---

Phone

---

Date of Birth

---

**SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT**

---

**DATE**

**Please return this form to:**

**Senior Resources Agency on Aging  
19 Ohio Avenue, Norwich, CT 06360  
Phone: 860-887-3561 • Fax: 860-886-4736  
Email: SeniorInfo@SeniorResourcesEC.org**

## **SENIOR RESOURCES AGENCY ON AGING GRIEVANCE PROCEDURE**

As required by the Older Americans Act, Senior Resources has established a grievance procedure for older individuals who are dissatisfied with or denied services.

Any individual dissatisfied with or denied services may register a written complaint to the Executive Director within 10 days of the first occurrence of the problem or the initial denial of service. A written determination shall be given to the individual within 10 days of the complaint along with a copy of this grievance procedure.

If the individual remains dissatisfied, they may register a written complaint to the Advisory Council of Senior Resources within 10 days of notification of the Executive Director's determination. The Advisory Council, either in whole or in part, shall hold a hearing for the purpose of receiving testimony from the individual filing the complaint. The hearing shall be held within 30 days of the receipt of the complaint. The Advisory Council will respond, in writing, to the individual within 10 days of the hearing.

If the individual remains dissatisfied, they may register a written complaint to the Board of Directors of Senior Resources within 10 days of notification from the Advisory Council. The Board of Directors will review the information and hold a hearing within 30 days of receipt of the complaint. The Board of Directors will present their option to the individual within 10 days of the hearing. The decision of the Board of Directors will constitute the final disposition of the matter.



**PRIVACY NOTICE ACKNOWLEDGEMENT**

Client Name \_\_\_\_\_

I acknowledge that I have received Senior Resources – Agency on Aging's **NOTICE OF PRIVACY PRACTICES**.

\_\_\_\_\_  
Signed by Client

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signed on behalf of Client

\_\_\_\_\_  
Date of Signature

If signed by Representative for Client:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date Received by Senior Resources – Agency on Aging

**NOTICE OF PRIVACY PRACTICES**

***THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.***

**PLEASE REVIEW IT CAREFULLY**

As your provider of care coordination services, we respect the privacy of your personal health information and are committed to maintaining your confidentiality. We are required by law to:

- A. Maintain the privacy of your health information;
- B. Provide you this detailed Notice of our legal duties and privacy practices relating to your health information; and
- C. Abide by the terms of the Notice that are currently in effect.

**I. WITH YOUR CONSENT WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR SERVICES AND HEALTH CARE OPERATIONS**

We have described these uses and disclosures below and provided examples of the types of uses and disclosures we may make in each of these categories.

**For Services** . We will use and disclose your health information in providing you with services and coordinating your care. We may disclose your health information to other providers involved in your care, such as physicians, nurses, physical therapists, occupational therapists, speech therapists, social workers, case managers, and home health aides.

**For Health Care Operations**. We may disclose your health information to another entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities. For example, health information of many patients may be combined and analyzed for purposes such as evaluating and improving quality of care and planning for services.

**II. WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES**

Below are described ways in which we may use or disclose your health information.

**Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a family member, close personal friend or other person you identify, including clergy, who is involved in your care.

**Emergencies**. We may use or disclose your health information as necessary in emergency treatment situations. **Appointment Reminders**. We may use or disclose health information to remind you about appointments. **Disaster Relief**. We may disclose health information about you to a disaster relief organization.

**As Required By Law**. We may use or disclose your health information when required by law to do so.

**To Avert a Serious Threat to Health or Safety**. We may use or disclose health information when necessary to prevent a serious threat to your health or safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.



**Public Health Activities.** We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury or disability; reporting child abuse or neglect or reporting births and deaths, or to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

**Reporting Victims of Abuse, Neglect or Domestic Violence.** If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

**Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure actions or for activities involving government oversight of the health care system.

**Business Associates.** We may disclose your protected health information to a contractor or business associate that needs the information to perform services for the Agency. Our business associates are also required to preserve the confidentiality of this information.

**Judicial and Administrative Proceedings.** We may disclose your health information in response to a court or administrative order. We may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

**Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations.** We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

**Law Enforcement.** We may disclose your health information for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to respond to certain requests for information concerning crimes.

**Research.** We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

**Military, Veterans and other Specific Government Functions.** If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

**Workers' Compensation.** We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

**Law Enforcement Custody.** If you are under the custody of a law enforcement official or a correctional institution, we may disclose your health information to the institution or official for certain purposes including the health and safety of you and others.

**Fundraising Activities.** We may use certain limited information to contact you in an effort to raise funds for the Agency and its operations. You have the right to opt out of receiving such communications.

**Treatment Alternatives and Health-Related Benefits and Services.** We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

### **III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF PERSONAL HEALTH INFORMATION**

We will use and disclose your personal health information (other than as described in this Notice or required by law) only with your written Authorization. You may revoke your Authorization in writing at

any time. If you revoke your Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

#### **IV. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION**

Following is a listing of your rights regarding your personal health information. Exercise of these rights may require submitting a written request to the Agency. At your request, the Agency will supply you with the appropriate form to complete.

**Right to Non-Disclosure of Certain Health Information Without Prior Written Authorization.** Your prior written Authorization is required and will be obtained for most uses and disclosures of health information (1) that are psychotherapy notes; (2) for marketing purposes; (3) where we receive money in exchange for disclosing such health information; and (4) any other uses and disclosures of health information not described in this Notice of Privacy Practices.

**Request Restrictions.** You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We will honor your request for restriction on our use or disclosure of your health information when your request is with regard to treatment that is paid for out-of-pocket and in full and the disclosure would be solely for payment or health care operations purposes to a healthcare plan.

We are not required to agree to your other requested restrictions (except that if you are competent you may restrict disclosures to family members or friends). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

**Right of Access to Personal Health Information.** You have the right to inspect and obtain a copy of billing records or other written information that may be used to make decisions about your care, subject to some limited exceptions. Your request must be made in writing. We may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to health information, in some cases you have a right to request review of the denial. This review would be performed by a licensed health care professional designated by the Agency who did not participate in the decision to deny.

**Right to Request Amendment.** You have the right to request amendment of any information maintained by the Agency for as long as the information is kept by or for the Agency. Your request must be made in writing and must state the reason for the requested amount.

We may deny your request for amendment if the information: **A.** Was not created by the Agency, unless the originator of the information is no longer available to act on your request; **B.** Is not part of the health information maintained by or for the Agency; **C.** Is not part of the information to which you have a right of access; or **D.** Is already accurate and complete, as determined by the Agency.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

**Right to an Accounting of Disclosures.** You have the right to request an “accounting” of our disclosures of your personal health information. This is a listing of certain disclosures made by the Agency or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, disclosure made pursuant to your Authorization, or certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period that is within six years from the date of your request. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

**Right to Notice of a Security Breach.** You will be notified in the event of a security breach of your health information.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

#### **V. SPECIAL RULES REGARDING DISCLOSURE OF HIV, PSYCHIATRIC, AND SUBSTANCE ABUSE INFORMATION**

For disclosures concerning health information relating to care for psychiatric conditions, substance abuse or

HIV-related testing and treatment, special restrictions may apply. Except as provided below and as specifically permitted or required under state or federal law, health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment may not be disclosed without your special authorization.

HIV-related information: For the purposes of treatment or payment, HIV-related information may be disclosed.

Psychiatric information: Psychiatric information may be disclosed if needed for your diagnosis or treatment in a mental health program. Limited information may be disclosed for payment purposes.

Substance abuse treatment: With the exception of emergencies, if you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures.

#### **VI. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT**

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact Alison Dvorak, at Senior Resources – Agency on Aging at 860-887-3561. If you believe that your privacy rights have been violated, you may file a complaint in writing with the Agency or with the Office of Civil Rights in the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint. To file a complaint with the Agency, contact Alison Dvorak at 860-887-3561.

#### **VII. CHANGES TO THIS NOTICE**

We will promptly revise this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by the Agency as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request.