



*Serving people with Intellectual disabilities*

### **Link Associates Application Materials**

**Please submit the following information when applying for Day Habilitation, VIP, Job Development, Job Coaching, Project Search, LEEP or Adult SCL (hourly & 24 hr.) services:**

- Link Application
- Physical/Medical form (*TB and medical exam must be within past 12 months*)
- Equal Opportunity Policy Statement for signature
- HIPAA Notice and Signature page (**return ONLY the signature page**)
- Hep B Acknowledgement for signature
- Psychological Evaluation
- Social History
- Guardianship papers, if applicable
- Provider Reports (i.e. Initial Assessment or SIS, CCSP, ELP, or ICP)

**Applicants applying for Link Training Programs i.e. Project Search & LEEP will also need to complete a Rubric Guide.**

If you have any questions, please contact me at 515-262-8888, Ext 222 or [jkirts@linkassociates.org](mailto:jkirts@linkassociates.org)

Thank you for your interest in Link services and programs.

A handwritten signature in black ink that reads "Jessica Kirts".

Jessica Kirts  
Assistant Outreach Director



**United Way**  
of Central Iowa

*Employment/Day Services · Residential Services · Habilitation · Leisure · Transportation · Case Management*  
1452 29th Street, West Des Moines, Iowa 50266. Voice/TTY (515) 262-8888. FAX (515) 225-1631  
[www.linkassociates.org](http://www.linkassociates.org)

# Link Associates

## A-8: APPLICATION FOR SERVICES

The completed application materials will be reviewed by the Admissions Committee at Link Associates. Services are subject to the Admissions Committee approval. Please identify the service/program you are applying for:

**Day Habilitation Services**

- Day Program
- VIP

**Employment Services**

- Training Program – LEEP
- Job Development
- Job Coaching

**Residential Services**

- SCL 24 Hour Services
- SCL Hourly Services

**PERSONAL INFORMATION**

Applicant's Full Name: \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_  
(Street) (City/State) (Zip Code)

Telephone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Diagnosis (Primary): \_\_\_\_\_

Diagnosis (Secondary): \_\_\_\_\_

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Gender:  Male  Female Identifying Marks: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Language Spoken or Understood: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**FAMILY INFORMATION**

Mother	Father
Name:	Name:
Address:	Address:
Phone:	Phone:
Email:	Email:
Other Involved Family and/or Friends	
Relationship to Applicant:	Relationship to Applicant:
Name:	Name:
Address:	Address:
Phone:	Phone:
Email:	Email:

**LEGAL/FINANCIAL INFORMATION**

County of Legal Residence: \_\_\_\_\_

Funding Source (i.e. Waiver, County, State, Private Pay): \_\_\_\_\_

Can the applicant pass a drug screen, physical, and criminal background checks? \_\_\_\_\_

Case Manager / Service Coordinator	
Name:	Phone:
Agency:	Fax:
Address:	Email:
Legal Guardian / Conservator / Power of Attorney (circle one)	Payee
Name:	Name:
Address:	Address:
Phone:	Phone:
Email:	Email:

Does applicant receive:	Amount	ID Number
Medicaid Health Insurance (Title XIX): Yes/No	_____ N/A _____	_____
Medicare Health Insurance: Yes/No	_____ N/A _____	_____
Supplemental Security Income (SSI): Yes/No	_____	_____
Social Security Disability Insurance (SSDI): Yes/No	_____	_____
Veterans Administration Benefits: Yes/No	_____	_____
Railroad Pension: Yes/No	_____	_____

Does the applicant have:

Private Hospital Health Insurance: Yes/No Policy #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

If applying for Residential Services: Medicare Drug Card Policy #: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INFORMATION**

**Person to notify in an emergency:**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Primary Physician	Pharmacy
Name:	Name:
Address:	Address:
Phone:	Phone:

**MEDICAL INFORMATION Continued**

**TB Test required:** written documentation of TB test results required as follows:

**Single TB Test** (completed within the last 12 months)

Date of TB Test Results: \_\_\_\_\_

Is applicant capable of taking own medication with supervision? ( ) Yes ( ) No

**Allergies:**

Is applicant allergic to any medications? ( ) Yes ( ) No

Is applicant allergic to any foods? ( ) Yes ( ) No

Is applicant allergic to anything else? ( ) Yes ( ) No

If yes to any of these, please list specific allergy and the type of reaction: \_\_\_\_\_

**Diet:**

Is the applicant on a special diet ordered by a doctor? Yes/No

If yes, Physician's Name: \_\_\_\_\_

Date Started: \_\_\_\_\_ Type of Diet: \_\_\_\_\_

Reason for Diet: \_\_\_\_\_

**Seizures:**

Does applicant have seizures? Yes/No If yes, at what age did the seizures begin? \_\_\_\_\_

Type of seizure(s): \_\_\_\_\_

Frequency of seizures: \_\_\_\_\_

Date of last seizure: \_\_\_\_\_ Type of seizure: \_\_\_\_\_

**Assistive Devices:**

Does the applicant require any of the following?:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Wheelchair	( )	( )	Glasses	( )	( )
Brace	( )	( )	Communication	( )	( )
Walker	( )	( )	Lifts	( )	( )
Dentures	( )	( )	Other	( )	( )
Hearing Aid(s)	( )	( )			

**PREVIOUS PROGRAM INFORMATION**

**Applicant's Educational Background:**

Highest grade Completed: \_\_\_\_\_ Last School attended: \_\_\_\_\_

Other Schools Attended: \_\_\_\_\_

**Previous/Current Day Programs:**

Program	Address	Date	Hours/Days
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Previous/Current Residential Programs:**

Program	Date(s)	Discharge (voluntary/involuntary)
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_____	_____	_____
_____	_____	_____
_____	_____	_____

**PREVIOUS PROGRAM INFORMATION Continued**

**Other Agency Involvement (e.g.: Vocational Rehabilitation, etc):**

Agency: \_\_\_\_\_

Case Worker: \_\_\_\_\_

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

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

**Previous Evaluation:**

Other Agency Evaluations:

Agency: \_\_\_\_\_

Date: \_\_\_\_\_

Type of Evaluation: \_\_\_\_\_

**EMPLOYMENT HISTORY**

Have you ever been employed? ( ) Yes ( ) No

Does the applicant have a desire to work? ( ) Yes ( ) No

Does the applicant have a current work goal or plan? ( ) Yes ( ) No

Do you have the ability to maintain appropriate social/behavioral skills in the workplace? ( ) Yes ( ) No

Please list name of vocational/employment agency or employer:

1. Agency: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

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

Job Responsibilities: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Was Employment: ( ) Sheltered or ( ) Competitive

2. Agency: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

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

Job Responsibilities: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Was Employment: ( ) Sheltered or ( ) Competitive

**SKILLS CHECKLIST**

	<b>Independent</b>	<b>Assistance</b>	<b>Dependent</b>	<b>Comment</b>
<b>Personal Care</b>				
<b>Bathing</b>				
<b>Dressing</b>				
<b>Oral Hygiene</b>				
<b>Toileting</b>				
<b>Eating</b>				
<b>Room Care</b>				
<b>Laundry</b>				
<b>Walking</b>				
<b>Interacts with peers</b>				
<b>Writes/reads letters</b>				
<b>Uses the telephone</b>				
<b>Makes purchases</b>				
<b>Leisure activities</b>				

**ADDITIONAL INFORMATION:**

Please list leisure activities and interests: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant responds best to:** one to one ( ) small groups ( ) large groups ( )

	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Communicates wants and needs	( )	( )	How/style: _____
Accepts supervision or redirection	( )	( )	_____
Aggressive behavior	( )	( )	_____
Self-abusive behavior	( )	( )	_____
Understands own sexuality	( )	( )	_____
Inappropriate sexual behaviors in public	( )	( )	_____
Any situations or conversations that may upset the applicant	( )	( )	_____

Other Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LINK ASSOCIATES RELEASE**

I certify that all information given is the truth to the best of my knowledge. I give permission to have the information in this application shared with authorized personnel at Link Associates, for the purposes of the admission process. I will inform the Admissions Coordinator of whom to share any decisions regarding services.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Application completed by: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

**Link Associates**  
**MD: 14: PERSON SERVED MEDICAL EXAMINATION**

**NAME:** \_\_\_\_\_ **DATE OF EXAM:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **SEX:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Temp/Pulse/Resp.: \_\_\_\_\_ BP: \_\_\_\_\_

Heart Sounds/Rhythm: \_\_\_\_\_ EKG: \_\_\_\_\_

Lung Sounds: \_\_\_\_\_

Gastrointestinal: \_\_\_\_\_ Rectal check: (if over 40) \_\_\_\_\_

Genitourinary: \_\_\_\_\_

Ears, Nose, Throat: \_\_\_\_\_ Eyes: \_\_\_\_\_

Neurological: \_\_\_\_\_ Skin: \_\_\_\_\_

Male: Prostate and/or Testicular Exam: \_\_\_\_\_ Date: \_\_\_\_\_

Female: Pap Smear: Date \_\_\_\_\_ Results: ( ) Normal ( ) Abnormal

Breast Exam \_\_\_\_\_ Mammogram (if over 35) \_\_\_\_\_

Onset menstruation: \_\_\_\_\_ Birth control: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATIONS – provide dates**

Polio \_\_\_\_\_ MMR (measles, mumps, rubella) \_\_\_\_\_

Chicken Pox (varicella) \_\_\_\_\_ OR had disease \_\_\_\_\_

DPT (diphtheria, tetanus, pertussis) \_\_\_\_\_ Td (tetanus, diphtheria) \_\_\_\_\_

Pneumonia \_\_\_\_\_ Influenza \_\_\_\_\_

Hepatitis B (required for RCF/ID residents) (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

**MEDICATIONS**

**DOSAGE & DIRECTIONS**

**RELATED DIAGNOSIS**

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Significant History of Illness, Disease, or Injury not mentioned above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Diet Order: \_\_\_\_\_  
 \_\_\_\_\_

**REQUIRED TUBERCULIN TESTING:**

**Current Symptoms Assessment** (Check all, *if any*, that apply):

<input type="checkbox"/> Persistent cough, 3 weeks or longer	<input type="checkbox"/> Cough up blood or Sputum	<input type="checkbox"/> Pain in Chest
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	
<input type="checkbox"/> Unintentional weight loss		

**Tuberculin Test:**

Step One:      Date: \_\_\_\_\_ Pos. ( )                      Neg. ( ) \_\_\_\_\_ mm of induration  
                   If positive, chest x-ray required                      Pos. ( )                      Neg. ( )

**RCF only**

Step Two:      Date: \_\_\_\_\_ Pos. ( )                      Neg. ( ) \_\_\_\_\_ mm of induration

**LABORATORY** (ordered at health care provider's discretion)

List ordered labs: \_\_\_\_\_  
 \_\_\_\_\_



**PHYSICAL RESTRICTIONS**

Check activities in which this individual will be limited and working conditions which he/she should avoid.

- Restricted Activities:       Walking                       Lifting  
     Standing                       Pushing  
     Stooping                       Pulling  
     Kneeling                       Other

Specify: \_\_\_\_\_

- Restricted Conditions:       Outside                       Dusty  
     Inside                       Sudden Temperature change  
     Humid                       Other  
     Dry

Specify: \_\_\_\_\_

**PHYSICIAN'S CERTIFICATE OF CARE**

I find and certify that \_\_\_\_\_ (name of person served) to be free of clinical evidence of communicable disease and I believe the statement(s) checked below indicates the optimal service(s) for this individual:

**Residential Services:**

\_\_\_\_\_ This person is appropriate for care provided in a licensed "Residential Care Facility" (RCF/ID) with assistance in personal care and supervision, but does not require nursing services

\_\_\_\_\_ This person is appropriate for "Home and Community Based Services for the Intellectually Disabled" (HCBS/ID)

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Address

Link Associates  
**A-6: PERSONS SERVED / GUARDIAN / ADVOCATE  
EQUAL OPPORTUNITY**

It is the policy of Link Associates to provide services equally to all individuals who meet eligibility requirements regardless of their sex, race, creed, religion, sexual orientation, pregnancy, age, color, national origin, gender identity, physical or mental disability, veteran status, marital status or political affiliation. It is also the policy of Link Associates to employ staff with these same principles. Therefore, all persons served, guardians, family members or advocates for those we serve served must abide by the same principles should they choose services from our agency.

Link Associates realizes that some prejudices can be corrected for the people we support and will eagerly work with both the family and the person served to attempt to resolve such conflicts before discharge is considered.

If the persons served, guardian and/or advocates requests, displays, or engages in any unlawful discrimination or practice that promote such discrimination of our employees that can not be corrected or resolved through agency mediation with both the family and the person served, an agency-initiated discharge will occur.

.....

I have received the Link Associates Policy on Persons served/Guardian/Advocate equal opportunity and have had the opportunity to ask questions or seek clarification. I/we agree to comply with the policy statement.

\_\_\_\_\_  
**Persons served Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Guardian Signature**

**LINK ASSOCIATES**  
**A-9: HEPATITIS B ACKNOWLEDGEMENT**

Hepatitis B is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of infected patients. An estimated 300,000 new cases of Hepatitis B occur per year in the U.S. Most people with Hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. There are an estimated 500,000 - 1,000,000 carriers in the U.S. Most of these people have no symptoms, but continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be associated with the development of liver cancer.

The Vaccine

Recomibvax HB is a non-infectious viral vaccine derived from Hepatitis B surface antigen produced in yeast cells. No plasma is used in the process. It has been extensively tested for safety and efficacy in large scale clinical trials with human subjects. Up to 90% of healthy people who receive three doses of the vaccine achieve protection against Hepatitis B. Persons with immune system abnormalities (hypersensitivity) such as dialysis patients, and those who are sensitive to yeast, should not receive the vaccine.

Full immunization requires three doses of vaccine over a six month period, although some may never build immunity even after three doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical Hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects

The incidence of reported side effects is low. A small percentage of persons (15%) receiving the vaccine may experience tenderness and redness at the site of injection. Low grade fever may occur. Rash, nausea, headache, joint pain, and mild fatigue have also been reported. Few cases of serious effects have been reported with the vaccine. With the older vaccine Heptavax B, rare neurological disorders such as Optic neuritis, myelitis, Guillain--Barre syndrome, and peripheral neuropathy had been noted. These have not been reported with Recombivax HB.

I have read the above information about hepatitis B and the Hepatitis B vaccine and have had an opportunity to ask questions and understand the benefits and risks.

I \_\_\_\_\_ ,  
Name of Person Served)

\_\_\_\_\_ will contact my personal physician for a Hepatitis Panel to determine immunity.

\_\_\_\_\_ will contact my personal physician for administration of the vaccine.  
(required/ group home residents)

\_\_\_\_\_ have had the immunizations and documented the dates accordingly on the medical form.

\_\_\_\_\_ have declined any screening for the disease and/or the immunizations.

\_\_\_\_\_  
Person Served/Parent or Guardian

\_\_\_\_\_  
Date

## C-3: NOTICE OF PRIVACY PRACTICES-PERSONS SERVEDS

This notice describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This facility is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" (PHI) or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact our Privacy Officer: Executive Director, at 515-262-8888.

### Understanding Your Health Record and Information

Each time you are served by our organization, a record of our service is made containing health and financial information. Typically, this record contains information about your condition, the service we provide and payment for the treatment. We may use and/or disclose this information to:

- Plan your care and treatment
- Communicate with other health professionals involved in your care
- Document the care you receive
- Educate health professionals
- Provide information for medical research
- Provide information to public health officials
- Evaluate and improve the care we provide
- Obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- Ensure it is accurate
- Better understand who may access your health information
- Make more informed decisions when authorizing disclosure to others.

### How We May Use and Disclose Protected Health Information About You

The following categories described the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

#### A. Uses and Disclosures for Treatment, Payment and Administrative Operations

1. For Treatment. We may use or disclose health information about you to provide you with services. We may disclose health information about you to doctors, nurses, therapists or other organization personnel in order to coordinate and manage your services. For example, we may need to disclose information to a case manager who is responsible for coordinating your care. We may also disclose your health information among our staff or we may disclose your health information to your primary physician. We may consult with other health care providers and in the process of that consultation share your health information with them.
2. For Payment. We may use or disclose your protected health information (PHI) so that the services you receive are billed to, and payment is collected from, your funders or other interested parties. For example, we may disclose your PHI to permit funders to approve or pay for your services. This may include: making a determination of eligibility for services, reviewing your services, reviewing your services to determine if they were appropriately authorized, reviewing your services for purposes of utilization review, to ensure the appropriateness of your services, or to justify the charges for your services.
3. For Administrative Operations. We may use and disclose PHI about you for our day-to-day administrative operations. These uses and disclosures are necessary to run our organization and make sure that you receive quality services. For example, these activities may include quality reviews, medication reviews, licensing, business planning and development, and general administration activities. We may also combine health information about many individuals to help determine what additional services should be offered, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by the administrative offices for business development and planning, cost management

analyses, insurance claims management, risk management activities, and in developing and testing information systems programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical review, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the organization including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the organization. In limited circumstances, we may disclose your health information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of the person served. We may disclose your age, birth date and general information about you in the organization newsletter, on activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions.

We may also provide your PHI to other service providers or to your funders to assist them in performing their own operations. We will do so only if you have or have had a relationship with the other provider or funder. For example, we may provide information about you to your funder to assist them in their quality assurance activities.

#### Other Allowable Uses of Your Health Information

- Business Associates – There are some services provided in our facilities through contracts with business associates. Examples include outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- Providers – Many services provided to you, as part of your care at our facilities, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g. MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g. Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs, hospice, caregivers, pharmacies, psychologists, LCSW's and suppliers (e.g. prosthetic, orthotics).
- Treatment Alternatives – We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- Health Related Benefits and Services and Reminders – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Fundraising Activities – We may use health information about you to contact you in an effort to raise money as part of fundraising effort. We may disclose health information to a foundation related to the facility so that the foundation may contact you in raising money for the facility. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services from our organization. You have the right to opt out of any use of protected health information for fundraising activities. If you do not want Link Associates, or its foundation, to contact you for fundraising you must notify the Privacy Officer: Executive Director at 515-262-8888.
- Facility Directory – Unless you object, we may include information about you in the facility directory while you are receiving services at Link Associates. This information may include your name, location in the facility, your general condition and your religion. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends, and clergy can visit you in the facility and generally know how you are doing. If you do not want to be included in our directory, or you want to restrict the information we include in the directory, you must notify the Privacy Officer: Executive Director at 515-262-8888.
- Individuals Involved in Your Care or Payment for Your Care – Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. Such information will be directly relevant to that person's involvement in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. In the event of your death, we may disclose information, to those persons who were involved in your care prior to your death, PHI unless doing so is inconsistent with any preference, known to us, expressed by you prior to your death. If there is a family member or personal friend that you do not want to receive information about you, please notify the Privacy Officer: Executive Director at 515-262-8888.
- As Required By Law – We will disclose health information about you when required to do so by federal, state or local law.

- To Avert a Serious Threat to Health or Safety – We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- Organ and Tissue Donation – If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- Proof of Immunization – We may use or disclose immunization information to a school about you: (a) if you are a student or prospective student of the school; (b) the information is limited to proof of immunization; (c) the school is required by State or other law to have the proof of immunization prior to admitting you; and (d) we obtain and document the agreement to the disclosure from either: (1) you, your parent or guardian, or (2) from you if you are an adult or an emancipated minor.
- Victims of Abuse, Neglect or Domestic Violence – We may disclose PHI to a government authority authorized by law to receive reports of abuse, neglect or domestic violence, if we believe you are a victim of abuse, neglect or domestic violence. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by you; or (c) authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims, or, if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.
- Military and Veterans – If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- Research – Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents who received one medication to those who received another, for the same condition. All research projects however are subject to a special approval process. This process evaluates a proposed need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a facility.
- Workers Compensation – We may disclose health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Reporting – Federal and state laws may require or permit the organization to disclose certain health information related to the following:
  - Public Health Risks – We may disclose health information about you for public health purposes including:
    - < Prevention or control of disease, injury or disability
    - < Reporting births and deaths
    - < Reporting child abuse or neglect
    - < Reporting reactions to medications or problems with products
    - < Notifying people of recalls of products
    - < Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
    - < Notifying the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
  - Health Oversight Activities – We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
  - Judicial and Administrative Proceedings – If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement – We may disclose health information when requested by a law enforcement official:
  - < In response to a court order, subpoena, warrant, summons or similar process;
  - < To identify or locate a suspect, fugitive, material witness, or missing person;

- < About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
  - < About a death we believe may be the result of criminal conduct;
  - < About criminal conduct at the Facility; and
  - < In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- Coroners, Medical Examiners and Funeral Directors – We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person to determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
  - National Security and Intelligence Activities – We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.
  - Correctional Institution – Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

#### Other Uses of Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Specifically, without your written authorization we will not use or disclose your health information for the following purposes: 1. Most uses and disclosures of psychotherapy notes; 2. Uses or disclosures for marketing purposes; and 3. Uses and disclosures that involve the sale of your protected health information.

#### Your Rights Regarding Health Information About You

Although your health record is the property of the organization, the information belongs to you. You have the following rights regarding your health information:

A. Right to inspect and copy.

You have the right to request to inspect or copy health information used to make decisions about your care - whether they are decisions about your services or payment of your care. You must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge you a fee for the cost of copying, mailing and supplies associated with your request. We may deny your request to inspect or copy your health information in certain limited circumstances, such as psychotherapy notes or if the information is compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request may be reviewed. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer. If your health information is kept electronically, you have the right to receive an electronic copy of your health information subject to the restrictions set forth above.

B. Right to amend.

For as long as we keep records about you, you have the right to request us to amend any health information used to make decisions about your care - whether they are decisions about your service or payment of your care. To request an amendment, you must submit a written request to our Privacy Officer and tell us why you believe the information is incorrect or inaccurate. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend health information that:

- < was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;
- < is not part of the health information we maintain to make decisions about your care;
- < is not part of the health information that you would be permitted to inspect or copy; or
- < is accurate and complete.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request. If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the health information that is the subject of your request.

C. Right to an accounting of disclosures.

You have the right to request that we provide you with an accounting or list of disclosures we have made of your health information. This list will not include certain disclosures of your health information, for example, those we have made for purposes of service, payment and health care operations; disclosure made to you or authorized by you; disclosures that are incident to another use or disclosure, etc. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. The request must state the time period for which you wish to receive an accounting. This time period should not be longer than six years and not include dates before April 14, 2003. The first accounting you request within a twelve month period will be free. For additional requests during the same 12 month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge and you may choose to withdraw or modify your request before you incur any costs.

In addition to your right to an accounting of disclosures, we have a legal obligation to notify you if your protected health information is affected by any security breach that may occur

D. Right to request restrictions.

You have the right to request a restriction on the health information we use or disclose about you. You may also ask that any part or all of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency care. You must submit your request in writing to the Privacy Officer and list: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and (c) to whom you want the limits to apply. The above notwithstanding, you have the right to request a restriction of disclosures to a health plan for payment or health care operations regarding any services you have paid for, in full, out of pocket and we are required to honor that request.

E. Right to request confidential communications.

You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only at work or by e-mail. To request such a confidential communication, you must make your request in writing to the Privacy Officer. We will accommodate all reasonable requests. You do not need to give us a reason for the request; but your request must specify how or where you wish to be contacted.

F. Right to a paper copy of this notice.

You have the right to obtain a paper copy of this Notice of Privacy Practices. You may request a copy at any time by contacting the Privacy Officer. A copy of the Notice of Privacy Practices is on our web site at: [linkassociates.org](http://linkassociates.org).

#### Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at our primary business office and at each site where we provide services. You may also obtain a copy of the current Notice of Privacy Practices by calling us at 515-262-8888 and requesting a copy be sent to you in the mail or by asking for one any time you are at our business office or service sites.

#### Complaints



If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. Our Privacy Officer will assist you with writing your complaint, if you request such assistance. We will not retaliate against you for filing a complaint. To file a complaint with us, contact our Privacy Officer: Executive Director by telephone at 515-262-8888 or by mail at Link Associates, 1452 29<sup>th</sup> Street, West Des Moines, IA 50266 ATTN: Executive Director.

ACKNOWLEDGMENT OF  
RECEIPT OF  
NOTICE OF PRIVACY PRACTICE

\_\_\_\_\_  
NAME OF PERSON SERVED

I, \_\_\_\_\_, do hereby acknowledge receipt of a copy of the Notice of Privacy Practice, Policy and Procedure.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

\_\_\_\_\_  
Signature of personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal authority of personal representative