Epilepsy Society of Southern New York, Inc.

Chris McCarthy Summer Camp Scholarship Information Sheet

Mail or fax this completed application to be in our office by 11:59 pm on May 15, 2011

Epilepsy Society of Southern New York (ESSNY)
450 West Nyack Road, Suite 9
West Nyack, New York 10994
845-627-0629 (fax)

Funds are limited!

Eligibility Criteria: This scholarship is available to children:

- who are ages 5 to 18 (as of May 31, 2011) and
- have been diagnosed with a seizure disorder and
- need financial assistance to attend summer camp and
- who reside within New York's Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster or Westchester counties.

Selection Criteria: The Chris McCarthy Scholarship Program Review Board will award scholarships, based on:

- Submission of a complete application by the deadline and
- Adherence to the above eligibility criteria and
- Financial need and persuasiveness of the Parent's Statement and
- Financial constraints as determined by the Chris McCarthy Scholarship Program Review Board.

A complete application must include the following:

- A written statement of a diagnosis of epilepsy from the child's physician.
- The signed Chris McCarthy Summer Camp Scholarship Application with Parent's Statement attached and all questions answered (Application Page #1 attached).
- The signed ESSNY – Authorization to Release Protected Health Information (Application Page #2 attached).
- Complete copies of the parents 2009 or 2010 federal tax returns.
- The signed Acknowledgement page from ESSNY's Notice of Privacy Practices (Privacy Notice Page 6 of 6 attached). Please keep the Notice of Privacy Practices (Pages 1 – 5) for your information.

Completed applications must be received in our offices by the deadline of 11:59 pm on May 15, 2011 (faxes will be accepted).

It is the policy of ESSNY to provide equal opportunity to all people without regard to race, color, creed, sex, gender, genetics, national origin or disability. The camp choice is that of the parent however, ESSNY reserves the right to not provide support to any camp which discriminates or otherwise professes qualities not in line with ESSNY's mission/beliefs.

The decisions of the Chris McCarthy Scholarship Committee are final.

Chris McCarthy Summer Camp Scholarship Application

Child's Name: ______________________________ Date of Birth: ________ Age:___

Parent/Guardian Name: ____
Address: ____
______________________________ County: __________________

Phone: ______________ Email: ______________

Parent's Statement:
This is an important part of the application. The committee wants to get to know your child and how this scholarship may help him or her. As funds are very limited this year consideration will be given to those most in need. Please use a separate piece of paper and address the following:

- Describe your child.
- How has epilepsy affected his or her life?
- What going to camp means to your child and how your child would benefit.
- Describe your financial situation. Explain why attendance at this camp would be a financial hardship for your family and how you will pay for the rest of the camp tuition. You must include copies of your 2009 or 2010 federal tax returns (you should black our social security numbers). If your child is OPWDD eligible please indicate if you have applied to the local DDSO for a scholarship and the outcome of that application. Indicate any extenuating circumstances. Your statement should include any information that might be helpful such as recent unemployment, poor health or excessive medical bills. As funds are very limited this year consideration will be given to those most in need.
- Indicate all other scholarships you have applied for and the outcome of those applications.

Camp Information:
Name/Address: ______________________________ Day Camp or Sleep-away?

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____

Cost for one week at this camp: ______________________________

Number of weeks you would like your child to attend camp: ________________________

Total cost you will be charged for attendance at this camp: _________________________

Certification:
I understand that if my child is selected for this scholarship, the choice of camp he/she will attend is entirely mine and that neither the Epilepsy Society of Southern New York (ESSNY) nor the Chris McCarthy Scholarship Program bear **any** responsibility for my child's experience at that camp.

I agree that if my child is selected I will provide written verification that my child has been accepted to a camp, including the name and address of the camp and the cost. My signature below verifies that my child meets the eligibility criteria stated in this application including the financial hardship criteria.

I understand that this application will be reviewed and evaluated by members of ESSNY and the Chris McCarthy Scholarship Program Review Board.

____________________________________ ___________
Signature of Parent or Guardian: Date:

ESSNY - Authorization to Release Protected Health Information

This document gives the Epilepsy Society of Southern New York (ESSNY) permission to use your protected health information for the purpose indicated below. Please read it carefully before signing.

- You may revoke this authorization at any time by writing to ESSNY at 450 West Nyack Road, Suite 9, West Nyack, New York, 10994. However, you must understand that if you revoke the authorization, it will be applicable to all future uses and disclosures, but cannot 'take back' any use or disclosure already completed while the authorization was in effect.
- ESSNY may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization except for (1) research-related treatment requiring authorization, (2) enrollment or eligibility for benefits under a health plan requiring an authorization (not of psychotherapy notes) to determine risk or eligibility or for (3) the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for disclosure of the protected health information to such third party.
- The potential exists for the information disclosed pursuant to this authorization to be further disclosed by the recipient and thus, may no longer be protected.
- You have the right to get a copy of this authorization if ESSNY seeks the authorization from you.

Description of the protected health information to be used and disclosed:

Health Information provided on the Chris McCarthy Scholarship Application and that provided by any physician in support of the application.

Who at ESSNY has authorization to make this disclosure?

ESSNY staff working on the scholarship application process.

Who is the recipient of this protected health information?

The Chris McCarthy Scholarship Program Review Board, which is composed of ESSNY staff members and members of Chris McCarthy's family and friends and if a scholarship is awarded, a check indicating the Chris McCarthy Fund and the Epilepsy Society of Southern NY will be mailed to the camp.

What is the purpose of the requested use or disclosure?

To determine eligibility for the scholarship, to evaluate the application for a scholarship and to process the distribution of scholarship funds.

The date this authorization expires (must be reasonable): **November 1, 2012**

Child's Name (print) ______________________________

Parent's or Personal Representative Signature ______________________________

Date ________________________

Relationship to child of person Completing this form ____________________________

Privacy Notice

Epilepsy Society of Southern New York, Inc.

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

This notice is effective as of **April 14, 2003**. If you have any questions about this notice, please contact the ESSNY staff person who provides you service or call the Privacy Officer at 845-627-0627.

Our Privacy Commitment to You

At the Epilepsy Society of Southern New York (hereafter referred to as ESSNY) we understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information to assure quality services for you. This notice tells you how ESSNY uses and discloses information about you. It describes your rights and what our responsibilities are concerning information about you.

Who will follow this notice:

All people who work for ESSNY in all areas including, but not limited to, residential habilitation services, vocational services, service coordination services, educational services, counseling services as well as in our administrative offices will follow this notice. This includes all employees, contractors, our Board of Directors, Professional Advisory Board, Consumer Advisory Council, and volunteers/interns who provide services to you either directly or indirectly.

What information is protected:

All information we create or keep that relates to your health care and/or treatment, including your name, address, birth date, social security number, your medical information, your individualized service plan and other information about your care in our programs will be protected.

ESSNY Responsibilities Regarding Your Health Information

ESSNY is required by law to:

- Maintain the privacy of your protected health information
- Give you this notice of our legal duties and practices concerning the health information we have about you. If you received this notice electronically, you have the right to receive a paper copy as well. You may ask an ESSNY staff member to give you a paper copy or you may call (845) 627-0627 to request one be mailed out to you.
- Follow the rules in this notice. ESSNY will use or share information about you only with your permission except for the reasons explained in this notice.

Your Health/Clinical Information Rights

You have the following rights concerning your health/clinical information. When we use the word "you" in this notice we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may be your guardian, involved parent, spouse, adult child, or your advocate.

- You generally have a right to see or inspect your health/clinical information and obtain a copy. Your request must be in writing and there may be a fee associated with copying and mailing. Some exceptions apply, such as psychotherapy notes, records regarding incident reports and investigations and information compiled for use in court or administrative proceedings. If we deny your request to see your health/clinical information, you have the right to request a review of that denial. A professional chosen by ESSNY who was not involved in denying your request will review the record and decide if you may have access to the record.
- You have the right to ask ESSNY to change or amend your health/clinical information that you believe is incorrect or incomplete. Your request must be in writing and must state a reason for the change. We may deny your request in some cases, for example, if the record was not created by ESSNY or if after reviewing your request, we believe the record is accurate and complete.
- You have the right to request a list of the disclosures ESSNY has made of your health/clinical information. Your request must be in writing. We will not, however, keep or provide you with a list of certain disclosures, for example, disclosures made for treatment, payment, and health care operations, or disclosures made to you or made to others with your permission.
- You have the right to request further restrictions on how ESSNY uses or disclosures your health information related to treatment, payment and health care operations as well as disclosures made to involved family/friends. Your request must be in writing. ESSNY, however, is not required to agree to your request.
- You have the right to request that ESSNY communicates with you in a way that will help you keep your information confidential such as by alternative means or at alternative locations. Your request must be in writing. ESSNY will accommodate all reasonable requests.

To request access to your health/clinical information or to request any of the rights listed here, you may contact the ESSNY staff person providing service to you or you may contact the Privacy Officer of ESSNY at 450 West Nyack Road, Suite 9, West Nyack, New York 10994 or at (845) 627-0627.

How ESSNY Uses and Discloses Health Care Information

Uses and Disclosures For Treatment, Payment and Healthcare Operations

ESSNY may use and disclose health/clinical information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- Treatment: ESSNY will use your health/clinical information to provide you with treatment and services. We may disclose health/clinical information to doctors, nurses, psychologists, social workers, qualified mental retardation professionals, developmental aides, and other ESSNY personnel, contractors, volunteers or interns who are involved in providing you care. For example, involved staff may discuss your health/clinical information to develop and carry out your individualized service plan (ISP). Other ESSNY staff may share your health/clinical information to coordinate different services you need, such as medical tests, respite care and transportation. We may also need to disclose your health/clinical information to your service coordinator and other providers outside of ESSNY who are responsible for providing you with the services identified in your ISP or to obtain new services for you. ESSNY 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.
- Payment: ESSNY will use your health/clinical information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid or other government agencies. For example, we may need to provide the NYS Department of Health (Medicaid) with information about the services you received from ESSNY or through a waiver program so they will pay us for the services. Also, we may disclose your health/clinical information to the US Social Security Administration, or the Department of Health to determine your eligibility for coverage or your ability to pay for services. These disclosures may be part of the regulations mandated for the services you receive under Medicaid guidelines.
- Health Care Operations: ESSNY will use and disclose health/clinical information in order to conduct our normal business operations. These uses and disclosures are necessary to operate our programs and to make sure all consumers receive appropriate, quality care. For example, we may use health/clinical information for quality improvement to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information for on-the-job training. We will share your health/clinical information for such administrative operations as obtaining legal services, conducting fiscal audits, resolving complaints and for fraud and abuse detection and compliance. We may also disclose health/clinical information to our business associates who need access to the information to perform administrative or professional services on our behalf.
  We may contact you with regard to our fundraising events.

Other Uses and Disclosures that Do Not Require your Authorization

In addition to treatment, payment and health care operations, ESSNY will use your health/clinical information without your permission for the following reasons:

- When we are required to do so by federal or state law;
- For public health reasons, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with products and to notify people who may have been exposed to a disease or are at risk of spreading the disease;
- To report domestic violence and adult abuse or neglect to government authorities if you agree or if we feel this is necessary to prevent serious harm;
- For health oversight activities, including audits, investigations, surveys, inspections and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are subject;
- For judicial and administrative proceedings, including hearings and disputes. If you or your estate are involved in a court or administrative proceeding we will disclose health/clinical information if the judge or presiding officer orders us to share the information;

- For law enforcement purposes, in response to a subpoena, or other legal process, to identify a suspect or witness or missing person, regarding a victim of a crime, a death, criminal conduct and in emergency circumstances to report a crime;
- Upon your death, to coroners or medical examiners for identification purposes or to determine cause of death, and to funeral directors to allow them to carry out their duties;
- To organ procurement organizations to accomplish cadaver, eye, tissue, or organ donations in compliance with state law;
- For research purposes when you have agreed to participate in the research or when an Institutional Review Board or Privacy Committee has approved the use of the health/clinical information for the research purposes;
- To prevent or lessen a serious and imminent threat to your health and safety or someone else's. In an emergency situation and/or in the event of harm to yourself or others we may disclose health/clinical information to avert or lessen a serious situation.
- To authorized federal officials for intelligence and other national security activities authorized by law or to provide protective services to the President and other officials;
- To correctional institutions or law enforcement officials if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution;
- To governmental agencies that administer public benefits if necessary to coordinate the covered functions of the programs;
- To the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries or illness without regard to fault.

Uses and Disclosures that Require Your Agreement or Authorization

ESSNY may disclose health/clinical information to the following persons if we tell you we are going to use or disclose it and you agree or do not object.

- To family members and personal representatives who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location; or
- To disaster relief organizations that need to notify your family about your condition and locations should a disaster occur.

Authorization Required For all Other Uses and Disclosures

For all types of uses and disclosures not described in this Notice, ESSNY will use or disclose health/clinical information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are always required for use and disclosure of psychotherapy notes and for marketing purposes. Note: If you cannot give permission due to an emergency, ESSNY may release health/clinical information in your best interest. We must tell you as soon as possible after releasing the information.

You may revoke your authorization at any time, in writing. If you revoke your authorization in writing we will no longer use or disclose your health/clinical information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain health/clinical information that indicates the services we have provided to you.

Changes to This Notice

ESSNY reserves the right to change this notice at any time. We reserve the right to make the revised notice effective for all health/clinical information we already have about you as well as any health/clinical information we receive in the future. The effective date of this notice and any revised notice may be found on the bottom of each page. Any revised notice will be posted on our website at www.epiinfo.org and posted in all our offices. You may always get a copy of our current notice by asking your ESSNY staff person who provides you service or by calling (845) 627-0627.

Use of E-Mail

You may wish to communicate with the staff at ESSNY via e-mail. This is possible however you must be aware that such communication is not secure and could be intercepted by a third party. Hence, ESSNY cannot and will not take any responsibility for the security and privacy of information you transmit in this manner. For your protection, you should avoid sending any identifying information, such as social security number, through e-mail. ESSNY staff will not send any protected health information via an e-mail.

Complaints

If you believe your privacy rights have been violated you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact Anna Vero, Privacy Officer and Executive Director at ESSNY's main offices at 450 West Nyack Road, Suite 9, West Nyack, New York 10994 or call (845) 627-0627. All complaints must be submitted in writing. No one will retaliate or take action against you for filing a complaint.

Further Information

If you have any questions with regard to our Privacy Policy or if you would like further information, please contact the ESSNY worker who is your service provider or call the Privacy Officer of ESSNY at (845) 627-0627.

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Acknowledgement of Receipt of Privacy Notice

(Please keep the attached Privacy Notice for your records)

I have received a copy of the Notice of Privacy Practices of the Epilepsy Society of Southern New York dated April 14, 2003.

I acknowledge that I have been provided with a copy of this document and have therefore been advised of how medical information about me may be used and disclosed by ESSNY.

If I have any questions with regard to this notice I understand that I can approach the ESSNY staff person who provides services to me or I can call (845) 627-0627.

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Signature of Parent/Guardian or Personal Representative

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Print Name of Child

____

Date

____

Description of Personal Representative's Authority

Please mail this form to:

Epilepsy Society of Southern New York
450 West Nyack Road Suite 9
West Nyack, New York 10994
Or fax: (845) 627 – 0629