BrightView

Phone: 833.510.4357 Fax: 833.510.4329 brightviewhealth.com

WELCOME

It takes real courage to face your addiction. The BrightView Health staff is here to help guide, support, and encourage you on your journey. Our experienced team of caring and trusted professionals work together to ensure that each patient is given the best possible tools and support to successfully reach their goals. Everyone deserves the opportunity to regain control of their life and return to a productive and meaningful way of living.

Addiction is a chronic, progressive, and potentially fatal disease for which there are effective medical treatments. Given this, BrightView Health is committed to addressing the unique needs of each patient, their family, and the communities we serve. We adhere to the medical model of addiction, recognizing that it needs to be treated on the biological, psychological, and social levels. The goal of life-long remission is the target, and the use of ongoing programs to maintain recovery is necessary. Our individualized treatment plans focus on these issues and are designed to ensure the best possible outcome for each patient.

BrightView's program provides a framework for each patient to apply addiction recovery education to their personal history of substance use. Because addiction not only affects the lives of individuals with the disease but also those around them, BrightView Health offers education for both the patient and the family about the facts of addiction and the consequences of leaving it untreated. Our staff will assist patients in developing recovery skills and help build other tools to address the complex behaviors of addiction. Individual counselors will provide comprehensive case management services tailored to each patient's needs. And for those struggling to obtain stable recovery, we can provide crisis intervention when needed. In addition to our comprehensive services, BrightView Health advocates for community peer-group involvement and encourages patients to utilize these sober support networks.

Please let us know if there is anything we can do to assist in your recovery. Your success is our success...we want to do everything in our power to assist you in reaching your goals.

Sincerely,

Corey Waller, MD, MS
Chief Medical Officer

WHO WE ARE

BrightView was established to address a significant area of need for medical care that has been created by the current prescription drug/opiate epidemic that is plaguing our nation. This will be accomplished by providing those who suffer under the burden of opiate addiction and other chemical dependencies the chance to recover in a place where they are welcomed, encouraged, and respected. Through the use of medication-assisted treatment and in conjunction with psychological and social services, we will provide those suffering from addiction to receive the necessary assistance to reach their goals.

Our Core Values:

- **RESPECT** - For our patients, our employees, and our community
- **RESPONSIBILITY** – By patients and employees, for the decisions we make and the actions we take
- **ACCOUNTABILITY** - To our patients and their families, and to our colleagues
- **EXCELLENCE** - In every task we perform, most importantly the care we provide

Our Standards of Care & Commitment:

- **COMMUNITY** - Offering the community the best possible medical and mental health services is our goal and commitment.
- **SAFETY** - Providing our patients the safest level of care and treatment available.
- **SERVICE** - Being stewards of the community by delivering high quality medical and mental health care in a safe, cost-effective manner.
- **KNOWLEDGE** - Providing treatment based on the latest scientific and clinical data. Being a leader and innovator in patient treatment and care.
- **ETHICS** - Acting with integrity and honesty. Upholding professional ethical standards and ensuring that the patient always comes first.
- **TEAMWORK** - Recognizing the contributions and resources of every member of our team and realizing that each member is essential to achieving our goals.

BrightView

ACKNOWLEDGEMENT OF PATIENT EDUCATION & MATERIALS

I acknowledge I have received education and/or materials on the following items and have been afforded the opportunity to ask any questions/clarifications:

- Patient orientation to Program and Premises
- Hours of operation and dispensing
- Patient Rights and BrightView Grievance Procedures
- BrightView's Notice of Privacy Practices and written summary of Federal confidentiality laws
- BrightView's guidelines and rules/regulations
- BrightView patient fees and billing procedures
- Financial Assistance
- Treatment options, including withdrawal management
- Benefits and risks associated with each treatment option
- Addiction treatment and pregnancy, including Neonatal Abstinence Syndrome and the risk and benefits of taking buprenorphine while pregnant, if applicable[1]
- Resources for parenting/parenting skills
- Use of voluntary long-acting reversible contraception, if applicable
- Risk of exposure, prevention & treatment of chronic viral diseases including HIV, Hepatitis, Tuberculosis, and sexually transmitted infections
- Expected therapeutic benefits and adverse effects of treatment medication
- Risk for overdose, including drug interactions with the central nervous system depressants
- Risk for overdose, including relapse after a period of abstinence from opioids
- Overdose prevention and reversal agents
- The disease of addiction
- Information regarding the patient's diagnosis
- The effects of alcohol and other drug abuse
- Family issues related to substance use disorder
- Relapse prevention
- Noncompliance and discharge procedures
- Potential drug interactions
- Toxicology testing and Phlebotomy Services Procedures
- Take Home Medications
- Crisis Services
- Ohio Automated Rx Reporting System" (OARRS).
- Medication Adherence Policy
- Consent for Alcohol or Drug Assessment and Treatment
- Central Registry Authorization
- Telemedicine Consent
- Text Consent

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

[1] For all female patients of child-bearing age and potential

BrightView

PATIENT CONFIDENTIALITY AGREEMENT

Dear Patient:

BrightView is a confidential counseling service. BrightView is bound by State and Federal laws of confidentiality of both mental health and substance abuse services. Once an appointment is made, no information can be disclosed to anyone without your written permission on a Release of Information Form. When you come to your first appointment, the policy on confidentiality and your rights as a patient will be discussed in detail.

What this means for you:

BrightView will not share your information with a third-party without your written consent. BrightView staff will work diligently to protect information provided in counseling sessions.

- Confidentiality does not apply to cases of reported or suspected abuse/neglect of children or the elderly
- Confidentiality does not apply to cases of potential harm to self or others
- In cases of medical emergency, information may be shared with medical personnel
- On rare occasions, there will be a request by a court for your records. BrightView may be required to share that information. BrightView will make an effort to discuss with you any instances where your confidentiality may be breached. BrightView will make an effort to share only information which is deemed legally necessary.
- Information must be shared with your insurance provider, should you choose to use insurance. This information may be seen by various employees of the insurance provider. There is also potential that certain members of your employer may see this information.

Your Responsibility:

It is also your responsibility to protect the confidentiality of other patients. Do not discuss other patients (names, diagnoses, etc.) outside of group therapy sessions. In order to protect your confidentiality, all patients must agree to honor this policy as well. If you are found to have breached this confidentiality policy, you may be discharged from the program.

By signing this form, you acknowledge that there may be instances where BrightView must share your confidential information and you recognize that you are responsible for helping maintain the confidentiality of other patients. Discussing other patients outside of the group sessions may result in your termination from the program.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

BRIGHTVIEW, LLC
NOTICE OF PRIVACY PRACTICES

Effective Date: 3/4/2019
Publication Date: 3/4/2019

Our Privacy Policy
BrightView is committed to providing you with quality behavioral healthcare services. An important part of that commitment is protecting your health information according to applicable law. This notice ("Notice of Privacy Practices") describes your rights and our duties under Federal Law. Protected health information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition; the provision of healthcare services; or the past, present or future payment for the provision of healthcare services to you.

Our Duties
We are required by law to maintain the privacy of your PHI, provide you with notice of our legal duties and privacy practices with respect to your PHI, and to notify you following a breach of unsecured PHI related to you. We are required to abide by the terms of this Notice of Privacy Practices. This Notice of Privacy Practices is effective as of the date listed on the first page of this Notice of Privacy Practices. This Notice of Privacy Practices will remain in effect until it is revised. We are required to modify this Notice of Privacy Practices when there are material changes to your rights, our duties, or other practices contained herein.

We reserve the right to change our privacy policy and practices and the terms of this Notice of Privacy Practices, consistent with applicable law and our current business processes, at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Notification of revisions of this Notice of Privacy Practices will be provided as follows upon request, electronically via our website or via other electronic means, or as posted in our place of business.

In addition to the above, we have a duty to respond to your requests (e.g. those corresponding to your rights) in a timely and appropriate manner. We support and value your right to privacy and are committed to maintaining reasonable and appropriate safeguards for your PHI.

Confidentiality of Substance Use Disorder Patient Records
The confidentiality of substance use disorder patient records maintained by us is also protected by Federal law and regulations. Generally, the law and regulations provide that:

1. We may not disclose to a person outside the treatment center that you are present in the treatment center, that you are a patient of the treatment center, or any information identifying you as having or having had a substance use disorder.
2. Except in specific, limited circumstances described in the federal regulations, we will not disclose any of your substance use disorder patient information to any person outside of the treatment center unless you consent in writing (as discussed below in "Authorization to use or Disclose Confidential Information").

3. Information related to your commission of a crime on the premises of the treatment center or against personnel of the treatment center is *not* protected; and
4. Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities is *not* protected.

See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.

Violation of the federal law and regulations by the treatment center is a crime. Suspected violations may be reported to United States Attorney for the judicial district in which the violation occurs as well as to the Substance Abuse and Mental Health Services (SAMHSA) office responsible for oversight of the treatment center.

Uses and Disclosures

Uses and disclosures of your PHI may be permitted, required, or authorized. The following categories describe various ways that we use and disclose PHI.

Among BrightView Personnel: We may use or disclose information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse, provided such communication is (i) within the treatment center; or (ii) between the treatment center and BrightView. For example, our staff, including doctors, nurses, and clinicians, will use your PHI to provide your treatment care. Your PHI may be used in connection with billing statements we send you and in connection with tracking charges and credits to your account. Your PHI will be used to check for eligibility for insurance coverage and prepare claims for your insurance company where appropriate. We may use and disclose your PHI to conduct our healthcare business and to perform functions associated with our business activities, including accreditation and licensing.

Secretary of Health and Human Services: We are required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rules.

Business Associates: We may disclose your PHI to Business Associates that are contracted by us to perform services on our behalf which may involve receipt, use or disclose of your PHI. All of our Business Associates must agree to:

(i) protect the privacy of your PHI; (ii) use and disclose the information only for the purposes for which the Business Associate was engaged; (iii) be bound by 42 CFR Part 2; and (iv) if necessary, resist in judicial proceedings any efforts to obtain access to patient records except as permitted by law.

Crimes on premises: We may disclose to law enforcement officers information that is directly related to the commission of a crime on the premises or against our personnel or to a threat to commit such a crime.

Reports of suspected child abuse and neglect: We may disclose information required to report under state law incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, we may not disclose the original patient records, including for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect, without consent.

Court order: We may disclose information required by a court order, provided certain regulatory requirements are met.
Emergency situations: We may disclose information to medical personnel for the purpose of treating you in an emergency.
Research: We may use and disclose your information for research if certain requirements are met, such as approval by an Institutional Review Board.
Audit and Evaluation Activities: We may disclose your information to persons conducting certain audit and evaluation activities, provided the person agrees to certain restrictions on disclosure of information.
Reporting of Death: We may disclose your information related to cause of death to a public health authority that is authorized to receive such information.
Central Registry: By enrolling for Medication Assisted Treatment Services at this facility, your health information may be released to the Central Registry within the State of Ohio.

This information will be viewed by staff at any legally licensed Medication Assisted Treatment facility in the United States when you present and request enrollment and/or emergency medication services. In addition, the above described information could be released to any duly appointed State Opioid Treatment Authority and their staff for the purposes of monitoring dual enrollment verifications.

The above information will be maintained in the LightHouse Software Systems, LLC ("LHSS") central registry system for the purposes of your participation in a Central Registry within the State of Ohio, and also for the purpose of aiding your care in times of disaster and preventing multiple opioid treatment program enrollments. LHSS is located at 2120 Placentia Ave, Costa Mesa, CA. The central registry will contain presently prescribed medication(s) used for your treatment and your schedule of dosing records. This information will reside in the LHSS Central Registry while you remain a patient at this treatment facility and will be available to staff where you may present for admission or emergency medication services for up to 60 days after your discharge from treatment at this location. Your name will be encrypted in the LHSS Central Registry system database with technology that meets HIPAA compliance requirements.

Authorization to use or disclose PHI
Other than as stated above, we will not use or disclose your PHI other than with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI unless you have signed an authorization. If you or your representative authorizes us to use or disclose your PHI, you may revoke that authorization in writing at any time to stop future uses or disclosures. We will honor oral revocations upon authenticating your identity until a written revocation is obtained. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Patient/Client Rights
The following are the rights that you have regarding PHI that we maintain about you. Information regarding how to exercise those rights is also provided. Protecting your PHI is an important part

of the services we provide you. We want to ensure that you have access to your PHI when you need it and that you clearly understand your rights as described below.

Right to Notice
You have the right to adequate notice of the uses and disclosures of your PHI, and our duties and responsibilities regarding same, as provided for herein. You have the right to request both a paper and electronic copy of this Notice. You may ask us to provide a copy of this notice at any time. You may obtain this notice on our website at www.americanaddictioncenters.org or from facility staff or our Privacy Official.

Right of Access to Inspect and Copy
You have the right to access, inspect and obtain a copy of your PHI for as long as we maintain it as required by law. This right may be restricted only in certain limited circumstances as dictated by applicable law. All requests for access to your PHI must be made in writing. Under a limited set of circumstances, we may deny your request. Any denial of a request to access will be communicated to you in writing. If you are denied access to your PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by BrightView will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the decision made by the designated professional. If you are further denied, you have a right to have a denial reviewed by a licensed third-party healthcare professional (i.e. one not affiliated with us). We will comply with the decision made by the designated professional.
We may charge a reasonable, cost-based fee for the copying and/or mailing process of your request. As to PHI which may be maintained in electronic form and format, you may request a copy to which you are otherwise entitled in that electronic form and format if it is readily producible, but if not, then in any readable form and format as we may agree (e.g. PDF). Your request may also include transmittal directions to another individual or entity.

Right to Amend
If you believe the PHI we have about you is incorrect or incomplete, you have the right to request that we amend your PHI for as long as it is maintained by us. The request must be made in writing, and you must provide a reason to support the requested amendment. Under certain circumstances we may deny your request to amend, including but not limited to, when the PHI: 1. was not created by us; 2. is excluded from access and inspection under applicable law; or 3. is accurate and complete. If we deny amendment, we will provide the rationale for denial to you in writing. You may write a statement of disagreement if your request is denied. This statement will be maintained as part of your PHI and will be included with any disclosure. If we accept the amendment, we will work with you to identify other healthcare stakeholders that require notification and provide the notification.

Right to Request an Accounting of Disclosures
We are required to create and maintain an accounting (list) of certain disclosures we make of your PHI. You have the right to request a copy of such an accounting during a time period specified by applicable law prior to the date on which the accounting is requested (up to six years). You must make any request for an accounting in writing.
We are not required by law to record certain types of disclosures (such as disclosures made

pursuant to an authorization signed by you), and a listing of these disclosures will not be provided. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the fee to be charged (if any) at the time of the request.

Right to Request Restrictions
You have the right to request restrictions or limitations on how we use and disclose your PHI for treatment, payment and operations. We are not required to agree to restrictions for treatment, payment and healthcare operations except in limited circumstances as described below. This request must be in writing. If we do agree to the restriction, we will comply with restriction going forward, unless you take affirmative steps to revoke it or we believe, in our professional judgment, that an emergency warrants circumventing the restriction in order to provide the appropriate care or unless the use or disclosure is otherwise permitted by law. In rare circumstances, we reserve the right to terminate a restriction that we have previously agreed to, but only after providing you notice of termination.

Out-of-Pocket Payments
If you have paid out-of-pocket (or in other words, you or someone besides your health plan has paid for your care) in full for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations, and we are required by law to honor that request unless affirmatively terminated by you in writing and when the disclosures are not required by law. This request must be made in writing.

Right to Confidential Communications
You have the right to request that we communicate with you about your PHI and health matters by alternative means or alternative locations. Your request must be made in writing and must specify the alternative means or location. We will accommodate all reasonable requests consistent with our duty to ensure that your PHI is appropriately protected.

Right to Notification of a Breach
You have the right to be notified if we (or one of our Business Associates) discover a breach involving unsecured PHI.

Right to Voice Concerns
You have the right to file a complaint in writing with us or with the U.S. Department of Health and Human Services if you believe we have violated your privacy rights. Any complaints to us should be made in writing to our Privacy Official at the address listed below. ***We will not retaliate against you for filing a complaint.***

Questions, Requests for Information and Complaints
For questions, requests for information, more information about our privacy policy or concerns, please contact us. Our company Privacy Official can be contacted at:

BrightView
Attn: Privacy Officer
4600 Montgomery Road, Ste. 4000
Cincinnati, OH 45212
513.834.7063

We support your right to privacy of your protected health information. You will not be retaliated against in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you believe your rights have been violated and would like to submit a complaint directly to the U.S. Department of Health & Human Services, then you may submit a formal written complaint to the following address:

U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775
OCRMail@hhs.gov
https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Patient Signed Consent
I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Name: _____

Patient/Parent/Guardian Signature: _____

Date: _____

BrightView

UNDERSTANDING THE DISEASE OF ADDICTION

What Causes a Person to Become Addicted?

Nobody starts out intending to develop an addiction, but many people get caught in its snare. Consider the latest government statistics—almost one in 10—are addicted to alcohol or other drugs. Today, we recognize addiction as a chronic disease that changes both brain structure and function. Just as cardiovascular disease damages the heart and diabetes impairs the pancreas, addiction is a alters and disrupts the normal function of the brain. Although breaking an addiction can be challenging, it can be done.

How is addiction a chronic disease of the brain?

Our brains have specific areas that help us identify everything from what we need to survive to the things that are important to us and bring us pleasure. These areas have the ability to override "rational thinking" to make sure we attain what we need to stay alive or we pursue our greatest desires.

Addiction, in effect, hijacks these systems so that the drugs are perceived to be necessary for survival or even more important to tend to than our family and friends.

Drugs actually alter and adapt the structure and systems of the brain to the point that these substances become necessary to ensure normal brain function. These alterations eventually lead to intense cravings with strong, intrusive, and compulsive thoughts and urges to obtain drugs. Even after "detoxing" off of a substance the brain alterations remain- leaving a "sober" brain still under constant attack from the brain that craves and demand these substances.

How do you treat the disease of addiction?

There is hope in recovery from addiction. Recovery from addiction is reversing, diminishing, and coping with these brain adaptations. In some cases, medication can improve treatment outcomes. In most cases, the combination of therapy and ongoing care medical management provides the best results. Addiction professionals and persons in recovery know the hope that is found in recovery.

Recovery is available even to persons who may not at first be able to perceive this hope.

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AN OVERVIEW OF BRIGHTVIEW'S LEVELS OF CARE AND TREATMENT STAGES

Treatment is provided at various levels and is based on the medical and psychosocial needs of each patient. These levels include Intensive Outpatient, Outpatient, and Aftercare. General program length is between 18-24 months. Provider Visit and therapy frequency is individualized and at the discretion of the treatment team.

STAGE 1: ASSESSMENT, INTAKE, AND INDUCTION

Clinical Team: In conjunction with the medical team, assessments are performed to determine the level of treatment needs and appropriateness for treatment. Case management will also begin to coordinate care with outside providers and key individuals in the patient's environment. Additionally, the clinical team begins to place appropriate referrals to address overall physical, mental, and social health.

Medical Team: Once a patient is determined to be appropriate for admission to the program, medical induction is focused on optimal medication utilization to address withdrawal and ongoing maintenance treatment for identified substance use disorders. This is typically done over 2 days with observed dosing. Pharmacologic interventions focused on increasing the success of overall recover is frequently referred to as Medication Assisted Treatment or MAT.

STAGE 2: STABILIZATION AND MAINTENANCE

Clinical Team: The clinical team assists and motivates individuals to achieve abstinence, wellness and recovery by providing structured treatment services in line with the patient's needs. This occurs through individual counseling, group counseling, and case management. The intensity of services depends on the severity and acuity of the individual. Individuals may progress back and forth through levels of care until they complete this stage.

Medical Team: Providers continue to manage and optimize medication utilization until patients have discontinued or greatly reduced the use of their drug of abuse, no longer has cravings, and is experiencing few or no side effects.
In conjunction with the clinical team, providers make recommendation on level of care, frequency of toxicology studies, treatment planning, and work to conduct the team to facilitate the patient's completing treatment goals.

STAGE 3: STEP DOWN & AFTERCARE

Clinical Team: BrightView believes that continuing care is an essential element of the recovery process and relapse prevention.
When clinically appropriate our Patients will begin a gradual transition into the community with ongoing support from our staff. The patient would attend one- 1-hour individual therapy session per month or less, one-30-minute case management session per month or less, and 1 time per month of group therapy or less (3 hours).

Medical Team: At this stage providers work with the clinical team to create and manage a treatment plan that allows for the lowest and effective dose of medication and therapy to maintain their treatment gains indefinitely. For some individuals that may mean tapering their medication assisted treatment to the lowest effective dose. Tapering MAT is not an absolute indication and should be individualized for each patient. For some forms of MAT, the vast majority of individuals show greater success while continuing some form of it indefinitely.

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PATIENT RIGHTS

Subject to applicable State and Federal law, BrightView will comply with the following Patient Rights established by the Ohio Department of Mental Health and Addiction Services to the extent applicable to our program:

1) The right to be treated with consideration and respect for personal dignity, autonomy and privacy;
2) The right to reasonable protection from physical, sexual or emotional abuse, neglect, and inhumane treatment;
3) The right to receive services in the least restrictive, feasible environment;
4) The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
5) The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;
6) The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;
7) The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;
8) The right to be informed and the right to refuse any unusual or hazardous treatment procedures;
9) The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;
10) The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;
11) The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;
12) The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;
13) The right to be informed of the reason for denial of a service;

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PATIENT RIGHTS, CONTINUED

14) The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
15) The right to know the cost of services;
16) The right to be verbally informed of all client rights, and to receive a written copy upon request;
17) The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;
18) The right to file a grievance;
19) The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;
20) The right to be informed of one's own condition; and,
21) The right to consult with an independent treatment specialist or legal counsel at one's own expense.

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PATIENT GRIEVANCE PROCEDURES

It is the policy of BrightView to ensure that individuals applying for or receiving substance abuse services are guaranteed the protection of fundamental human, civil, constitutional, and statutory rights. As part of these rights, patients have the right to file a grievance with the organization.

1. Any current or former Patient of Bright View may file a grievance with the client advocate of BrightView, and this may occur at any time before, during, or after receiving services at BrightView. The grievance should include: date, time, description of the incident or situation, and the names of the individuals involved. The client advocate will assist the griever in filing a grievance upon request.
2. The grievance must be put into writing. However, if the grievance is made verbally and the client advocate shall be responsible for preparing the written text of the grievance.
3. The griever may use the BrightView Complaint/Grievance Form. The form should be signed by the patient or individual filing the grievance on behalf of the patient, and the grievance should be submitted in writing to the client advocate.

   BrightView Client Advocate:
   Manager of Corporate Compliance
   BrightView
   Nichole Florey
   446 Morgan St.
   Cincinnati, Ohio 45206
   833.510.4357 or 513.486.5373
   Hours of Availability: Monday through Friday 8:00 am until 5:00 pm

4. Following submission of a grievance, the client advocate will respond to the griever with a written acknowledgement of receipt of the grievance within three business days of receipt of the grievance. This written acknowledgement will include: the date the grievance was received; a summary of the grievance; an overview of the grievance investigation process; a timetable for completion of the investigation and notification of resolution; and the treatment provider contact name, address, and telephone number.
5. BrightView will make a resolution decision on the grievance within 20 business days of receipt unless there are extenuating circumstances indicating a need for extension. In which case, written notification will be given to the griever.
6. If the grievance cannot be resolved to the griever's satisfaction through the client advocate, he/she may request a hearing with the Chief Medical Officer.
7. At any time, the Patient or his/her designated representative has the option to file a grievance with outside organizations such as: the Ohio Department of Mental Health and Addiction Services by phone at 614-466-2596 or in writing at OMHAS, 30 E Broad St. Suite 742, Columbus, OH 43215-3430; Disability Rights Ohio by phone at 1-800-282-9181 or in writing at Disability Rights Ohio, 200 S Civic Center Dr. Suite 300, Columbus, Ohio 43215; The U.S. Department of Health and Human Services, Office for Civil Rights, by phone at (800) 368-1019 or in writing at U.S. Department of Health and Human Services 233 N. Michigan Ave., Suite 240, Chicago, IL 60601; The Joint Commission by phone at 630-792-5800 or in writing at 1 Renaissance Boulevard, Oakbrook Terrace, Illinois 60181; or the appropriate local/state/federal licensing or regulatory associations at: https://www.oacbha.org/mappage.php

BrightView

THINGS TO KNOW ABOUT

What is Buprenorphine?
Buprenorphine is an opioid medication. It is not a treatment for physical dependence, but it is a treatment for addiction. The purpose of Buprenorphine is not to assist in detox or to maintain a person's customary substance use, but to suppress the unnatural brain hijacks and the associated debilitating symptoms of cravings and withdrawal that occur as a result of drug use and the disease of addiction.

How is Buprenorphine Taken?
The medications is taken sublingual (held underneath the tongue). Medication that is swallowed does not get absorbed very well at all. Therefore, it is important to take the medication as directed and remember to not smoke or eat before or after taking the medication.

What side effects may occur with Buprenorphine?
Side effects include constipation or sedation. Make sure you assess how you feel before operating a vehicle when you start. Let provider know if you have any change in your bowel movements. Other side effects such as headaches, nausea and vomiting are possible but less likely to occur. Abruptly stopping the medication will lead to signs and symptoms of opioid withdrawal (nausea, vomiting, chills, anxiety, etc.). It is important to continue the medication as prescribed and work with your provider regarding dose changes.

Will Buprenorphine react with any other medications?
This medication can cause life threatening respiratory depression and sedation if it is taken with other CNS sedatives. Other sedatives include, but are not limited to: alcohol, benzodiazepines, sleeping medication, etc. Discuss any substance or medication use with your doctor and be sure to follow your providers instructions. Some other medications may affect the levels of buprenorphine in your body. In general, it is important to discuss any new medication or change with your buprenorphine prescriber. Antibiotics, antifungals, and antiviral medications especially should be discussed with your provider.

How should I store my Buprenorphine or other prescribed medication?
Even a small amount of buprenorphine is extremely dangerous especially to a child.
ALWAYS keep these medicines stored in the original container. ALWAYS keep these medicines out of sight and out of reach of children in a locked box or cabinet. CALL Poison Control Center right away at 1-800-222-1222 if someone has ingested these medicines. CALL the Poison Control Center to find out the safest way to dispose of these medicines.

Are there alternative treatments to Buprenorphine?
There are alternative treatment options for buprenorphine in the treatment of opioid use disorder. Methadone, is also an opioid taken daily to address cravings, urges, and other symptoms of addiction. It is dispensed at specially certified programs that initially require daily attendance and onsite dosing. Naltrexone is a non-opioid medication that is given as a daily pill or monthly injection. It is an opioid blocker that inhibits the effects of opioids used in order to break the cycle of addiction. This treatment is available even at some PCP offices and is often covered by insurance .

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HOW IS BUPRENORPHINE PRESCRIBED AT BRIGHTVIEW?

If it is determined that the correct medication regimen for you include Buprenorphine you will likely have the first dose in the office observed to ensure tolerance and dosing. Your first prescription will usually be approximately a seven-day supply and ensure that you have enough medication through the following Wednesday.

Buprenorphine prescriptions are commonly written on 7, 14, and 28-day cycles. Prescriptions are usually available at the pharmacy by Wednesday at 3 PM. The length of the prescription is determined by the amount of time you have been in the BrightView program and/or your compliance with your individualized treatment plan including appropriate attendance and sensation of drug use. If you miss provider appointments or take medication other than how it is prescribed, you prescription will be disrupted.

IS BUPRENORPHINE TREATMENT TRADING ONE ADDICTION FOR ANOTHER?

No. With successful buprenorphine treatment the compulsive behavior, the loss of control, the constant cravings, and all of the other hallmarks of addiction dissipate. When all signs and symptoms of the disease of addiction dissipate we call that remission not switching addictions. The key to understanding this is knowing the difference between physical dependence and addiction.

Buprenorphine will maintain some of the pre-existing physical dependence but that is easily managed medically. Physical dependence on like addiction is not a dangerous medical condition that requires treatment. Addiction is damaging and life-threatening, while physical dependence is an inconvenience and is normal physiology for anyone taking large doses of opioids for an extended period of time. It is essential to understand the definition of addiction and how it differs from physical dependence or tolerance.

☐ I acknowledge that I have read and understood the above information.

BrightView

MEDICATION GUIDE: BUPRENORPHINE SUBLINGUAL TABLETS, CIII

IMPORTANT:
Keep buprenorphine sublingual tablets in a secure place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally uses buprenorphine sublingual tablets, get emergency help right away.

Read this Medication Guide before you start taking buprenorphine sublingual tablets and each time you get a refill. There may be new information. This Medication Guide does not take the place of talking to your doctor. Talk to your doctor or pharmacist if you have questions about buprenorphine sublingual tablets. Share the important information in this Medication Guide with members of your household.

What is the most important information I should know about buprenorphine sublingual tablets?

- Buprenorphine sublingual tablets can cause serious and life-threatening breathing problems. Call your doctor right away or get emergency help if:
    - You feel faint, dizzy or confused
    - Your breathing gets much slower than is normal for you

These can be signs of an overdose or other serious problems.

- Buprenorphine sublingual tablets contain an opioid that can cause physical dependence.
    - Do not stop taking buprenorphine sublingual tablets without talking to your doctor. You could become sick with uncomfortable withdrawal signs and symptoms because your body has become used to this medicine
    - Physical dependence is not the same as drug addiction
    - Buprenorphine sublingual tablets are not for occasional or "as needed" use
- An overdose, and even death, can happen if you take benzodiazepines, sedatives, tranquilizers, or alcohol while using buprenorphine sublingual tablets. Ask your doctor what you should do if you are taking one of these.
- Call a doctor or get emergency help right away if you:
    - Feel sleepy and uncoordinated
    - Have blurred vision
    - Have slurred speech
    - Cannot think well or clearly
    - Have slowed reflexes and breathing
- Do not inject ("shoot-up") buprenorphine sublingual tablets.
    - Injecting this medicine may cause life-threatening infections and other serious health problems.
    - Injecting buprenorphine sublingual tablets may cause serious withdrawal symptoms such as pain, cramps, vomiting, diarrhea, anxiety, sleep problems and cravings.

- In an emergency, have family members tell the emergency department staff that you are physically dependent on an opioid and are being treated with buprenorphine sublingual tablets.

What are buprenorphine sublingual tablets?

- Buprenorphine sublingual tablets are a prescription medicine used to begin treatment in adults who are addicted to (dependent on) opioid drugs (either prescription or illegal drugs), as part of a complete treatment program that also includes counseling and behavioral therapy.
- Buprenorphine sublingual tablets are most often used for the first 1 or 2 days to help you start with treatment.

Buprenorphine sublingual tablets are a controlled substance (CIII) because they contain buprenorphine, which can be a target for people who abuse prescription medicines or street drugs. Keep your buprenorphine sublingual tablets in a safe place to protect it from theft. Never give your buprenorphine sublingual tablets to anyone else; it can cause death or harm them. Selling or giving away this medicine is against the law.

- It is not known if buprenorphine sublingual tablets are safe and effective in children.

Who should not take buprenorphine sublingual tablets?

Do not take buprenorphine sublingual tablets if you are allergic to buprenorphine.

What should I tell my doctor before taking buprenorphine sublingual tablets?

Buprenorphine sublingual tablets may not be right for you. Before taking buprenorphine sublingual tablets, tell your doctor if you:

- Have trouble breathing or lung problems
- Have an enlarged prostate gland (men)
- Have a head injury or brain problem
- Have problems urinating
- Have a curve in your spine that affects your breathing
- Have liver or kidney problems
- Have gallbladder problems
- Have adrenal gland problems
- Have Addison's disease
- Have low thyroid (hypothyroidism)
- Have a history of alcoholism
- Have mental problems such as hallucinations (seeing or hearing things that are not there)
- Have any other medical condition
- Are pregnant or plan to become pregnant. It is not known if buprenorphine sublingual tablets will harm your unborn baby. If you take buprenorphine sublingual tablets while pregnant, your baby may have symptoms of withdrawal at birth. Talk to your doctor if you are pregnant or plan to become pregnant.

- Are breast feeding or plan to breast feed. Buprenorphine sublingual tablets can pass into your milk and may harm the baby. Talk to your doctor about the best way to feed your baby if you take buprenorphine sublingual tablets. Breast feeding is not recommended while taking buprenorphine sublingual tablets.

Tell your doctor about all the medicines you take, including prescription and nonprescription medicines, vitamins and herbal supplements. Buprenorphine sublingual tablets may affect the way other medicines work, and other medicines may affect how buprenorphine sublingual tablets works. Some medicines may cause serious or life-threatening medical problems when taken with buprenorphine sublingual tablets.

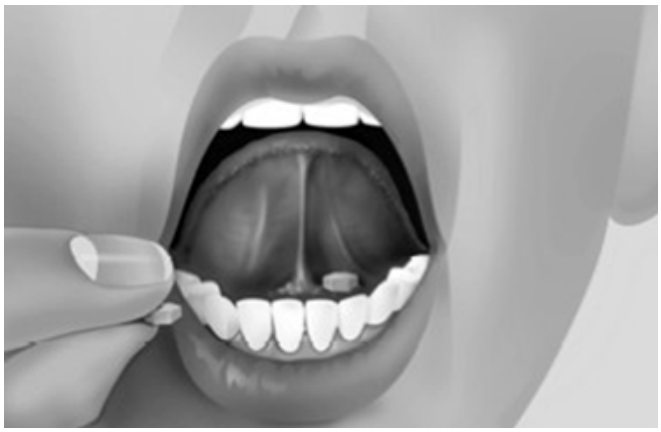
Sometimes the doses of certain medicines and buprenorphine sublingual tablets may need to be changed if used together. Do not take any medicine while using buprenorphine sublingual tablets until you have talked with your doctor. Your doctor will tell you if it is safe to take other medicines while you are using buprenorphine sublingual tablets.

Be especially careful about taking other medicines that may make you sleepy, such as pain medicines, tranquilizers, sleeping pills, anxiety medicines or antihistamines.

Know the medicines you take. Keep a list of them to show your doctor and pharmacist each time you get a new medicine.

How should I take buprenorphine sublingual tablets?

- Always take buprenorphine sublingual tablets exactly as your doctor tells you . Your doctor may change your dose after seeing how it affects you. Do not change your dose unless your doctor tells you to change it.
- Do not take buprenorphine sublingual tablets more often than prescribed by your doctor.
- If you are prescribed a dose of 2 or more buprenorphine sublingual tablets at the same time:
    - Ask your doctor for instructions on the right way to take buprenorphine sublingual tablets
    - Follow the same instructions every time you take a dose of buprenorphine sublingual tablets
- Put the tablets under your tongue. Let them dissolve completely.



- While buprenorphine sublingual tablets are dissolving, do not chew or swallow the tablet because the medicine will not work as well.
- Talking while the tablet is dissolving can affect how well the medicine in buprenorphine sublingual tablets is absorbed.
- If you miss a dose of buprenorphine sublingual tablets, take your medicine when you remember. If it is almost time for your next dose, skip the missed dose and take the next dose at your regular time. Do not take 2 doses at the same time unless your doctor tells you to. If you are not sure about your dosing, call your doctor.
- Do not stop taking buprenorphine sublingual tablets suddenly. You could become sick and have withdrawal symptoms because your body has become used to the medicine. Physical dependence is not the same as drug addiction. Your doctor can tell you more about the differences between physical dependence and drug addiction. To have fewer withdrawal symptoms, ask your doctor how to stop using buprenorphine sublingual tablets the right way.
- **If you take too much buprenorphine sublingual tablets or overdose, call Poison Control or get emergency medical help right away.**

What should I avoid while taking buprenorphine sublingual tablets?

- **Do not drive, operate heavy machinery, or perform any other dangerous activities until you know how this medication affects you.** Buprenorphine can cause drowsiness and slow reaction times. This may happen more often in the first few weeks of treatment when your dose is being changed, but can also happen if you drink alcohol or take other sedative drugs when you take buprenorphine sublingual tablets.
- **You should not drink alcohol** while using buprenorphine sublingual tablets, as this can lead to loss of consciousness or death.

Buprenorphine sublingual tablets can cause serious side effects including:

- **Respiratory problems.** You have a higher risk of death and coma if you take buprenorphine sublingual tablets with other medicines, such as benzodiazepines.
- **Sleepiness, dizziness, and problems with coordination**
- **Dependency or abuse**
- **Liver problems.** Call your doctor right away if you notice any of these signs of liver problems: Your skin or the white part of your eyes turning yellow (jaundice), urine turning dark, stools turning light in color, you have less of an appetite, or you have stomach (abdominal) pain or nausea. Your doctor should do tests before you start taking and while you take buprenorphine sublingual tablets.
- **Allergic reaction.** You may have a rash, hives, swelling of your face, wheezing, or loss of blood pressure and consciousness. Call a doctor or get emergency help right away.
- **Opioid withdrawal.** This can include: shaking, sweating more than normal, feeling hot or cold more than normal, runny nose, watery eyes, goose bumps, diarrhea, vomiting and muscle aches. Tell your doctor if you develop any of these symptoms.
- **Decrease in blood pressure.** You may feel dizzy if you get up too fast from sitting or lying down.

Common side effects of buprenorphine sublingual tablets include:

- Headache
- Nausea
- Vomiting
- Increased sweating
- Constipation
- Drug withdrawal syndrome
- Decrease in sleep (insomnia)
- Pain

Tell your doctor about any side effect that bothers you or that does not go away.

These are not all the possible side effects of buprenorphine sublingual tablets. For more information, ask your doctor or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store buprenorphine sublingual tablets?

- Store buprenorphine sublingual tablets at 20° to 25°C (68° to 77°F).
- Keep buprenorphine sublingual tablets in a safe place, out of the sight and reach of children.

How should I dispose of unused buprenorphine sublingual tablets?

- Dispose of unused buprenorphine sublingual tablets as soon as you no longer need them.
- Flush unused tablets down the toilet.

General information about the safe and effective use of buprenorphine sublingual tablets:

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use buprenorphine sublingual tablets for a condition for which it was not prescribed. Do not give buprenorphine sublingual tablets to other people, even if they have the same symptoms you have. It may harm them and it is against the law.

This Medication Guide summarizes the most important information about buprenorphine sublingual tablets. If you would like more information, talk to your doctor or pharmacist. You can ask your doctor or pharmacist for information that is written for healthcare professionals.

What are the ingredients in buprenorphine sublingual tablets?

Active Ingredient: buprenorphine hydrochloride Inactive Ingredients: anhydrous citric acid, corn starch, crospovidone, lactose monohydrate, magnesium stearate, mannitol, povidone, and sodium citrate

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CONSENT FOR ALCOHOL OR DRUG ASSESSMENT AND TREATMENT

Name: _____

DOB: _____

Record #: _____

I understand that as a patient of BrightView Health, LLC ("BrightView") I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several months.

1. Consent to Evaluate/Treat: I voluntarily consent that I will participate in an alcohol or drug assessment and/or treatment by staff from BrightView. I understand that following the assessment and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)
e. Probable consequences of not receiving treatment

Treatment will be conducted within the boundaries of Ohio substance abuse treatment laws. I understand that a range of mental health professionals, some of whom are in training, provides BrightView services. All professionals-in-training are supervised by licensed staff.

2. Benefits and Risks to Assessment/Treatment: Assessment and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this assessment include diagnosis, assessment of recovery or treatment, estimating prognosis, and education and rehabilitation planning.

Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. I understand that while psychotherapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I realize that sometimes medications may have unwanted side effects.

3. Research: As part of ongoing client satisfaction surveys and future research some information from your file may be submitted to third parties or utilized by BrightView. Your identifying information will not be shared, however, general information (age, race, and sex) may be shared.

4. Charges: Fees are based on the length or type of the assessment or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

5. Confidentiality: Information from my assessment and/or treatment is contained in a confidential medical record at BrightView. I understand that BrightView will obtain my photograph for the purpose of providing me with a BrightView identification card. This same photograph will be stored electronic health records as a primary form of my identification. The purpose of these photos is to be in compliance with BrightView's policy and procedures of using two forms of identification to recognize each client.

I understand surveillance cameras are located throughout BrightView for routine observation. I further understand surveillance cameras that do not record are located in the patient restrooms for the purpose of monitoring my compliance when providing a urine drug screen.

6.Right to Withdraw Consent: I have the right to withdraw my consent for assessment and/or treatment at any time by providing a written request to the treating clinician.

7. General Laboratory Testing and Reporting: Laboratory testing, including, but not limited to blood work, may be requested. This testing may be to identify diagnosis of HIV, Hepatitis B or C, or other bloodborne disease. Positive results from this lab work must be reported to the appropriate authorities. I authorize BrightView to disclose any reportable infectious disease and information regarding that infectious disease to my local and state health department for purposes of coordinating care. Only the minimum amount of protected health information needed to accomplish the intended purpose of the use is permitted for these disclosures. I understand that my alcohol and/or drug abuse treatment records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent. I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will remain valid 90 days after discharge.

8. Toxicology Testing: I understand that upon admission and throughout my course of treatment, I will be required to submit to a variety of toxicology tests to include urine drug testing, alcohol testing, pregnancy testing (if applicable), and blood/lab work testing. The treatment team and provider will determine the frequency of these tests. I give my consent to undergo all tests described above as they apply to me. I further give my consent to allow BrightView to send my urine specimen to the laboratory for analysis.

9. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

10. Informed Consent for Medication Assisted Treatment: In accordance with evidence-based practices, BrightView, upon assessment and evaluation and at the recommendation of a physician may prescribe various medications to patients in recovery. These medications are used in conjunction with group counseling, individual counseling, and family counseling. Any medication I receive may have an adverse reaction and/or possible side effects.

The goal of medication assisted treatment is to stabilize functioning. I realize that for some patients' treatment may continue for relatively long periods of time, but that periodic consideration shall be given concerning my complete withdrawal from the use of all drugs.

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Treatment with Buprenorphine (if applicable):

Buprenorphine is an FDA approved medication for the treatment of opioid addiction. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications. The appropriate treatment plan for you will be determined by your primary counselor and a physician.

Use of buprenorphine will maintain your physical dependence. If you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine as it could eventually cause physical dependence. The medication you will be taking will likely contain both buprenorphine and an opiate blocker (naloxone). If the medication is abused by snorting or injection, the naloxone will cause severe withdrawal but when taken as directed, the naloxone has no effect.

If you are dependent on opioids **you should be in as much withdrawal as possible when you take the first dose of buprenorphine/ naloxone. If you are not in withdrawal, buprenorphine/ naloxone can cause severe opiate withdrawal.** We recommend that you arrange not to drive after your first dose, because some patients may experience drowsiness during the early phases of treatment. It may take several days to feel completely comfortable with the transition to buprenorphine/naloxone.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths. Although sublingual buprenorphine has not been shown to be liver-damaging, your doctor will monitor your liver tests while you are taking buprenorphine. (This is a blood test.) Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. You should not take any other medication without discussing it with the physician first.

I understand that buprenorphine products and other medication assisted treatment medications may interact with other prescription medications, vitamins and nutritional supplements. Potential interactions include increasing or decreasing the level of buprenorphine products in my body or, in extremely rare instances, possibly causing an abnormal heart rhythm that has the potential to be lethal. I agree that it is my responsibility to provide documentation of all medication, vitamins and nutritional supplements I am taking on at least a monthly basis.

I understand that I may withdraw from this treatment and discontinue when indicated the use of the medication at any time, and I shall be afforded medical withdrawal under medical supervision. The medically supervised withdrawal could be either a short-term withdrawal or long-term withdrawal. This will be at the discretion of the Medical Director/Provider. I understand that once I complete a medically supervised withdrawal, I may be offered an aftercare program which will include counseling only.

I have read and understand these details about medication assisted treatment, including risks and benefits. I understand there are alternatives and wish to be treated with buprenorphine if that is medication that the physician deems medically appropriate.

Treatment with Methadone (if applicable):

I understand that I have been diagnosed as suffering from opioid dependence (i.e. that I am or have been addicted to an opiate drug, such as heroin or oxycodone) and that it has further been determined that an appropriate treatment is opioid maintenance therapy, which involves the daily use of medication (methadone), along with medical and rehabilitative (counseling) services, to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. The overall goal of opioid maintenance therapy is improved quality of life and freedom from illicit drugs.

I understand that methadone does not cure addiction, and is itself an opioid drug, which is addictive and can have serious, even fatal, side effects. The most commonly reported side effects are constipation and sweating/flushing. It may also cause dizziness, especially after sitting or lying down; drowsiness; mood changes; vision problems; difficulty falling or staying asleep; and sexual side effects. Serious and sometimes fatal side effects include seizures; severe allergic reaction; slowed or difficult breathing; and irregular heartbeat, especially in patients with certain existing heart conditions (known as prolonged QT interval).

I understand that mixing methadone with other depressants (such as alcohol or benzodiazepines) is especially dangerous and will refrain from doing so. I agree to take methadone only as prescribed, and to inform other healthcare providers that I take methadone to avoid potentially harmful interactions. Until I know how methadone will affect me, I will use caution when driving or operating machinery. I have made the Medical Director/Provider aware of all medical conditions I have and medications (prescription, over-the-counter, or illicit) I take, and will keep this information current throughout treatment.

I understand that methadone maintenance therapy generally takes place over an extended period of time, but that I am free to discontinue treatment at any time. I understand that if I stop taking methadone suddenly that it may

produce severe withdrawal symptoms. I understand that at periodic intervals, and with my full consultation, the Program will discuss my present level of functioning, my course of treatment, and my future goals.

I understand that all medical decisions, including, but not limited to, diagnosis and treatment, are made by the Medical Director/ Provider, and hereby release the Program from any and all liability arising from such decisions.

I understand that other treatments are available, including, but not limited to, inpatient treatment, detoxification programs, buprenorphine treatment, and abstinence programs.

FOR EKG/ECG TESTING (if applicable): An electrocardiogram (sometimes called EKG or ECG) is a noninvasive procedure to obtain a graphical presentation of the heart's electrical activity derived by amplification of the minutely small electrical impulse normally generally by the heart. The tracing is obtained using 10 electrodes placed on the skin of the chest, arms, and legs. If any artifact (like static) occurs, some electrodes may need to be repositioned to ensure a clear recording of the heart. This test is used to identify and diagnose several different heart conditions. Risks include possible redness and itching at the sites of the electrode placement and possible minor skin irritation.

FOR WOMEN WHO ARE OR MAY BECOME PREGNANT: While methadone is approved by the FDA for medication-assisted treatment for opioid addiction in pregnant patients, there are no conclusive data regarding the safety of methadone in human pregnancy and it may be harmful to unborn babies. Tell your doctor and the Program's Medical Director/Provider if you are pregnant or plan to become pregnant. After delivery, babies may experience withdrawal symptoms. A small amount of methadone is transmitted through breast-milk; therefore, discuss breastfeeding with your doctor.

Understanding the risks and benefits associated with methadone maintenance therapy, as well as alternatives to it, I hereby give my informed and voluntary consent to receive methadone maintenance therapy from BrightView.

11. Opiate Treatment Program (OTP) (if applicable)

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a substance use disorder treatment program, since the use of other medications in conjunction with medication assisted treatment prescribed by the treatment program may cause me harm. In addition, I agree that I am not currently enrolled in another OTP at this time.

I understand State and Federal law prohibits dual enrollment in opiate treatment programs. I therefore give my consent to allow BrightView to disclose my enrollment status, via fax or verbal confirmation, to all opiate treatment programs in accordance with state and federal law guidelines. I further give my consent to allow BrightView to disclose my enrollment status, via fax, electronic transfer or verbal confirmation, to a statewide Central Registry in accordance with State and Federal law as well as any other OTP within a 100-mile radius.

I hereby certify that no guarantee or assurance has been made as to the results that may be obtained from alcohol and drug treatment. With full knowledge of the potential benefits and possible risks involved, I consent to assessment and treatment.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

MEDICATION ADHERENCE AT BRIGHTVIEW

Medication adherence simply means sticking to the medication prescribed/ordered for you. Adhering to medication is also taking the medication as directed by a health care professional - whether taken in pill form, inhaled, injected, or applied topically.

Not taking medication as prescribed is called non-adherence. Many people never fill their medications, or they may never pick up their filled prescriptions from the pharmacy. Other people bring their medication home, but don't follow their health care professional's instructions - they skip doses or stop taking the medicine.

Specifically, non-adherence includes:

- Not filling a new medication or refilling an existing medication when you are supposed to
- Stopping a medicine before the instructions say you should
- Taking more or less of the prescribed/ordered medicine; or at the wrong time of day

Often there is no single reason someone does not take their medicine as directed, but rather a combination of reasons. One person may face different barriers at different times as he or she manages his or her condition. Whatever the reason, the result is always the same - patients miss out on life -saving benefits, a better quality of life, and lose protection against future illness or serious health complications.

All medicines have risks and benefits. When a patient works with their health care professional to decide to use medicine to help manage a long-term health condition, he or she accepts certain risks in exchange for potential health benefits. Consumers can help manage those risks by using medicines safely, including storing & disposing of them safely.

Importance of Medication Adherence Specifically at BrightView

Some of the medications prescribed at BrightView are controlled substances which have an increased requirement for compliance from patients. This is very important because of the health and possible legal consequences associated.

- All patients must take medication EXACTLY as prescribed/ordered.
  - Do not attempt to adjust the dose of your medication up or down without consultation of your physician.
- Keep medications in a safe and secure location.
  - Theft of medication will not result in an early refill.
- If you have any questions concerning medication, set up an appointment with the nurse practitioner/physician.
- Because of the medication you are taking and a history of substance abuse, it is vital that you coordinate your other medical appointments or surgical/dental procedures that you have with BrightView. Plan ahead.
- It is important that you tell your primary care physician or any other physician who writes a prescription that you are receiving treatment services at BrightView.
- DO NOT EVER SELL YOUR MEDICATION OR TRY TO BUY M EDICATION FROM SOMEONE. THIS WILL LIKELY RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM AND CAN RESULT IN LEGAL CONSEQUENCES FOR YOU AS A PATIENT.
- NON-ADHERENCE WITH YOUR MEDICATION REGIMEN CAN ALSO RESULT IN RESTRICTIONS BY YOUR INSURANCE COMPANY THAT CANNOT BE RESOLVED BY THE TEAM AT BRIGHTVIEW. YOU MAY LOSE THE ABILITY TO GET YOUR MEDICATIONS PAID FOR BY INSURANCE.
- **BRING ALL MEDICATIONS PRESCRIBED BY BRIGHTVIEW PROVIDERS TO EVERY MEDICAL APPOINTMENT.**

Patient: _____ Date: _____

TREATMENT CONTRACT

I, _____ , understand that the goal of Medication-Assisted Treatment (MAT) is to suppress my withdrawal symptoms and cravings for my drug of choice. This assistance should allow me to regain a normal state of mind so that I can focus my efforts on making changes in my thoughts, behaviors and environment to better support my recovery. I understand that BrightView's plan may include tapering me completely off medication during the final phase of treatment.

WHAT I MUST DO TO REMAIN IN BRIGHTVIEW RECOVERY:

1. I agree to work with my treatment team to create an individualized treatment plan and abide by the recommendations of the medical and clinical providers.
2. I agree to keep and be on time to all my appointments. If I miss my scheduled appointment, I must call within 24 hours to reschedule.
3. I agree to conduct myself in a courteous manner on BrightView property and not to conduct any illegal or disruptive activities on BrightView property.
4. I agree to respect and protect the confidentially of others regarding the presence and disclosures of all patients.
5. I agree to complete the entire program which has been recommended by my treatment providers.
6. I agree to accept referral to a higher level of care (i.e. residential or inpatient) if recommended.
7. I agree to abstain from all non-prescribed medications, alcohol, opioids, marijuana, cocaine, and other addictive substances [except nicotine].
8. I agree to maintain a safe and sober living environment at all times.
9. I understand that if I engage in highly dangerous behavior, such as abusing benzodiazepine, a sedative or sleeping medication, or I consume a heavy amount of alcohol while on Buprenorphine medication that I may be promptly referred to a higher level of care (hospital or residential) and no further medication will be prescribed to me.
10. I agree to provide a urine sample for drug testing at intake, every day that I have appointments, and as requested thereafter and to have my blood alcohol level tested.
11. I agree to take my medications exactly as prescribed. I understand that adjusting my own dosage may result in discharge from the program.
12. I agree to keep my medication in a locked, safe, and secure location in my home and out of the reach of children and others at all times.
13. I agree to disclose the names of all doctors and dentists who have prescribed a controlled substance (an opioid, benzodiazepine or amphetamine/stimulant) to me in the past year and sign a release of information form so that a BrightView physician can coordinate my care with that, or those, prescribers.
14. I agree to inform all doctors, dentists and hospitals that treat me while I am in the BrightView MAT program that I am prescribed Buprenorphine or any other medication for opioid or other substance use disorder and sign a release of information form so that a BrightView physician can coordinate my care with that, or those, providers.

CAUSES FOR DISMISSAL

1. I understand that I may be discharged if I engage in any of the following unacceptable behaviors:
2. If I use any rude, profane, or threatening language with any BrightView staff member at any time.
3. If I provide any false or misleading information about my identity, my criminal history, or any reporting requirements for probation, parole or Children's Protective Services (CPS).
4. If I provide any false or misleading information about my medical history, any prior treatment for substance abuse including the prescribing of Buprenorphine or methadone, or any false information regarding the use or prescribing of benzodiazepines (Xanax, Valium, Librium, Serax, Klonopin etc.)
5. I attempt to give, buy, or sell medication or drugs to any other person.
6. I attempt to alter or falsify a prescription, or a urine drug specimen.

7. I refuse to provide a urine drug specimen or come in for a medication count when requested.
8. My urine does not show the expected presence of Suboxone (buprenorphine) or other medication prescribed by BrightView.
9. If I fail to tell a doctor or dentist that I am on Buprenorphine or other medication and I attempt to obtain or obtain a controlled substance from that doctor or dentist.
10. If I fail to promptly inform BrightView staff that I have been prescribed a controlled substance by another doctor, dentist, hospital, urgent care or emergency department.
11. I miss a scheduled detoxification/induction appointment.
12. I fail to attend a scheduled case review.
13. I fail to make satisfactory payment arrangements for an outstanding balance of $500 (five hundred dollars) or more which is more than 30 days past due.
14. Need to leave program for a medical or other mental health issue (Suspension to be determined by the Medical Director)

DISCHARGE FROM THE PROGRAM

I understand that once dismissed from the program, there may be a period before I can re-engage in services. Even after this designated period, reinstatement into the treatment program is not guaranteed. Reinstatement is at the sole discretion of the Medical Director and/or the patient's clinical treatment team. If I am discharged, a final prescription or medications will be released at the discretion of the medical team/director. A final prescription/medication is not guaranteed.

I understand that BrightView may discharge me prior to completion of treatment:

1. If I violate any of the above items or engage in any of the unacceptable behaviors described in the above section.
2. If I have persistently not complied with my attendance requirements, treatment recommendations, or met my financial obligations to BrightView as I agreed to do this in the treatment contract.
3. If I have been referred to a higher level of care (residential or hospital) but refuse to go.
4. Need to leave program for a medical or other mental health issue
5. If I request a voluntary discharge.

I understand that discharge from treatment at BrightView is a decision made by the entire treatment team and not any single member of the team. The rationale for this is to ensure that my treatment team utilizes multiple strategies to engage with me before discharge occurs.

ACKNOWLEDGMENT:

The staff at BrightView has reviewed each of the items contained in this Treatment Contract with me. I believe these terms and requirements are reasonable. I understand that they are meant to help support me in my recovery, and I agree to them all and agree to abide by all guidelines.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

ALCOHOL & DRUG SCREENS AND PHLEBOTOMY SERVICES

It is the policy of BrightView to perform alcohol & drug screens on all patients via urinalysis. Patients will be screened at intake as well as periodically and randomly throughout treatment. A positive alcohol and/or drug screen is not cause for immediate termination from the program. However, a positive alcohol and/or drug screen could result in a change in a patient's treatment plan. In some cases, urine specimens may be sent to outside laboratories for screening. If a specimen is sent to an outside laboratory and results in a positive screening, the positive result will be reviewed by BrightView staff with the patient. Alcohol and/or drug screens may not be covered by an insurance provider. If this is the case, the patient will be responsible for payment for the alcohol and/or drug screen.

Refusal to consent to an alcohol or drug screen will be recorded as a "positive" result in the patient record. Repeated positive alcohol and/or drug screens can result in a change in treatment plan and/ or termination from the program.

CONSENT FOR ALCOHOL & DRUG SCREENS

By signing below, I am giving BrightView and any/all approved employees of BrightView permission to take a urine and/or saliva sample from me for evidence of alcohol and drug use. The purpose of obtaining the specimen is to monitor the possible use of illegal substances. I also understand that to maintain the integrity of the specimen I may be observed by a BrightView staff member while the urine specimens are obtained. However, I will be afforded a reasonable amount of privacy and will not be required nor allowed to expose my genitals at any time.

Patient Signature: _____ Date: _____

BrightView

PHLEBOTOMY SERVICES

We will perform a blood draw on Day 2 of induction and subsequently every six months.
We are required to draw the following tests:

Hep C w/ Refl HCV
Hep B Surf AG w/conf
Quantiteron (R) PI
HIV 1/2 AG/AB 4 w/Refl
RPR Monito w/ Refl

Patient Signature: _____ Date: _____

It is recommended that the following additional tests be preformed:

Heptatic Function Panel
Basic Metab Pnl
Hep B Surf AM QL
CBC Diff/Plt
Hep A AB, Total
Hep B Core AB, Total

Patient Signature: _____ Date: _____

Testing is performed by a third party vendor. While most of these tests are covered by insurance, self-pay patients may receive a bill from a third party vendor for $140-$240.

BrightView

OPIATE TREATMENT PROGRAM (OTP) TAKE HOME DOSING

Take home doses of a buprenorphine medication are personally furnished by our Physician's and will always be secured in a childproof bottle and caps. Medications are to be in a safe area and away from food and wet areas and out of the reach of children. All clients of the Brightview OTP with buprenorphine medication are required to have a working lock bag at the time of the dispensing and always use the locking bag to contain their buprenorphine medication. An OTP facility identification card will be issued and is required for further dosing or take homes at the OTP window.

All Brightview OTP clients are required to return empty bottles that are dispensed by the Brightview OTP. Returning dispensed bottles are not reused by the Brightview OTP. The used bottle is accepted by our dispensary nurse with the client name peeled off before discarding into the trash. All Brightview OTP clients are subject to call back pill counts. Once called for a pill count the patient has 24 hours to present for a count, bringing your original bottle the medication was dispensed in, locked in a bag, and with OTP facility identification, during the open hours of the OTP window. A valid, working phone number is the responsibility of the patient. Brightview's inability to reach a patient based on a non-answering, non- working number, or number change is the sole responsibility of the client and results in a missed pill count. A missed pill count may require in facility dosing at the window for some time based on the multidisciplinary treatment team recommendation and physician orders.

Bring all medications to medical appointments at all times. You may do walk in pill counts to the OTP window while here for other appointments if time permitting by the OTP nurse.

Take homes and window dosing appointments are set to better service all patient needs. If a patient misses their assigned appointment time, they are welcome to attempt a walk in but are not guaranteed the visit will be honored as we will service those who are meeting their appointment times first. The patient is welcome to reschedule for the next available appointment times.

Take home medications are a privilege given to the patient by the physician with multidisciplinary treatment team input. At any time, the physician may order in facility dosing to occur. Take home consideration uses the federal guidelines of:

- Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol;
- Regularity of clinic attendance;
- Absence of serious behavioral problems at the clinic;
- Absence of known recent criminal activity, e.g., drug dealing;
- Stability of the patient's home environment and social relationships;
- Length of time in comprehensive maintenance treatment;
- Assurance that take-home medication can be safely stored within the patient' s home; and
- Whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

BrightView

Name: _____
MRN: _____
DOB: _____

SUBSTANCE USE HISTORY

Have you EVER used the following substances before?

Drug/Substance	Age First Used	Date Last Used	Amount	How Often	How Was It Used
Heroin/Fentanyl o Yes o No					Oral Smoked Injected Snorted
Oxycodone or Hydrocodone o Yes o No					Oral Injected Snorted
Other Opioids o Yes o No					Oral Smoked Injected Snorted
Benzodiazepines o Yes o No					Oral Injected Snorted
Gabapentin/Lyrica o Yes o No					Oral Snorted
Alcohol o Yes o No					Oral
Methamphetamine o Yes o No					Oral Smoked Injected Snorted
Cocaine o Yes o No					Oral Smoked Injected Snorted
Marijuana o Yes o No					Oral Smoked
Tobacco o Yes o No					Oral Smoked

BrightView

SAFE MEDICATION USE WHILE ON BUPRENORPHINE (SUBOXONE)

Patients who are prescribed buprenorphine/naloxone (Suboxone, Zubsolv, etc.) or other medication assisted treatment, may need other medications at times (both prescription and over-the-counter). Many medications interact with buprenorphine/naloxone (Suboxone, Zubsolv, etc.). Some medications raise, and some lower the blood level of buprenorphine.
It is essential that patients inform all healthcare providers that they have been diagnosed with opioid dependence and are taking buprenorphine/ naloxone (Suboxone, Zubsolv, etc.) before starting any new medication.
Any mood-altering substance or medication, even if it is not the "drug of choice", can trigger the reward pathway in the brain and eventually lead the addict back to the behaviors of addiction. This is called cross-addiction. Below are two tables that patients should consult when trying to determine if a medication is safe to take while being on buprenorphine/naloxone (Suboxone, Zubsolv, etc.).

POTENTIAL DRUG INTERACTIONS WITH BUPRENORPHINE (SUBOXONE)			
Drug	**Use**	**Common Name/Brand Names**	**Potential Effect**
Benzodiazepines	Anxiety/Panic Disorder	Xanax, Ativan, Klonopin, Librium, Serax, Tranxene	Can suppress breathing, deaths reported if abused (especially IV)
Alcohol	Recreational	Beer, wine, champagne, liquor	Can suppress breathing, deaths reported with heavy use
Hypnotics	Insomnia	Ambien, Lunesta, Benadryl, Tylenol PM, Nyquil	Can suppress breathing
Naltrexone	Relapse prevention	Revia, Vivitrol	Can cause withdrawal
Erythromycin	Antibiotic	Biaxin, Z-Pack	Can **increase** levels of buprenorphine
Rifampin	Antibiotic		Can **increase** levels of buprenorphine
Metronidazole	Antibiotic	Flagyl	Can **increase** levels of buprenorphine
Fluconazole	Anti-fungal	Diflucan	Can **increase** levels of buprenorphine
Ketoconazole	Anti-fungal	Nizoral	Can **increase** levels of buprenorphine
Anti-virals	HIV treatment	Multiple drugs	Can **increase** levels of buprenorphine
Paroxetine	Anxiety, depression	Paxil	Can **increase** levels of buprenorphine
Sertraline	Anxiety, depression	Zoloft	Can **increase** levels of buprenorphine
Fluoxetine	Anxiety, depression	Prozac	Can **increase** levels of buprenorphine
Carbamazepine	Seizures, Neuropathy	Tegretol	Can **decrease** levels of buprenorphine
Phenobarbital	Seizures	Phenobarbital	Can **decrease** levels of buprenorphine
Phenytoin	Seizures	Dilantin	Can **decrease** levels of buprenorphine
Primidone	Seizures	Mysoline	Can **decrease** levels of buprenorphine

☐ I acknowledge that I have read and understood the above information.

Consent for Participation in Central Registry

I, _____, authorize BrightView, LLC Opioid Dependency Treatment Program, to disclose my photograph and demographic information (Name, Alias, last 4 digits SSN, gender, DOB, mother's first name, admit date, Medication (type, form and dose), discharge date, reason, and last dose of medication) for admission to all Medication

Assisted Treatment Programs, including programs that open in the future, within the state of Ohio and any other states that participate in the Central Registry. The information will be shared via secured electronic transmission.
The purpose for such disclosure is to prevent dual enrollment in Medication Assisted treatment as well as assist with emergency medication services during a disaster. This consent for disclosure is in compliance with Federal Confidentiality Laws (Federal Register, Vol. 4-Number 127, or July 1, 1975 subpart 2.31, 2.34) and 65D-30.

I hereby specifically authorize this clinic, known as BrightView, LLC to disclose the above described information as permitted by State Law to The Central Registry. I further authorize The Central Registry to disclose the above described information to the clinic above to prevent my dual enrollment or assist me in times of emergencies/disasters to receive medication elsewhere should the clinic listed above be forced to close.

(please initial)

_____I understand my records are protected under the Federal Confidentiality Regulations and may not be disclosed without my express written consent, unless otherwise provided for in the regulations. I also understand I may revoke this consent at any time except to the extent that action has been taken in accordance with it, and in any event this consent expires automatically as set forth below.

_____I understand the above information will be maintained in the Lighthouse Software Systems, LLC ("LHSS") central registry system for purposes of my participation in a Central Registry within this state named above, and also for the purpose of aiding my care in times of disaster and dual enrollment verification to prevent multiple medication assisted treatment program enrollments. LHSS is located at 17352 Derian Ave, Irvine, CA 92614. The Central Registry will contain presently prescribed medication(s) used for my treatment and my schedule of dosing records. This information will reside in the LHSS Central Registry system while I remain a patient at this clinic and will be available to staff where I may present for admission or emergency medication services for up to 60 days after my discharge from treatment at this location. My name will be encrypted in the LHSS Central Registry System database with technology that will meet HIPAA compliance requirements.

_____I understand when any clinic which participates in the Central Registry requests information from the Central Registry and I am found to be enrolled in another clinic, the Central Registry will disclose the name, address, and telephone number of the clinic in which I am already enrolled to the requesting clinic.

_____I understand this is a limited disclosure for the purpose or purposes as stipulated above, and so indicated by the person whose records this information has been extracted from. "This information has been released and disclosed to you from records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164 which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of Medical or other information is NOT sufficient for this purpose".

_____ I understand this form is invalid after 120 days post- discharge.

_____ I understand I may view and request a copy of the information described above and/ or in this form.

_____ I understand this treatment facility named above gets no compensation for using or disclosing health information noted above

_____ I understand my information collected by the Central Registry will be shared with the State's Prescription Drug Monitoring Program (PDMP) for the purpose of preventing dual enrollments and/or preventing me from receiving contra indicated medications. Data sharing with the PDMP is voluntary, and leaving this box unchecked will mean that no records are shared. Persons who consent to this box may withdraw that consent at any time. Records will no longer be shared with the PDMP 30 days after discharge from the program.

_____ I approve my mobile phone number to be used by the Central Registry to text information to me about my clinic's emergency closures due to natural and man-made disasters, closure/disaster information updates, program reminders and notifications from the SOTA's office.

_____ I approve my email address to be used by the Central Registry to email information to me about my clinic's emergency closures due to natural and man-made disasters, closure/disaster information updates, program reminders and notifications from the SOTA's office.

Patient Notification:
This program is required to notify each patient prior to admission that it cannot provide methadone, buprenorphine, or naltrexone containing product to a patient who is simultaneously receiving methadone, buprenorphine, or naltrexone containing product from another treatment program, unless the medication is being provided in response to an emergency or disaster that forced the closure of the patient's regular home clinic.

Patient Statement:
I am not receiving medication and/or treatment from another Medication Assisted Treatment facility, its satellite or an Office Based Opioid Treatment provider and I understand if I do not sign this statement I will not be admitted for treatment or provided emergency medication services.

I understand I might be denied treatment if I refuse to consent to a disclosure for purposes of this Central Registry, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release Brightview, LLC from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

BrightView

PREVENTION OF INFECTIOUS DISEASE

	What are examples of preventable infectious disease?	How are these diseases spread?	How can these diseases be prevented?
Hepatitis B (HBV)* **Hepatitis C (HCV)***	Hepatitis B & C are contagious liver viruses that cause liver inflammation & damage. Infection can lead to liver failure, cancer, and death.	Contact with infected blood, semen, and other body fluids primarily through: • During birth from mother to child • Sexual contact with an infected person • Sharing of contaminated needles, syringes, or other injection drug equipment • Needlesticks or other sharp instrument injuries	There is a vaccination for HBV to prevent infection. HCV and HIV do not have vaccinations available, so it is important to do the following to prevent all three diseases: • Follow "safer sex" practices (e.g., using condoms) • Avoid direct exposure to blood or blood products • Don't share personal care items Never share needles **Get tested on a yearly basis.**
Human Immunodeficiency Virus (HIV)*	HIV is a contagious virus that primarily attacks immune systems cells and can lead to AIDS. Infection can lead to a weakened immune system, severe illness, and death.		
Tuberculosis (TB)*	Tuberculosis is a contagious bacterial infection that usually attacks the lungs but can also damage other parts of the body. Infection can lead to severe respiratory systems, organ failure, and death.	TB is spread through the air when a person with active TB disease of the lungs or throat coughs, sneezes, speaks, or sings. People nearby may breathe in these germs and become infected.	If you are exposed to someone that has had TB, let your doctor know. Make sure to have regular follow up with your primary care provider
Syphillis*/STDs	These include chlamydia, gonorrhea, genital herpes, human papillomavirus (HPV), syphilis, and HIV.	You can get an STD by having vaginal, anal or oral sex with someone who has an STD. Anyone who is sexually active can get an STD. You don't even have to "go all the way" (have anal or vaginal sex) to get an STD. This is because some STDs, like herpes and HPV, are spread by skin-to-skin contact.	• Abstinence • Follow "safer sex" practices (e.g., using condoms) • Routine testing

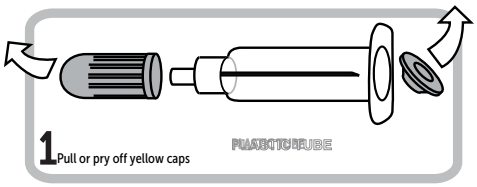
***At BrightView your medical team will obtain baseline labs at induction and every 6 months for these infectious diseases. If any of the tests are positive, then we will assist in referring you to a treatment provider that can create a plan to help manage this aspect of your treatment.**

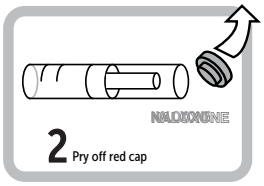
For more information, please contact your local health department or see below:

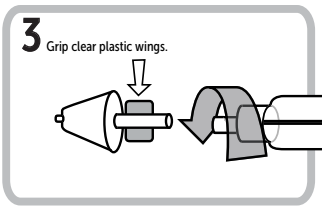
CDC-INFO Contact Center
1-800-CDC-INFO (1-800-232-4636)
TTY: (888) 232-6348

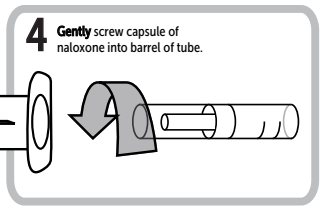
Naloxone Device Instructions

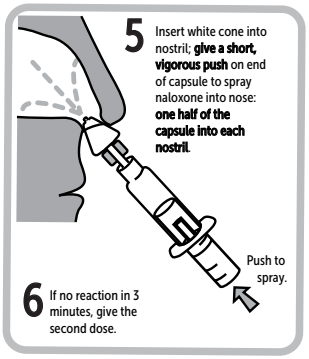
Naloxone Intranasal Atomizing Device







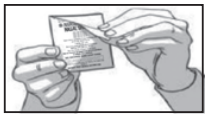




Evaluate and Support

- Continue rescue breathing
- Give another 2 sprays of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem

NARCAN Nasal Spray



Give NARCAN Nasal Spray

REMOVE NARCAN Nasal Spray from the box. Peel back the tab with the circle to open the NARCAN Nasal Stray.

HOLD the NARCAN Nasal Spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

GENTLY INSERT THE TIP OF THE NOZZLE INTO EITHER NOSTRIL
Tilt the person's head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into **one nostril**, until your fingers on either side of the nozzle are against the bottom of the person's nose.

PRESS THE PLUNGER FIRMLY to give the dose of NARCAN Nasal Spray.
Remove the NARCAN Nasal Spray from the nostril after giving the dose.

Call for emergency medical help, Evaluate and Support

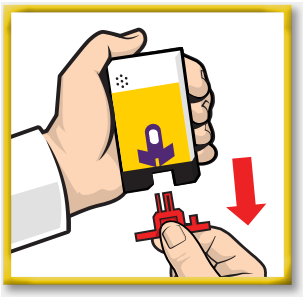
GET EMERGENCY MEDICAL HELP RIGHT AWAY

MOVE THE PERSON ON THEIR SIDE (recovery position) after giving NARCAN Nasal Spray.

IF THE PERSON DOES NOT RESPOND by waking up, to voice or touch or breathing normally another dose may be given. NARCAN Nasal Spray may be dosed every 2 to 3 minutes, if available.

REPEAT STEP 2 USING A NEW NARCAN NASAL SPRAY TO GIVE ANOTHER DOSE IN THE OTHER NOSTRIL. If additional NARCAN Nasal Sprays are available, repeat step 2 every 2 to 3 minutes until the person responds or emergency medical help is received.

Evzio Naloxone HCL Injection



1. PULL OFF THE RED SAFETY GUARD

2. PLACE BLACK END AGAINST OUTER THIGH, THEN PRESS FIRMLY AND HOLD IN PLACE FOR 5 SECONDS

After using EVZIO, get emergency medical help right away.

BrightView

Information on Naloxone

An overdose is a MEDICAL EMERGENCY! Call 9-1-1 immediately

HOW DO I KNOW IF SOMEONE IS OVERDOSING?
If someone takes more opioids than their body can handle, they can pass out, stop breathing and die. An opioid overdose can take minutes or even hours to occur. A person who is experiencing an overdose may have the following symptoms:

- Slow breathing (less than 1 breath every 5 seconds) or no breathing
- Vomiting
- Face is pale and clammy
- Blue lips, fingernails, or toenails
- Slow, erratic, or no pulse
- Snoring or gurgling noises while asleep or nodding out
- No response when you yell the person's name or rub the middle of their chest with your knuckles

HOW TO RESPOND TO AN OVERDOSE:

1. Try to wake the person up by yelling their name and rubbing the middle of their chest with your knuckles (sternum rub).
2. Call 9-1-1. Indicate the person has stopped breathing or is struggling to breathe.
3. Make sure nothing is in the person's mouth that could be blocking their breathing. If breathing has stopped or is very slow, begin rescue breathing.
4. Give Rescue Breathing
   a. Step 1: Tilt their head back, lift chin, pinch nose shut.
   b. Step 2: Give 1 slow breath every 5 seconds. Blow enough air into their lungs to make their chest rise.
5. Use naloxone and continue rescue breathing at one breath every 5 seconds.
6. If the person begins to breathe on their own, put them on their side so they do not choke on their vomit.
7. Continue to monitor their breathing and perform rescue breathing if respirations are below 10 breaths a minute. If vomiting occurs, manually clear their mouth and nose.
8. Stay with the person until EMS arrives.

WHAT IS NALOXONE?
Naloxone (Narcan®) is a prescription medication that can reverse an overdose that is caused by an opioid drug. When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing. It can be given as an injection into a muscle or as a nasal spray.

Naloxone has no potential for abuse. If it is given to a person who is not experiencing an opioid overdose, it is harmless. If naloxone is administered to a person who is experiencing an opioid overdose, it will produce withdrawal symptoms. Naloxone does not reverse overdoses that are caused by non-opioid drugs.

Naloxone should be stored at room temperature and away from light. The shelf life of naloxone is approximately two years.

OVERDOSE RISK FACTORS & PREVENTION

Opioids include both heroin as well as prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (Oxycontin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora) and hydromorphone (Dilaudid, Exalgo). The following are some common risk factors for opioid overdose as well as some prevention strategies:

Mixing Drugs
Many overdoses occur when people mix heroin or prescription opioids with alcohol and/or benzodiazepines. Alcohol and benzodiaz-epines (Xanax, Klonopin, Ativan and Valium) are particularly dangerous because, like opioids, these substances impact an individual's ability to breathe. Avoid mixing opioids with other drugs or alcohol. If prescribed an opioid and a benzodiazepine by a prescriber, take only as directed.

Tolerance
Tolerance is your body's ability to process a drug. Tolerance changes over time so that you may need more of a drug to feel its effects. Tolerance can decrease rapidly when someone has taken a break from using an opioid. When someone loses tolerance and then takes an opioid again, they are at-risk for an overdose, even if they take an amount that caused them no problem in the past. If you are using opioids after a period of abstinence, start at a lower dose.

Physical Health
Your physical health impacts your body's ability to manage opioids. Since opioids can impair your ability to breathe, if you have asthma or other breathing problems you are at higher risk for an overdose. Individuals with liver (hepatitis), kidney problems and those who are HIV-positive are also at an increased risk of an overdose.

Previous Overdose
A person who has experienced a nonfatal overdose in the past, has an increased risk of a fatal overdose in the future. To prevent a fatal overdose, teach your family and friends how to recognize and respond to an overdose.

If you or someone you know needs help, please call 1.833.510.4357 to find an addiction services provider near you.

1ST TRIMESTER PRENATAL EDUCATON

WHAT TO EXPECT

- In general your first office visit should be within the first 8-12 weeks of pregnancy.
- Visits should be every 4 weeks during your first 28 weeks of pregnancy.
- Visits should be every 2-3 weeks during the 29th and 36th weeks of pregnancy.
- Visits should be weekly after 36 weeks of pregnancy.
- Your breasts will get larger and firmer. The nipples will get darker and may develop bumps on them.
- Veins in the breasts may become more noticeable. At the 4th or 5th months your nipple may start giving off a clear or cloudy liquid.
- You make feel nauseous during the first half of your pregnancy. You may also have heartburn. These discomforts can be helped by eating more often. For example, rather than eating three regular meals a day, try eating six small meals each day. Also, try to snack on plain crackers, especially early in the morning before getting out of bed.
- Your moods may change. It is not unusual for a pregnant woman to feel happy one minute, then sad soon after without an apparent reason.
- You may notice pains in your lower belly and hip areas. These are caused by the growth of your uterus.
- You may also experience changes in your legs such as mild swelling, leg cramps, and even possibly develop enlarged blood vessels in your legs (varicose veins). Getting off your feet and elevating your legs whenever possible may help.
- You may notice skin changes, such as stretch marks later in the pregnancy.
- You may get become constipated and have to strain to have a bowel movement. Hemorrhoids may develop. Constipation is best prevented or relieved by including more fiber in your diet.
- Regular sexual relations can be continued as long as it is not causing you to have pain or bleeding. For certain problems or conditions, you may be told to avoid having sex.

NUTRITION

- Take a prenatal vitamin with folic acid of 400 micrograms daily and iron. Iron supplementation should include iron of 27mg per day with vitamin and food sources.
- Consume dairy products for calcium by eating dairy products, particularly yogurt and hard cheeses, to 1,000mg daily.
- Ideal weight gain is 15-35 pounds over the course of pregnancy or about 300 extra calories a day.
- No soft cheeses such as Feta, Queso Fresco, Brie, Camembert, Blue Veined, Panela, or fresh Mozzarella.
- Avoid cold cuts, lunch meats, hot dogs, meat spreads, and dry sausage unless they are heated to an internal temperature of 165 degrees just before serving.
- Protein to 2-3 servings a day to include enough protein grams that are half of your pre-pregnant weight. protein.
- Vitamin C to 2 servings a day by eating citrus fruits, tomatoes, strawberries, melons, peppers, and potatoes.
- Vitamin A to 770 micrograms per day by eating leafy green vegetables, deep yellow and orange vegetables, milk, and liver.
- Vegetables to 3 servings a day.
- Fruits to 2 servings a day.
- Wholes grains to 3 servings a day.
- Iron foods every day by eating red meats or dark green leafy vegetables.
- Drink 8 glasses of water a day.
- Limit caffeine.

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EXERCISE

- Exercise done prior to pregnancy is generally okay. No new exercise programs unless approved by your obstetrical provider.
- Your heart rate should not exceed 130 beats per minute.

PRENATAL TESTING

- Complete blood count (CBC) screens for blood problems such as anemia (low iron).
- RPR screens for syphilis (a sexually transmitted disease).
- Rubella - tests for immunity (protection) against German measles.
- HBSAG - tests for hepatitis B (a liver infection).
- Urinalysis - tests for kidney infection and bladder infection.
- HIV - screens for antibodies in your blood.
- Cystic Fibrosis - screens for the presence of the CF gene.
- Type and screen - determines your blood type and Rh factor* (an antigen or protein on the surface of blood cells that causes an immune system response).
- Sickle cell screen.
- Gonorrhea and chlamydia testing.
- Sequential Screening of an ultrasound and blood testing to determine Down Syndrome and Open Neural Tube Defects.

PREVENTION OF ILLNESS

- Hand washing.
- Stay away from those that are ill with colds, fevers, stomach.
- Meats to be fully cooked and counter tops cleaned. No raw fish products due to Hepatitis concern.
- Do not change a cat litter box and wash hands after handling cats due to Toxoplasmosis..

SAFETY

- Always wear a seatbelt! Lap belt should be dropped across the thighs and not the abdomen..
- Have someone clean your home or work area of any chemicals or objects that could harm your baby.
- Talk with us about receiving help if you are living with domestic violence.
- Call us for any major traumas, abuse, car wrecks, or falls.
- Do not use a ladder or step stool.
- Please discuss any travel plans with your obstetrical provider.
- Please secure in open and loaded firearms in your house.
- No Jacuzzi, whirlpool, or hot tubs due to the heat

MEDICATIONS

- Avoid medications, herbs, and supplements.

VACCINATION

- Vaccinations considered safe to give to pregnant women are Hepatitis B, Influenza, and Tetanus/Diphtheria.

ALCOHOL/TOBACCO/STREET DRUGS

- No alcohol. Drinking alcohol when you are pregnant can cause birth defects, learning disabilities, behavioral problems, and mental retardation in your baby.
- No smoking. If you are a smoker, we advise you to quit. Tell us about your willingness to quit and past quit attempts so we can help understand what works for you. Let's set a quit date together. You may obtain help by calling 1-800-QUITNOW. Pregnancy complications of smoking can include preterm birth, premature rupture of membranes, vaginal bleeding, and placental abruption. It is a proven fact that women who smoke during their pregnancy give birth to babies whose birth weights are lower than average.
- No street or illicit drugs of any type. If you have a drug problem, please share that with us now. Recovery is available and it starts with being honest to us and your baby. Illegal drugs are passed along to your baby and increase the risk of a baby born with an addiction or serious health problem. You may also call the National Drug and Alcohol Treatment Referral Service at 1-800-662-4357.

WHEN TO CALL THE PROVIDER OFFICE

- A fever higher than 100.4 degrees Fahrenheit.
- Heavy bleeding, soaking more than one pad an hour for three hours.
- Unusual or severe cramping or abdominal pain.
- Severe or persistent vomiting and/or diarrhea.
- Fainting spells or dizziness.
- Pain, burning, or trouble urinating.
- Unusual vaginal discharge.
- Swelling in your hands, fingers, or face.
- Blurred vision or spots before your eyes.
- One extremity swollen more than the other.
- Severe headaches.
- Pain or cramping in your arms, legs, or chest.

MEDICATIONS

- No drug can be considered 100% safe during pregnancy.
- Allergy: Benadryl® and Claritan®
- Cold & Flu: Benadryl®, Robitussin®, plain Mucinex®, Vicks Vapor Rub®, Halls Mentho-lyptus® Cough Drops, Tylenol®, Saline nasal spray, and warm salt water gargle.
- Diarrhea: Imodium® (after the 1st Trimester-12 weeks-for 24 hours only)
- Constipation: Citrucil®, Colace®, Fiberall®, Fibercon®, and Metamucil®
- First Aid Ointment: Bacitracin®
- Headache: Tylenol®
- Heartburn: Pepcid AC®, Maalox®, Mylanta®, Titralac®, Tums®, and Zantac®
- Hemorrhoids: Preparation H®, Tucks® pads or ointment, or witch hazel.
- Nausea & Vomiting: Benadryl®, Vitamin B6 100mg tablet, and Sea-Bands®
- Rashes: Benadryl® cream, Hydrocortisone cream or ointment, Aveeno® oatmeal bath
- Sleep: Benadryl®
- Yeast Infection: Monistat®

REFERENCES

The Cleveland Clinic Foundation (1995-2014). First Trimester.
Available: http://my.clevelandclinic.org/ccf/media/files/OB_GYN/First-Trimester.pdf

RESOURCES FOR PARENTING / PARENTING SKILLS

Building good parenting skills help parents to encourage children and adolescents to feel positive about themselves and to become the winners they were meant to be.

These resources offer practical solutions for parents as well as tips for improving communication, building positive relationships and other useful parenting skills.

The goal of parenting is to teach kids to develop self-discipline. When parents learn and apply the three Fs of Effective Parenting using the parenting techniques on this page and other resources available to them, they find that a positive relationship is established.

ADDITIONAL RESOURCES AVAILABLE AT:

https://childdevelopmentinfo.com/how-to-be-a-parent/parenting/#gs.4mqv8i
Child Development Institute

https://childdevelopmentinfo.com/child-psychology/self-esteem/#gs.4n2jvd
Child Development Institute

https://www.samhsa.gov/talk-they-hear-you/parent-resources

https://www.samhsa.gov/talk-they-hear-you/parent-resources/small-conversations

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GUIDELINES FOR PARENT - CHILD RELATIONSHIPS

1) Try to set a side time on a regular basis to do something fun with your child.
2) Never disagree about discipline in front of the children.
3) Never give an order, request, or command without being able to enforce it at the time.
4) Be consistent, that is, reward or punish the same behavior in the same manner as much as possible.
5) Agree on what behavior is desirable and not desirable.
6) Agree on how to respond to undesirable behavior.
7) Make it as clear as possible what the child is to expect if he or she performs the undesirable behavior.
8) Make it very clear what the undesirable behavior is. It is not enough to say, "Your room is messy." Messy should be specified in terms of exactly what is meant: "You've left dirty clothes on the floor, dirty plates on your desk, and your bed is not made."
9) Once you have stated your position and the child attacks that position, do not keep defending yourself. Just restate the position once more and then stop responding to the attacks.
10) Look for gradual changes in behavior.
11) Don't expect too much. Praise behavior that is coming closer to the desired goal.
12) Remember that your behavior serves as a model for your children's behavior.
13) Reward desirable behavior as much as possible by verbal praise, touch or something tangible such as a toy, food or money.
14) Both parents should have an equal share in the responsibility of discipline as much as possible.

THE "3 Fs" OF EFFECTIVE PARENTING

Discipline should be:

FIRM:
Consequences should be clearly stated and then adhered to when the inappropriate behavior occurs.

FAIR:
The punishment should fit the crime. Also in the case of recurring behavior, consequences should be stated in advance so the child knows what to expect. Harsh punishment is not necessary. Using a simple Time Out can be effective when it is used consistently every time the behavior occurs. Also, use of reward for a period of time like part of a day or a whole day when no Time Outs or maybe only one Time Out is received.

FRIENDLY:
Use a friendly but firm communication style when letting a children know they have behaved inappropriately and let them know they will receive the "agreed upon" consequence. Encourage them to try to remember what they should do instead to avoid future consequences.

Work at "catching them being good" and praise them for appropriate behavior. Demonstrate in detail how you would like them to behave. Have them practice the behavior. Give them encouragement along with constructive criticism.

Rather than tell them what not to do, teach and show them what they should do. Use descriptive praise when they do something well. Say, "I like how you ____ when you ____." Be specific. Help your child learn to express how he feels. Say: "You seem frustrated." "How are you feeling?" "Are you up set?" "You look like you are angry about that." "It's O.K. to feel that way."

Try to see a situation the way your children do. Listen carefully to them. Try to form a mental picture of how it would look to them. Use a soft, confident tone of voice to redirect them when they are upset. Be a good listener: Use good eye contact. Physically get down to the level of smaller children. Don't interrupt. Ask open ended questions rather than questions that can be answered with a yes or no. Repeat back to them what you heard.

Make sure they understand directions. Have them repeat them back. When possible give them choices of when and how to comply with a request. Look for gradual changes in behavior. Don't expect too much. Praise behavior that is coming closer to the desired goal. Develop a nonverbal sign (gesture) that your children will accept as a signal that they are being inappropriate and need to change their behavior. This helps them to respond to your prompt without getting upset.

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HOW TO HELP CHILDREN AND TEENS DEVELOP HEALTHY SELF-ESTEEM

Self-esteem is how we feel about ourselves, and our behavior clearly reflects those feelings.

A child or teen with high self-esteem will be able to:

- act independently
- assume responsibility
- take pride in his accomplishments
- tolerate frustration
- attempt new tasks and challenges
- handle positive and negative emotions
- offer assistance to others

A child with low self-esteem will:

- avoid trying new things
- feel unloved and unwanted
- blame others for his own shortcomings
- feel, or pretend to feel, emotionally indifferent
- be unable to tolerate a normal level of frustration
- put down his own talents and abilities
- be easily influenced

Parents, more than anyone else can promote their child's self-esteem. It isn't a particularly difficult thing to do. If fact, most parents do it without even realizing that their words and actions have great impact on how their child or teenager feels about himself. Here are some suggestions to keep in mind.

Teach your child about decision-making and to recognize when he/she has made a good decision. Children make decisions all the time but often are not aware that they are doing so. There are a number of ways parents can help children improve their ability to consciously make wise decisions. Help the child clarify the problem that is creating the need for a decision. Ask him questions that pinpoint how he sees, hears, and feels about a situation and what may need to be changed. Brainstorm the possible solutions. Usually there is more than one solution or choice to a given dilemma, and the parent can make an important contribution by pointing out this fact and by suggesting alternatives if the child has none. Allow the child to choose one of the solutions only after fully considering the consequences. The best solution will be one that solves the problem and simultaneously makes the child feel good about himself or herself. Later join the child in evaluating the results of that particular solution. Did it work out well? Or did it fail? if so, why? Reviewing the tactics will equip the child to make a better decision the next time around.

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TEN ADDITIONAL STEPS YOU CAN TAKE TO HELP YOUR CHILD DEVELOP A POSITIVE SELF-IMAGE:

1) Teach children to change their demands to preferences. Point out to children that there is no reason they must get everything they want and that they need not feel angry either. Encourage them to work against anger by setting a good example and by reinforcing them when they display appropriate irritation rather than anger.

2) Encourage your children to ask for what they want assertively, pointing out that there is no guarantee that they will get it. Reinforce them for asking and avoid anticipating their desires.

3) Let children know they create and are responsible for any feeling they experience. Likewise, they are not responsible for others' feelings. Avoid blaming children for how you feel.

4) Encourage your children to develop hobbies and interests which give them pleasure and which they can pursue independently.

5) Let children settle their own disputes between siblings and friends alike.

6) Help your children develop "tease tolerance" by pointing out that some teasing can't hurt. Help children learn to cope with teasing by ignoring it while using positive self-talk such as "names can never hurt me," "teases have no power over me," and "if I can resist this tease, then I'm building emotional muscle." (If your child has significant problems getting along with other children check out No One to Play With).

7) Help children learn to focus on their strengths by pointing out to them all the things they can do.

8) Encourage your children to behave toward themselves the way they'd like their friends to behave toward them.

9) Help your children think in terms of alternative options and possibilities rather than depending upon one option for satisfaction. A child who has only one friend and loses that friend is friendless. However, a child who has many friends and loses one, still has many. This same principle holds true in many different areas. Whenever you think there is only one thing which can satisfy you, you limit your potential for being satisfied! The more you help your children realize that there are many options in every situation, the more you increase their potential for satisfaction.

10) Laugh with your children and encourage them to laugh at themselves. People who take themselves very seriously are undoubtedly decreasing their enjoyment in life. A good sense of humor and the ability to make light of life are important ingredients for increasing one's overall enjoyment.

PREGNANCY:

Methadone and Buprenorphine

HOW SAFE IS IT TO TAKE METHADONE OR BUPRENORPHINE (SUBUTEX®) DURING PREGNANCY?

- In the right doses, both methadone and buprenorphine stop withdrawal, reduce craving, and block effects of other opioids.
- Treatment with either methadone or buprenorphine makes it more likely that the baby will grow normally and not come too early.
- Based on many years of research studies, neither medicine has been associated with birth defects.
- Babies born to women who are addicted to heroin or prescription opioids can have temporary withdrawal or abstinence symptoms in the baby (Neonatal Abstinence Syndrome or NAS). These withdrawal symptoms (NAS) also can occur in babies whose mothers take methadone or buprenorphine
- Talk with your doctor about the benefits versus the risks of medication treatment along with the risks of not taking medication treatment.

IS METHADONE OR BUPRENORPHINE A BETTER MEDICATION FOR ME IN PREGNANCY?

- A pregnant woman and her doctor should discuss both methadone and buprenorphine. The choice may be limited by which medication is available in your community.
- If a woman is already stable on methadone or buprenorphine and she becomes pregnant, doctors usually advise her to stay on the same medication.

Some women are surprised to learn they got pregnant while using heroin, Oxycontin, Percocet or other pain medications that can be misused (known as opioid drugs). You, along with family and friends, may worry about your drug use and if it could affect your baby.

Some women may want to "detox" as a way to stop using heroin or pain medicines. Unfortunately, studies have shown that 8 out of 10 women return to drug use by a month after "detox." Therefore, most doctors treat opioid misuse in pregnant women with either methadone or buprenorphine. These are long-acting opioid medications that are associated with improved outcomes in pregnancy.

HOW CAN I GET STARTED ON METHADONE OR BUPRENORPHINE?

- Depending where you live, there may be a special program that offers care to pregnant women who need methadone or buprenorphine. These programs can offer prenatal care and substance use counseling along with your medication.
- Methadone may only be given out by specialized clinics while buprenorphine may also be available from your primary care physician or obstetrician if they have received special training.
- Some women will prefer or benefit from starting these medications while in a residential (inpatient) treatment facility.

WHAT IS THE BEST DOSE OF METHADONE OR BUPRENORPHINE DURING AND AFTER PREGNANCY?

There is no "best" dose of either medication in pregnancy. Every woman should take the dose of methadone or buprenorphine that is right for her.

- The "right" dose will prevent withdrawal symptoms without making you too tired.
- The right dose depends on how your body processes the medications.
- In pregnancy, you process these medications more quickly, especially in the last several months and this affects what dose you need.
- The dose of methadone usually needs to increase with pregnancy – especially in the third trimester and you may need to take methadone more than once a day.
- There is less known about buprenorphine dose changes in pregnancy, but increases may be necessary.
- The dose does not seem to determine how much NAS a baby will have.
- After delivery, the methadone or buprenorphine dose may remain the same or may decrease as your body returns to its non-pregnant state. This can take up to a few months after delivery.

Your dose should be reduced if it begins to cause sedation. Be sure to discuss whether you are feeling too sleepy with your doctors, nurses, and counselors. *For further information, please see brochure Childbirth, Breastfeeding and Infant Care: Methadone and Buprenorphine.*

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CONSENT TO DISCLOSE INFORMATION FOR CENTRAL REGISTRY AND OARRS

Patient Name: _____ MRN: _____

I understand that by enrolling for medication assisted treatment services at the BrightView _____ (name of site) facility, that the following information about me will be released to the Central Registry:

- Full name and any aliases;
- Month, day, and year of birth;
- Mother's maiden name;
- Sex;
- Race;
- Height;
- Weight;
- Color of hair;
- Color of eyes;
- Distinguishing markings, such as scars or tattoos;
- Admission date, discharge date, discharge reason, medication issued through date; and
- Medication and dosage
- Social Security Number (optional)

I understand that this information will be viewed by staff at any legally licensed Medication Assisted Treatment facility in the United States when I present and request enrollment and/or emergency medication services. In addition, I understand the above described information could be released to any duly appointed State Opioid Treatment Authority and their staff for the purposes of monitoring dual enrollment verifications.

I hereby authorize BrightView to disclose the above described information as permitted by state and federal law to the State's Central Registry. BrightView may also disclose the above described information to withdrawal management or maintenance treatment programs within a radius of 100 miles from this location.

The purpose of the disclosure is to prevent dual enrollment in medication assisted treatment services facilities. I understand that this/these disclosure/disclosures will be made when I am accepted for treatment, when the type or dosage of my medications are changed, or when treatment is interrupted for a duration of greater than one week, resumed, or terminated.

I understand that the above information will be maintained in the Lighthouse Software Systems, LLC ("LHSS") central registry system for purposes of my participation in a Central Registry within the State of Ohio, and also for the purpose of aiding my care in times of disaster and preventing multiple medicated assisted treatment program enrollments. LHSS is located at 2120 Placentia Avenue, Costa Mesa, CA. The Central Registry will contain presently prescribed medication(s) used for my treatment and my schedule of dosing records.

A review if central Registry will occur at a minimum when:

(a) Accepting the patient for treatment;
(b) Changing the dosage being administered or dispensed to the patient; or,
(c) When the treatment is interrupted for a duration of greater than one week, resumed, or terminated.

OARRS is the State of Ohio's drug database maintained by the state board of pharmacy, it is a tool that can be used to address prescription drug diversion and abuse. It serves multiple functions, including: patient care tool; drug epidemic early warning system; and drug diversion and insurance fraud investigative tool. As the only statewide electronic database that stores all controlled substance dispensing and personal furnishing information, OARRS helps prescribers and pharmacists avoid potentially life-threatening drug interactions as well as identify individuals fraudulently obtaining controlled substances from multiple health care providers, a practice commonly referred to as "doctor shopping." It can also be used by professional licensing boards to identify or investigate clinicians with patterns of inappropriate prescribing and dispensing, and to assist law enforcement in cases of controlled substance diversion .

An OARRS review is done:

(a) At the patient's intake;
(b) At the initiation of treatment;
(c) After the initial thirty days of treatment;
(d) When the number of take home doses is increased;
(e) Every ninety days;
(f) When a patient refuses to participate in a drug screen; and,
(g) After any positive drug test indicating any drug screen inconsistent with the patient's treatment plan.

This information will reside in the LHSS Central Registry system while I remain a patient at this location and will be available to staff where I may present to admission or emergency medication services for up to 60 days after my discharge from treatment at this location. My name will be encrypted in the LHSS Central Registry System database with technology that will meet the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliance requirements.

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 C.F.R. Part 2) and HIPAA (45 C.F.R. Parts 160 and 164). I understand that my health information specified below will be disclosed pursuant to this authorization, that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA Privacy Law. The federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 C.F.R. Part 2), noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in a substance use disorder treatment program from re-disclosure. A central registry and any withdrawal management or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under Part 2.

This consent will automatically expire upon discharge from the program. I also understand that I may revoke this consent at any time. However, if I choose to revoke this consent I will not be allowed to continue treatment.

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Patient Notification:
This program is required to notify each patient prior to admission that it cannot provide medication assisted treatment to a patient who is simultaneously receiving medication assisted treatment from another program, unless the medication is being provided in response to an emergency or disaster that forced the closure of the patient's regular home clinic.

Patient Statement:
I am not receiving medication assisted treatment from another program and I understand that if I do not sign this statement I will not be admitted for treatment.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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PATIENT EDUCATION REGARDING OTP TRANSFER PROCESS

If you are currently receiving medication assisted treatment from another program and need to transfer to BrightView you should know the following about the transfer process:

- You will have to sign a release of information (ROI) consent for the purpose of authorizing BrightView to contact the previous program you were enrolled in to notify that previous program that you have applied for admission to BrightView's medication assisted treatment program.
- Once you have authorized the release of information to the previous program BrightView will contact the previous program by phone to notify the previous program that you have applied for admission in BrightView's program.
- BrightView will request information to be transferred from the previous program to BrightView within 72 hours. The information requested will include:
    - Medication type;
    - Medication dosage;
    - Length of time in treatment;
    - Current take home regimen or phase level; and
    - Most recent urine drug screens
- BrightView will also request that the previous program stop providing medication assisted treatment if it has not already done so, and only if BrightView has documentation to verify medication type and dosage.
- BrightView will also request that the previous program provide BrightView with written documentation (either a letter or discharge summary) that the previous program has discharged you as a patient. This information shall be provided within 72 hours of receiving the request from BrightView. If the previous program states that is has already discharged you as a patient, BrightView may then admit you for treatment.
- BrightView will document the following in your record:
    - The name of the previous program contacted;
    - The date and time of the contact;
    - The name of the program staff member contacted at the previous program; and
    - The results of the contact.
- If you state you are a visiting patient approved to receive services on a temporary basis, before BrightView provides medication assisted treatment it will contact your other program to determine that it has not already provided you with medication assisted treatment for the same time period and that it will not do so and BrightView will document the following in your record:
    - The name of the previous program contacted;
    - The date and time of the contact;
    - The name of the program staff member contacted at the previous program; and
    - The results of the contact.
- If you state that you are not currently receiving medication assisted therapy from another program then BrightView will proceed with its patient admission procedures.

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WHAT YOU SHOULD KNOW ABOUT HIV & AIDS^

WHAT IS HIV?

Human Immunodeficiency Virus (HIV) is a virus that weakens your immune system by destroying specific cells that fight infection and disease. HIV is an infection that progresses in three stages:

STAGE 1	Acute HIV infection	A person with acute HIV may develop flu-like symptoms within 2-4 weeks of infection, with symptoms that may last for several weeks.
STAGE 2	Chronic HIV infection	Once a person's body is infected, it is infected for life. However, with proper medical care, a person with HIV may live nearly as long as someone who does not have HIV. Untreated HIV can progress to AIDS, typically 8-10 years after testing positive for HIV.
STAGE 3	AIDS	**Acquired Immunodeficiency Syndrome (AIDS)** is the most severe phase of HIV infection. AIDS is diagnosed when the CD4 T cell count falls below 200, or a person experiences an AIDS-defining complication (e.g., serious infection or cancer). Antiretroviral therapy (ART) can prevent HIV from destroying the immune system and advancing to AIDS. Without treatment, people with AIDS can survive about 3 years.

WHAT IS AIDS?

HOW IS HIV TRANSMITTED?

- Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen, cervical/vaginal, and/or anal mucus secretions are exchanged
- Sharing syringes, needles, cotton, cookers, and other drug injecting equipment with someone who is infected
- Receiving contaminated blood or blood products (very unlikely after March 1985)
- An infected mother, not on ART, can pass HIV to her unborn child before or during childbirth, or through breastfeeding
- Receipt of transplant, tissue/organs, or artificial insemination from an infected donor (very rare)
- Needle stick or other sharps injury in a health care setting involving an infected person (very rare)

HIV IS NOT TRANSMITTED BY

EARLY DIAGNOSIS OF HIV INFECTION IS IMPORTANT!

GETTING TESTED FOR HIV:

Everyone should be tested at least once for HIV.
The Centers for Disease Control and Prevention (CDC) recommends persons who report any of the activities listed below should be tested at least yearly:

- A man who has had sex with another man*
- Injecting not medically prescribed drugs and sharing needles or other drug equipment
- Exchanging sex for money or drugs
- Diagnosed with or treated for another sexually transmitted infection, hepatitis, or tuberculosis
- Having more than one sexual partner since their last HIV test
- Having unprotected sex or sex with someone who has had unprotected sex

* Sexually active men who have sex with men may benefit from more frequent testing (e.g., every 3–6 months)

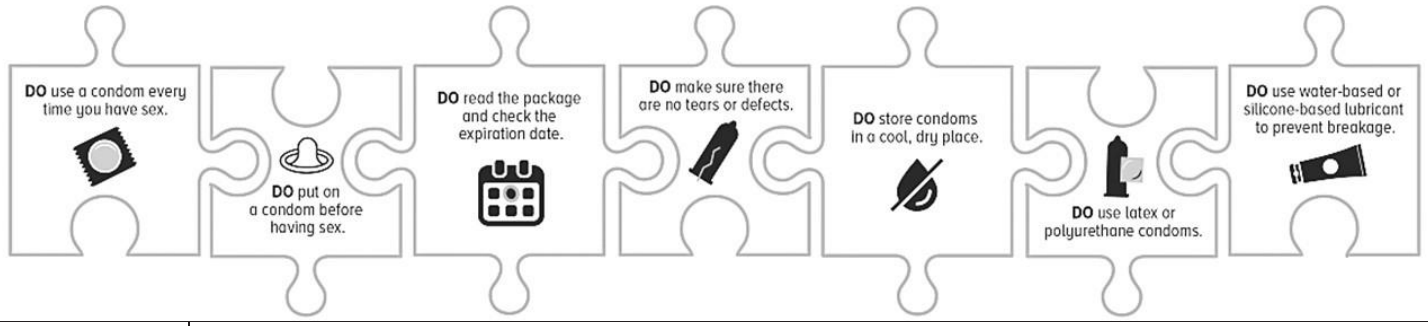
New infections may be identified as early as 4 weeks with new advances in screening tests. Free anonymous and confidential testing and counseling is available at every health department in Kentucky. If you have HIV, seek care immediately and a provider will help determine the best treatment plan. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible.

Remember, you cannot tell whether someone has HIV just by looking at them!

HOW CAN I PREVENT HIV?

- Educate yourself and others about HIV infection and AIDS
- Do not share needles or other drug paraphernalia
- Practice "safer" sex:
  - ✓ Abstinence (not having sex of any kind)
  - ✓ Sex only with a person who does not have HIV, does not practice unsafe sex, or inject drugs
  - ✓ Using either a male or female condom or dental dam (for oral sex)
  - ✓ Do not share sex toys
- Persons at higher risk can help prevent HIV infections through the use of pre-exposure prophylaxis (PrEP)
- Exercise universal precautions when coming into contact with HIV infected blood, semen, or vaginal fluid

HOW TO CORRECTLY USE A MALE CONDOM:



WHAT IS PrEP?

PrEP means taking HIV medications daily (i.e., Truvada, Descovy) by persons who have not been diagnosed with HIV, but who are at risk of acquiring HIV via sex or injection drug use. When taken daily, this medication can effectively stop HIV infection. Persons taking PrEP should continue to use condom for maximum protection.

WHAT IS PEP?

Post-exposure prophylaxis (PEP) is an HIV medication taken within 72 hours (3 days) of a potential exposure to HIV. Once prescribed, PEP will be dosed 1-2 times daily for 28 days. PEP is intended for persons who have tested negative for HIV or are uncertain of their HIV status and should only be used in emergency situations.

WOMEN AND HIV/AIDS

All pregnant women should have blood tests to check for HIV infection.

Women diagnosed with HIV who are not on treatment can pass HIV infection to their babies during pregnancy, labor and delivery, and through breastfeeding of passing HIV to the baby to 1% or less if they practice all of the following:

- Take ART daily
- Give HIV treatment to her baby for 4-6 weeks after giving birth
- Do not breastfeed or pre-chew her baby's food

UNDETECTABLE = UNTRANSMISSIBLE

Persons with HIV who take their HIV medicine as prescribed may remain virally suppressed or undetectable and healthy, with effectively no risk of sexually transmitting HIV to their HIV-negative partners.

LIVING HEALTHY WITH HIV

Begin treatment as soon as possible and take prescribed medications daily. Maintaining an undetectable viral load is the key to living a longer, healthier life.

- Healthy living behaviors for the general public are even more important for those living with HIV:
  - ✓ A healthy diet provides energy and nutrients a person's body needs to fight disease and infections (It may also improve absorption of prescribed medications and may help offset potential side effects.)
  - ✓ Exercise strengthens the immune system to better combat infections
- Discordant couples are at higher risk of HIV transmission:

HIV Negative Partner Should:	○ Be routinely tested for HIV ○ Ask their health care provider about PrEP
HIV Positive Partner Should:	○ Take ART daily as prescribed
Both Partners Should:	○ Use condoms during sex ○ Not engage in sex with other people

THIS AGENCY PROVIDES QUALITY SERVICES TO ALL PATIENTS, REGARDLESS OF HIV STATUS.

IF YOU NEED MORE INFORMATION CALL:	**Kentucky HIV/AIDS Program 502-564-6539**
1-800-CDC-INFO (232-4636) | 1-888-232-6348 TTY	-or- Your local health department's HIV/AIDS Coordinator

^retrieved 6/17/2020 from: https://www.cdc.gov/hiv/basics/

BrightView

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS

As a patient of BrightView, it is important that we be able to contact your using your wireless telephone or email to remind you of appointments, to obtain your feedback on your experience with our healthcare team, to obtain feedback for marketing purposes and to provide you with advertisements or telemarketing messages. We may use an automatic telephone dialing system or an artificial or pre- recorded voice to deliver these messages to you.

By entering your wireless telephone number or email below, you authorize BrightView, LLC, its employees and its agents, to send emails or text messages, and make telephone calls to that number. You agree that we may use your wireless telephone number or email address to send you information, including healthcare information, advertisements and telemarketing messages. You also understand that we may use an automatic telephone dialing system or an artificial or pre-recorded voice to deliver these messages to your wireless telephone number.

Brightview, LLC does not charge for these services, but regular text messaging or incoming call rates may apply. Contact your carrier for pricing plans and details.

You are not required to provide this consent in order to receive services from BrightView.

You may revoke this consent at any time by providing us with notice that you no longer want to receive these communications via your wireless telephone, or by replying "STOP" to any text message or email you receive from us.

You consent to receiving these communications at the following wireless telephone number:

_____

You consent to receiving these communications at the following email address: .

_____

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

- If BrightView determines that it is providing medication assisted treatment to you while you are also receiving medication assisted treatment from one or more other programs, all of the programs shall:
    - Determine which program will accept sole responsibility for your treatment;
    - Revoke your take-home medication privileges; and
    - Notify the state authority by phone within 72 hours of such determination.
- The program that agrees to accept sole responsibility for any patient with multiple enrollments shall continue to provide medication assisted treatment and all other programs shall:
    - Immediately discharge a patient from their program;
    - Document in that program's record why the patient was discharged from the program;
    - Provide to the new program, within 72 hours of the discharge, written documentation (either a letter or discharge summary) that it has discharged the patient; and
    - Send written notification of the discharge to the state authority within 72 hours of the discharge.
- If the state authority determines that you are enrolled in multiple programs, and none of the programs accept sole responsibility for you, the state authority shall designate one program to accept sole responsibility for your care.
- You have the right to be re-admitted to the transferring program if space is available.

☐ I acknowledge that I have read and understood the above information.

BrightView

Consent for the Release of Information under 42 C.F.R. PART 2 Confidentiality of Substance Use Disorder Patient Records

I, _____ authorize _____
(Name of patient) (Name of provider)

Information to be disclosed I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclosure of the substance use disorder records below:

☐ All my substance use disorder records;

or only the following specific types of records:

☐ Toxicology Results ☐ Medication(s)/dosing ☐ Assessments Treatment plan
☐ Lab results ☐ Appointments ☐ Diagnostic information
☐ Discharge Summary ☐ Substance Use History ☐ Trauma History Summary
☐ Progress in Treatment Insurance ☐ info/demographics

To: _____
(Name of person or organization to which disclosure is to be made)

Phone:_____ Fax: _____

For (purpose of disclosure): administration ☐ Continuity of Care ☐ Coordinating Treatment
☐ Emergency Contact ☐ Payment/Benefits
☐ Other:_____

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I also understand that, to the extent my patient records contain patient records from my other providers, those records cannot be re-disclosed without my express written consent which I am granting by signing this form. I do not need to sign this form to obtain treatment. I understand Insurance payment, enrollment or eligibility maybe affected if I do not sign. I understand I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either :

☐ in one year from the date of signature OR 90 days after discharge (whichever comes first); **OR upon a specific**
☐ **date, event, or condition as listed here:** _____
(Specific date, event or condition)

Patient's Signature: _____ Date: _____
If the patient is a minor, only the minor can sign this consent.

_____ _____ _____
Print Name Date of Birth (MM/DD/YY) Medical Record Number

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: _____

Print: _____

Legal Authority:_____ Date: _____

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Patient Revocation:_____ Date: _____

NOTICE TO RECIPIENT OF INFORMATION
42 CFR part 2 prohibits unauthorized disclosure of these records.

BrightView

Notice of Federal Requirements Regarding the Confidentiality of Substance Use Disorder Patient Information

The confidentiality of substance use disorder patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing; **or**
2. The disclosure is allowed by a court order accompanied by a subpoena; **or**
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; **or**
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program,

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

The releases of information will remain active and valid for one year from the date of signature OR until 90 days after discharge (whichever comes first) OR until a specific date, event, or condition as listed on the form. There are two ways to revoke a release of information: Come in to the BrightView facility where you were scheduled to receive treatment and sign the revocation, or fax in a written statement with your name, signature, date and release(s) you would like to be revoked.

(See 42 U.S.C. §290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Substance Use Disorder Patient Records.)

BrightView

BRIGHTVIEW INFORMED CONSENT - TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care.

Providers may include practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, treatment, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and medical data and will include measures to safeguard data to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in a clinical setting (or at a remote site) while the practitioner obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

Clinical Considerations:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Security considerations:

- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

Confidentiality considerations:

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.

TELEHEALTH LOCAL RESOURCES

1. Local suicide prevention hotline
2. Contact information for Local Police
3. Contact information for Local Fire Department,
   how to access crisis assistance for equipment malfunction

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My practitioner has explained the alternatives to my satisfaction.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
5. I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my practitioner or other treatment providers as designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Patient Name Printed: _____

Patient Signature: _____

Date: _____

EVERY VISIT COUNTS

Why is Consistency so Important in Recovery?

Our goal at BrightView is to help patients enjoy successful, long-term recovery. Every time a patient completes an appointment, they are increasing their chances of success and continuing to heal.

We evaluated the visit mix and outcomes of over 25,000 BrightView patients to develop the roadmap to recovery. We want to educate patients on the level of engagement needed to achieve their short- and long-term goals. While these monthly plans reflect the minimum level of engagement, we encourage our patients to participate in more sessions.

Now that BrightView has the data science to support the roadmap for patient engagement, we proactively guide patients who show signs of dropping out. Our research is clear that falling below these benchmarks indicates that patients will drop out of the program within the following 30 days. By following this outline, patients will achieve a minimum of one year of sobriety.

OUTCOMES & BENEFITS

After just 90 days in the program, patients experience:

- **70%** decrease in substance use and **50%** decrease in alcohol use
- **70%** decrease in arrests and **90%** decrease in jail time
- **50%** decrease in unemployment
- **40%** decrease in depression
- **50%** decrease in emergency room visits and **60%** decrease in hospitalizations

833.510.HELP (4357) brightviewhealth.com

BrightView

PHASE 1
MONTHLY PLAN

- **4** COUNSELING SESSIONS
- **4** MEDICAL APPOINTMENTS
- **2** CASE MANAGEMENT VISITS
- **2** GROUP THERAPY SESSIONS

PHASE 2
MONTHLY PLAN

- **2** COUNSELING SESSIONS
- **2** MEDICAL APPOINTMENTS
- **2** CASE MANAGEMENT VISITS
- **2** GROUP THERAPY SESSIONS

PHASE 3
MONTHLY PLAN

- **1** COUNSELING SESSION
- **1** MEDICAL APPOINTMENT
- **1** CASE MANAGEMENT VISIT
- **1** GROUP THERAPY SESSION

BrightView

CLINICAL ENGAGEMENT PERKS PROGRAM

You can collect tickets by participating in:

GROUP THERAPY

INDIVIDUAL COUNSELING

CASE MANAGEMENT

PEER SUPPORT

Redeem your tickets and completed punch cards for recovery support aids and other perks! Please note that to receive tickets, you must be on-time and actively engaged in therapy.

Questions about the program? Your clinical team would love to help!

513.510.HELP

brightviewhealth.com

BrightView

Dear Patient,

Welcome to BrightView. We appreciate the opportunity to be of service to you. Our office is dedicated to excellence in patient care. To maintain our high standards, we believe that it is important that we communicate our policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, the office staff is happy to help answer them. By presenting these policies in advance, we can avoid any surprises or misunderstandings. We appreciate your time and your understanding.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

• **Payment Responsibility:** I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. It is my responsibility to confirm coverage is provided by my insurance company or other provider. I understand that if I am a Kentucky or Indiana resident that no benefits provided by the State of Ohio will be provided to me.

• **Charges for Additional Services:** I understand that charges will be added to my account for other professional services rendered. These charges will be in increments of 15 minutes, or by encounter, and BrightView will always discuss additional charges with me. Other professional services include extended contact via email, consulting with other professionals (with my permission), preparation of records or treatment summaries, and the time spent performing any other service I may request.

• **Appointments & Cancellations:** I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. Repeated missed appointments may result in termination of therapy. There may be a time when my therapist or physician may need to cancel my appointment for an emergency; BrightView will make every effort to reschedule me/my family in an appropriate time frame. This will be at no charge to me.

I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Name: _____

Last First Middle Initial

Patient/Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

BrightView

Service	Additional Criteria	Billing Code	Self Pay Fee	Units
Individual Counseling		90832	$96.82	0-37 Minutes
		90834	$126.69	38-52 minutes
		90837	$188.49	53+ minutes
Group counseling session		90853	$163.00	Session
Case Management session		H0006	$19.54	Per 15 minutes
Medical visits				
	New Patient, level 2	99202	$112.27	Encounter
	New Patient, level 3	99203	$168.92	Encounter
	New Patient, level 4	99204	$246.17	Encounter
	New Patient, level 5	99205	$307.97	Encounter
	Established Patient, level 1	99211	$33.99	Encounter
	Established Patient, level 2	99212	$67.98	Encounter
	Established Patient, level 3	99213	$111.24	Encounter
	Established Patient, level 4	99214	$162.74	Encounter
	Established Patient, level 5	99215	$219.39	Encounter
Urine Pregnancy Screening		81025	$10.00	Test
Alcohol Breath Testing		82075	$30.90	Test
Interactive Complexity		90785	$23.69	Encounter
Behavior Assessment		96156	$38.11	Encounter
Intramuscular Injections		96372	$48.00	Encounter
Smoking Cessation		99406	$24.00	3-10 minutes
		99407	$48.00	10+ minutes
SUD Assessment		H0001	Individual Counseling (see above)	
Withdrawal Management		H0014	$348.50	Encounter
IOP Group (2+ hours)		H0015	Group Counseling (see above)	
OTP	**Additional Criteria**	**Billing Code**	**Self Pay Fee**	**Units**
J0574 - Buprenorphine/naloxone, oral, >6mg, <10mg		J0574	$13.86	10mg
J0571 - Buprenorphine, oral, 1 mg.		J0571	$2.65	mg
J0572 - Buprenorphine/naloxone, oral, less than or equal to 3 mg.		J0572	$9.24	3mg
S5000 - Buprenorphine/naloxone, generic, per 1mg bup/0.25mg Naloxone		S5000	$1.20	mg
Buprenorphine/naloxone Take Home		S5000: HD	$0.55	mg
Daily dose administration	Methadone/Buprenorphine	T1502: HF	$16.87	Encounter
1-week dose administration	Methadone/Buprenorphine	T1502: TV	$120.15	Encounter
2-week dose administration	Methadone/Buprenorphine	T1502: UB	$236.19	Encounter
3-week dose administration	Methadone/Buprenorphine	T1502: TS	$354.29	Encounter
4-week dose administration	Methadone/Buprenorphine	T1502: HG	$459.00	Encounter
Lab Services	**Additional Criteria**	**Billing Code**	**Self Pay Fee**	**Units**
Drug Screen		80307	$90.00	Test
Confirmatory Testing	1-7 analytes	G0480	$235.00	Test
	8-14 analytes	G0481	$320.00	Test
	15-21 analytes	G0482	$400.00	Test
	22+ analytes	G0483	$480.00	Test

BrightView

FINANCIAL ASSISTANCE

The Bright View Health is dedicated to servicing the health care needs of its patients. To assist in meeting those needs, we have established this "Financial Assistance Policy" to provide financial relief to those patients who first meet the requirements as described in this policy.

Brightview Health is committed to providing medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for services rendered.

Brightview Health offers financial assistance to patients seeking treatment whose income is at or under a percentage of the publicly available Federal Poverty Guidelines. To qualify for financial assistance from Brightview Health, the patient must:

- Cooperate with Case Manager and Financial Counselor efforts to apply and qualify for Medicaid and/or Foundation of Recovery.
- Be deemed ineligible for Medicaid or other governmental programs
- Submit application for financial assistance and all accompanying documentation

BrightView

Proof of income

As part of the application, at least one of the items in the following list of documentation is required for proof of income. If more than one is applicable, all should be submitted.

a. If you claim that you have no income, a sworn statement from the individual providing you basic support is required.
b. Three consecutive months of pay stubs, or all pay stubs within past three months if not employed for three months.
c. Copy of previous year's federal tax return.
d. Social Security, Unemployment, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.

Some individuals may not have income able to be documented as indicated above but have significant assets available to pay for healthcare services. In these situations, Brightview may require documented proof of assets for evaluation and approval of the application.

Application Processing

Upon receipt of the required documentation, the application will be processed by the Revenue Cycle team and resulting discounts will be applied to outstanding patient balances. The patient or guarantor is responsible for the remaining balance after discounts. The Revenue Cycle team will attempt to notify the patient of discounts, but no guarantees are made of notification, outside of the reflection of discounts on future statements or requests for payment.

Eligibility Criteria

Eligibility for discount will be based upon income for the family, as a percentage of Federal Poverty Guidelines. The qualification for discounts is listed in the table below and may be updated in accordance with updates to the Federal Poverty Guidelines.

For families/households with more than 8 persons, add $4,480 for each additional person.				
	100% discount	**100% discount**	**85% discount**	**50% discount**
Family Size	Under FPL	100% - 200% FPL	200% - 300% FPL	300% - 400% FPL
1	$12,760	$25,520	$38,280	$51,040
2	$17,240	$34,480	$51,720	$68,960
3	$21,720	$43,440	$65,160	$86,880
4	$26,200	$52,400	$78,600	$104,800
5	$30,680	$61,360	$92,040	$122,720
6	$35,160	$70,320	$105,480	$140,640
7	$39,640	$79,280	$118,920	$158,560
8	$44,120	$88,240	$132,360	$176,480

Approval Duration

Approval for Financial Assistance will be for six-month time periods. After six months, an updated application will be required.

BrightView

Date Received by Site:	
Primary Site:	
CareLogic MRN:	
Date Received by FCT:	

FINANCIAL ASSISTANCE APPLICATION

Today's Date: _____

Patient's Name: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

1. This application must be completed in its entirety to be considered for financial assistance.
2. Please list all family members (including yourself). Family members include the applicant, spouse, children (natural or adoptive) under the age of 18 in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security/Pension benefits, alimony, public assistance, self-employment, etc. Income also includes rent or living expenses that are being provided for you.

Family Member	Age	Relationship to Patient	Income Source	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.		Self			
2.					
3.					
4.					
5.					
6.					

Send proof of three months of gross income with this application:

Gross income is total income before taxes are taken out, and includes but is not limited to:

- Three consecutive months of pay stubs or all pay stubs within the last three months if not employed for three months.
- Copy of previous year's federal tax return.
- Social security, unemployment, alimony, child support, workers compensation award letter, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.
- Any other income statements.

3. If you reported zero total income, how are you being supported?

_____

_____

Please have the following support statement completed by the person(s) helping to support you and/or your family.

BrightView

FINANCIAL ASSISTANCE APPLICATION

Support Statement

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being supported financially. List services, if any, that you are receiving for providing this support.

_____

_____

_____

_____

I certify that all of the above information provided is true and correct to the best of my knowledge. My signature does not obligate me to provide financial support related to the medical service of the applicant.

_____ Signature of person providing financial support to applicant

_____ Address of responsible party

_____ City, State Zip Code

4. Have you applied for Medicaid or any other county assistance?

_____ No Yes (Date/State _____

5. Are you interested in applying for Medicaid (you may be eligible for secondary coverage even if you are currently insured)?

_____ No _____ Yes

6. Did you have health insurance on the date of service?

_____ No _____ Yes (Provide a copy of your card)

By signing this document, I affirm the answers on this application are true. Should further review of an individual's financial assistance application reveal that information provided was either incorrect of fraudulent, the decision to provide assistance may be reversed and the responsible party will be billed.

Patient Signature: _____ Date: _____

Applicant or Representative Signature: _____

Relationship: _____ Date: _____

Mail completed application and documentation to:

Brightview, LLC
P.O. Box 639886
Cincinnati, Ohio 45263-9886

BrightView

RESOURCES

- **Ohio Medicaid Managed Care Enrollment Center:** 1-800-605-3040
- **Official Ohio Medicaid Website:** https://medicaid.ohio.gov/
- **Ohio Department of Job and Family Services official website:** https://jfs.ohio.gov/
- **Medicaid Hotline:** 1-800-324-8680
- **Medicare:** 1800-633-4227
- **Foundation of Recovery:** 513-873-1199 (Fax number: 513-873-1567) (Website https://foundationofrecovery.org/)

Ohio
Department of Medicaid

Application for Health Coverage & Help Paying Costs

ODM 07216 (7/2014)

THINGS TO KNOW

Use this application to see what you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit **HealthCare.gov**.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

Apply faster online at **HealthCare.gov** or **benefits.Ohio.gov**.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, visit: https://medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/coverage/already-covered/rights/notice-of-privacy-practices

What happens next?

Send your complete, signed application to your local County Department of Job & Family Services office. Find your county office here: **jfs.ohio.gov/County/County_Directory.pdf**
If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call **(800) 324-8680**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** **HealthCare.gov** or **benefits.Ohio.gov**
- **Phone:** Call the Medicaid Consumer Hotline at **(800) 324-8680.**
- **In person:** Contact your local County Department of Job & Family Services office.
- **En Español:** Llame a nuestro centro de ayuda gratis al **(800) 324-8680.**

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or **benefits.Ohio.gov** or call us at **(800) 324-8680**. Para obtener una copia de este formulario en Español, llame **(800) 324-8680**. If you need help in a language other than English, call **(800) 324-8680** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(800) 292-3572**.

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.)

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. County

8. Mailing address (if different from home address)

9. Apartment or suite number

10. City

11. State

12. ZIP code

13. County

14. Phone number
(_____) _____- _____

15. Other phone number
(_____) _____- _____

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

19. For which programs would you like to apply? (Please check). For information about these programs, please see Appendix D.

☐ Healthy Start & Healthy Families (Medicaid)
☐ Child & Family Health Services (CFHS)
☐ Help Me Grow
☐ Nutritional Program for Women, Infants & Children (WIC)
☐ Bureau for Children with Medical Handicaps (BCMH)

STEP 2 Tell us about your family.

Who do you need to include on this application? Tell us about them.

If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you
- Anyone else who lives with you but is temporarily absent and there is a definite plan for their return.

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage, unless you have a common child who lives with you.
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

What is your expected due date? _____

8. **Do you want health coverage?** Even if you have insurance, there might be a program with better coverage or lower costs.

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** but you have immigration documents, please provide the following:

a. Alien number _____

b. Document type _____ c. Document ID number _____

d. Have you lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

e. Are you, your spouse, or your parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. If you live with at least one child under the age of 19, are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Self-employed**
Skip to question 27.

☐ **Not employed**
Skip to question 28.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
(_____) _____- _____

20. Wages/tips (before taxes) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number
(_____) _____- _____

24. Wages/tips (before taxes) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
$ _____

25. Average hours worked each WEEK

26. **In the past year, did you:** ☐Change jobs ☐Stop working ☐Start working fewer hours ☐None of these

27. **If self-employed, answer the following questions:**

a. Type of work
_____

b. How much net income (profits, once business expenses are paid) from this self-employment will you get this month?
$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often you receive it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ How often?
☐ Net rental/royalty $ How often?
☐ Other income $_____ How often? _____
Type: _____

29. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often you receive it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____
Type: _____

30. **YEARLY INCOME:** **Complete only if your income changes from month to month.**
If you don't expect changes to your monthly income, skip to the next person. ➡

Your total income **this year**
$

Your total income **next** year (if you think it will be different)
$

THANKS! Please complete STEP 2: Person 2 for anyone else listed in the "Do Include" column on Page 1.

STEP 2: PERSON 2

If you have more than two people to include, use copies of Appendix E to provide information about additional people for this application.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____
What is your expected due date? _____

9. **Does PERSON 2 want health coverage?** Even if they have insurance, there might be a program with better coverage or lower costs.

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** but has immigration documents, please provide the following:
a. Alien number _____
b. Document type _____ c. Document ID number _____
d. Has PERSON 2 lived in the U.S. since August 22, 1996? ☐ Yes ☐ No
e. Is PERSON 2, their spouse, or their parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. If PERSON 2 lives with at least one child under the age of 19, are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

Now, tell us about any income from PERSON 2 on the back.

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Self-employed**
Skip to question 29.

☐ **Not employed**
Skip to question 30.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
(_____) _____- _____

22. Wages/tips (before taxes) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
(_____) _____- _____

26. Wages/tips (before taxes) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐Change jobs ☐Stop working ☐Start working fewer hours ☐None of these

29. **If self-employed, answer the following questions:**

a. Type of work
_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often you receive it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ How often?
☐ Net rental/royalty $ How often?
☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often PERSON 2 receives it.
If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**
If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**
$ _____

PERSON 2's total income **next year** (if you think it will be different)
$ _____

THANKS! This is all we need to know about PERSON 2.

STEP 3 American Indian or Alaska Native family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** please also complete Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance

Name of health insurance

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance

Policy number

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse (including a parent or spouse not included on this application).

☐ **YES. If yes,** you'll need to complete and include Appendix A.

☐ **NO. If no, continue to Step 5.**

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Ohio Department of Medicaid if anything changes (and is different than) what I wrote on this application. I can call **1-800-324-8680** to report any changes within 10 days. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

Check one of the following:

☐ I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

☐ _____ is incarcerated (detained or jailed).
(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

STEP 5 Read & sign this application: continued

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Ohio Department of Medicaid or Marketplace to use income data, including information from tax returns.

The Ohio Department of Medicaid or the Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my/our eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Healthy Start, Healthy Families Medicaid program, WIC, and medical assistance programs. I also authorize the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, and the Ohio Department of Health to exchange any information I have provided on this form, to enable the departments to determine my eligibility.

My right to appeal

If I think the Ohio Department of Medicaid or the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Ohio Department of Medicaid or the Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Ohio Department of Medicaid at **1-800-324-8680**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your complete, signed application to your local County Department of Job & Family Services office.

Find your local office by visiting this link: **jfs.ohio.gov/County/County_Directory.pdf**

You can complete the voter registration form attached to this application.

APPENDIX A

Health Coverage from Jobs

You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last, Suffix)	2. Employee Social Security number _____- _____- _____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____- _____
5. Employer address		6. Employer phone number (_____) _____- _____
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) (_____) _____- _____	12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or call us at **(800) 324-8680**. Para obtener una copia de este formulario en Español, llame **(800) 324-8680**. If you need help in a language other than English, call **(800) 324-8680** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(800) 292-3572**.

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last, Suffix)	2. Social Security Number _____-_____-_____

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) _____-_____
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. Email address

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name _____ ☐ No	☐ Yes If yes, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often?_____	$ _____ How often?_____

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APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local County Department of Job and Family Services. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name, Suffix)		
BrightView LLC		
2. Address PO Box 639886		3. Apartment or suite number
4. City Cincinnati	5. State OH	6. ZIP code 45263
7. Phone number (513) 834 – 7063		
8. Organization name BrightView LLC		9. ID number (if applicable) 0124774

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or benefits.Ohio.gov or call us at **(800) 324-8680**. Para obtener una copia de este formulario en Español, llame **(800) 324-8680**. If you need help in a language other than English, call **(800) 324-8680** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(800) 292-3572**.

APPENDIX D

HEALTH COVERAGE PROGRAMS

Ohio offers families a variety of options for getting health care services. Below is a brief description of four publicly funded programs that are available throughout Ohio. Families can apply for one or all of the following programs by using the attached application.

Healthy Start and Healthy Families

The Healthy Start and Healthy Families programs offer free or low-cost health coverage to families, children (up to age 19) and pregnant women. Certain young adults meeting specific criteria may be covered up to age 21.

Coverage includes: doctor visits, hospital care, pregnancy-related services, prescriptions, vision, dental, substance abuse treatment, mental health services and much more! These are important health care services that your family needs to stay healthy and strong. Healthy Start and Healthy Families are Medicaid programs administered by the Ohio Department of Medicaid. For more information, please call 1-800-324-8680 or visit **medicaid.ohio.gov**.

Women, Infants & Children (WIC)

The Women, Infants, and Children (WIC) program provides nutritious foods, important nutrition information, and breastfeeding education and support. It also helps eligible families find health care or other services they need. To be eligible for WIC, you must be a woman who is pregnant or breastfeeding or have a baby less than six months old. Children from birth to age 5 also qualify. Families must meet WIC income and medical or nutritional risk guidelines. To apply, complete the attached application or visit your local WIC clinic. The WIC program is administered by the Ohio Department of Health.

Child & Family Health Services (CFHS)

The Child and Family Health Services (CFHS) program in your area may provide one or more of the following services: child and adolescent health care and prenatal care. Clinics offer physicals, nutrition counseling, social services, laboratory tests, health education and more. The cost of the clinic services is based on your family size and income but no one is turned away from services if they cannot pay. To apply, please complete the attached application or visit your local CFHS. This program is administered by the Ohio Department of Health.

Children with Medical Handicaps (BCMH)

The Children with Medical Handicaps program (BCMH) is a health care program providing services for children with special health care needs. To receive BCMH services, a child must be an Ohio resident younger than age 21 and be under the care of a BCMH-approved doctor. Families must also meet income eligibility criteria. BCMH works closely with public health nurses in local health departments to identify and coordinate services for children with medically handicapping conditions and their families. For more information, families can contact their local health department or call (800) 755 - GROW (4769). This program is administered by the Ohio Department of Health.

Help Me Grow (HMG)

The Help Me Grow Home Visiting program provides parenting education for pregnant women and first time mothers. The program helps families with young children connect with resources so that children start school healthy and ready to learn. The Help Me Grow Early Intervention program provides services to families with children birth to age three with developmental disabilities. Services are coordinated and families are connected to services which build the parent's ability to enhance their child's development so that children with disabilities or delays in development start school healthy and ready to learn.

Those who are interested in getting cash assistance through Ohio Works First or getting Food Assistance should contact their local County Department of Job & Family Services.

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or **benefits.Ohio.gov** or call us at **(800) 324-8680**. Para obtener una copia de este formulario en Español, llame **(800) 324-8680**. If you need help in a language other than English, call **(800) 324-8680** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(800) 292-3572**.

APPENDIX E

STEP 2 ADDITIONAL PERSON _____(give this person a number)

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does this person live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does this person plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will this person file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will this person claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is this person related to the tax filer? _____

8. Is this person pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

What is the expected due date? _____

9. **Does this person want health coverage?** Even if they have insurance, there might be a program with better coverage or lower costs.

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does this person have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If this person isn't a U.S. citizen or U.S. national,** but has immigration documents, please provide the following:

a. Alien number _____

b. Document type _____ c. Document ID number _____

d. Has this person lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

e. Is this person, their spouse, or their parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

13. Does this person want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. If this person lives with at least one child under the age of 19, are they the main person taking care of this child? ☐ Yes ☐ No

15. Was this person in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if this person is 22 or younger:

16. Did this person have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

Now, tell us about any income from ADDITIONAL PERSON _____ on the back.

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STEP 2 ADDITIONAL PERSON _____

Current Job & Income Information

☐ **Employed**
If this person is currently employed, tell us about their income. Start with question 20.

☐ **Self-employed**
Skip to question 29.

☐ **Not employed**
Skip to question 30.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
(_____) _____- _____

22. Wages/tips (before taxes) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If this person has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
(_____) _____- _____

26. Wages/tips (before taxes) ☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
$ _____

27. Average hours worked each WEEK

28. **In the past year, did this person:** ☐Change jobs ☐Stop working ☐Start working fewer hours ☐None of these

29. **If self-employed, answer the following questions:**

a. Type of work
_____

b. How much net income (profits once business expenses are paid) will this person get from this self-employment this month?
$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often this person receives it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ How often?
☐ Net rental/royalty $ How often?
☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often this person receives it.
If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME:** **Complete only if this person's income changes from month to month.**
If you don't expect changes to this person's monthly income, add another person or skip to the next section.

This person's total income **this year:**
$ _____

This person's total income **next year** (*if you think it will be different*):
$ _____

THANKS! This is all we need to know about this ADDITIONAL PERSON.