The Arc
Monroe
New York

The Arc of Monroe
Financial Intake Checklist

Name: Arc Address:

Please attach each of the following:

☐ **Copy of Birth Certificate (with Mother's Maiden name)**
☐ **Rep Payee Approval Form**
☐ **Medicaid/Food Stamp Authorization**
☐ **Authorization to Release Information**
☐ **Benefit Eligibility Questionnaire**

For each applicable item below, please attach documentation needed

☐ **Wages, last 4 pay stubs**
☐ **SSI, award letter**
☐ **SSD, award letter**
☐ **SSP, award letter**
☐ **SSA, award letter**
☐ **SNAP/Food Stamps, award letter**
☐ **Insurance Beneficiary Income, recent statement**
☐ **Trust Account, recent statement and agreement**
☐ **Burial Account, recent statement and agreement**

Resident Accounts Approval

☐ Documentation packet is complete

Approved by: Date:

☐ Documentation is incomplete

Still need:

The Arc
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New York

Rep Payee Approval Form

Name of wage earner, self-employed person or SSI claimant:

Social Security Number:

The Social Security Administration has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

I do not object to The Arc of Monroe becoming my representative payee.

Signature:

Date:

The Arc
Monroe
New York

MEDICAID/FOOD STAMP AUTHORIZATION TO COMPLETE AND SIGN APPLICATION

I, _____, hereby authorize and designate The Arc of Monroe to complete and sign my application for assistance. I understand that The Arc of Monroe will represent me in the application process and I authorize them to give any and all information necessary to complete my application.

I further understand that this designation does not relieve me of my obligation to cooperate with all aspects of initial and continuing eligibility for public assistance and care and to provide timely and accurate information to the Monroe County Division of Social Services (MCDSS). By authorizing and designating The Arc of Monroe to complete and sign my application for assistance, I am agreeing to any investigation made by **MCDSS** to verify or to confirm the information submitted in the application or any other investigation made by **MCDSS.** If additional information is requested, I will provide it. I will also cooperate fully with State and Federal personnel in a Quality Control Review.

I understand that I may revoke this authorization at any time by notifying **MCDSS** in writing, but if I do it will not have any effect on any actions that MCDSS took before they received the revocation.

Signature of applicant: Date:

CERTIFICATION BY DESIGNATED AUTHORITY

I hereby swear and affirm that I have met with the applicant _____ and have explained to them that I will be completing and signing an application for assistance on their behalf as their designated representative, that _____ has agreed to this designation and that he/she understands that I will have to verify the accuracy of the information I will give to MCDSS in support of this application.

Signature: Date:

Name:

Address: The Arc of Monroe
PO Box 23438
Rochester, NY 14692
(585) 271-0660 x1363

The Arc
Monroe
New York

AUTHORIZATION TO RELEASE INFORMATION

I,_____, hereby authorize and request that the:

- Social Security Administration
- Department of Social Services
- Health Care providers holding medical
- Financial Institutions
- Pension Plan Administrators
- Trustees, Executors
- Immediate Family Member

Give full, detailed and relevant information regarding me to The Arc of Monroe, for the purpose of applying for and/or maintaining Medicaid, Financial Assistance Programs, and/or other Entitlement and Community Based Programs to which I may be entitled.

In addition I authorize The Arc of Monroe to act as my representative in applying for, and/or maintaining Medicaid, Financial Assistance Programs and/or other Entitlement and Community Based Programs to which I may be entitled; and to act as my representative at any conference and/or fair hearing until they become my Rep Payee.

Signature of Applicant/Guardian:

Date:

Relationship to Applicant:

Print Name:

BENEFIT ELIGIBILITY QUESTIONNAIRE

A. INFORMATION ABOUT THE INDIVIDUAL

Full Name at Birth	Date of Birth	Social Security Number

Place of Birth (City, State) (attach a copy of the individual's birth certificate)	U.S. Veteran? ☐ YES ☐ NO

Marital Status	Spouse's Name	Date and Place of Marriage/Divorce

U.S. Citizen ☐ YES ☐ NO
If NO, please provide the individual's alien registration number, the date of entry, and the port of entry. Please attach a copy of both sides of the individual's Alien Registration Card or Permanent Resident Card and any other proof of lawful residence.

Is there a **court appointed** legal guardian, alternate or standby guardian, conservator, or committee for the individual?
☐ YES ☐ NO If YES, give the name and address (attach copies of the legal papers):

If the individual is under age 21, does he/she live with his/her parents? ☐ YES ☐ NO

Is the individual covered by Medicaid? ☐ YES ☐ NO

If YES: Client Identification Number (CIN):_____ Date approved:_____

If NO: Was a Medicaid application filed? ☐ YES ☐ NO If YES, complete the following:

Date of application: _____ Date of denial: _____

Reason for denial: _____

Is the individual enrolled in the HCBS Waiver? ☐ YES ☐ NO Enrollment Date:_____

If NO: Has a HCBS Waiver application been filed for the individual? ☐ YES ☐ NO

Date of application: _____ Date of denial: _____

Reason for denial: _____

What services is the individual receiving? *Include **all services** provided by your agency and any other agency:*

B. INFORMATION ABOUT THE INDIVIDUAL'S INCOME

Does the individual receive income from any source? ☐ YES ☐ NO
If YES, complete the following regarding all sources of income the individual received during the last 3 months:

Income Source	Who is Payee?	Claim Number	Monthly Amount
SOCIAL SECURITY			$
SUPPLEMENTAL SECURITY INCOME (SSI)			$
Other Benefits			$
			$

Was the individual ever employed or did he or she receive wages (including wages from a workshop)? ☐ YES ☐ NO
If YES, is the individual currently employed? ☐ YES ☐ NO
If YES, complete the following about the current employer(s), other employers, and monthly gross wages during the last 3 months.

Employer(s)	Address	Gross Wages

C. INFORMATION ABOUT THE INDIVIDUAL'S ASSETS

Answer the following question only if the individual will be residing in an ICF:
Has the individual sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months?
☐ YES ☐NO
If YES, attach a sheet with details, including the type of asset, value, to whom the asset was sold/given/transferred, the date of the transaction and the amount for which the asset was sold.

Has the individual placed any asset(s) into a trust or have any disbursements been made from a trust established for the individual's benefit?
☐ YES ☐ NO
If YES, attach a photocopy of the trust document or a sheet with details about the trust, including the source of the money, the name of the trustee, location of the trust, account number and the value of the trust.

Does the individual have any bank account(s), credit union account(s), certificates of deposit, annuity, 401(k), other retirement account, stocks, bonds, securities, or interest in real property?
☐ YES ☐ NO
If YES, attach copies (attach an additional sheet if needed for additional assets or details):

	Asset 1	**Asset 2**
Type of Asset		
Name of Person Receiving Bank Statements or Holding Records		
Current Asset Value		

Is there a burial fund for the individual? ☐ YES ☐ NO If YES, attach a sheet with details.

Does the individual have a pre-need funeral contract, a burial trust, a burial plot or other burial space items?
☐ YES ☐ NO If YES, provide details (attach a photocopy of the contract):

D. FUTURE INCOME OR ASSETS FOR THE INDIVIDUAL

Does the individual have an interest in, possible interest in, or expect to receive an inheritance, lawsuit settlement, trust fund or other asset? ☐ YES ☐ NO
If YES, describe the asset below (attach a sheet with details).

E. INFORMATION ABOUT THE INDIVIDUAL'S LIFE INSURANCE

Is there Life Insurance on the individual? ☐ YES ☐ NO If YES, complete the following:

Insurance Company Name and Address

Policy Number(s)	Face Value $

Name and Address of the Person Holding the Policy

F. INFORMATION ABOUT THE INDIVIDUAL'S HEALTH INSURANCE

Does the individual have Medicare? ☐ YES ☐ NO	**Effective Date**	**Claim Number**
Part A Hospital Insurance ☐ YES ☐ NO		
Part B Medical Insurance ☐ YES ☐ NO		
Part D Prescription Drug Plan ☐ YES ☐ NO		
Medicare Advantage Plan ☐ YES ☐ NO		

Medicare Advantage Plan Name, Address and Phone Number		
Is the individual covered by other health insurance? ☐ YES ☐ NO If YES, please enclose a copy of the insurance certificate, policy, booklet or card (front and back) and complete the following:		
Insurance Company Name and Address		
Policy Number	Group Number	Other Identifier(s)
Effective Date of Coverage	Subscriber's Name	
Name and Address of Group/Employer		

G. IDENTIFYING INFORMATION ABOUT THE INDIVIDUAL'S PARENTS and SPOUSE

	FATHER	MOTHER	SPOUSE
Full Name at Birth/Maiden Name			
Date of Birth			
Place of Birth (City, State)			
Social Security Number			
U. S. Citizen	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
U. S. Veteran If YES, provide:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Serial Number			
Claim Number			
Receiving Disability/Retirement Benefit	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Date of Disability/Retirement			
Date and Place of Death, if applicable			

H. FINANCIAL REPRESENTATIVES FOR THE INDIVIDUAL

Is there any other person(s) who has financial information about the individual? ☐ YES ☐ NO
If YES, provide the information below or attach a sheet with a detailed list:

NAME	ADDRESS AND PHONE NUMBER	RELATIONSHIP

I. THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of Person Completing Form	Print Name	
Relationship to Individual	Telephone	Date

The Arc of Monroe
Intake Checklist

Name: Arc Address:

Please attach each of the following:

☐ **Change of Access Authorization Form**
☐ **MyChart Proxy Access Form**
☐ **Health Care Proxy paperwork**
☐ **Legal Guardian paperwork**
☐ **DNI/DNR paperwork**

Staff Approval

☐ Documentation packet is complete

Approved by: Date:

☐ Documentation is incomplete

Still need:

The Arc
Monroe
New York

Furthering Opportunities for Independence

Date:_____

To Whom it may Concern:

I, _____ (person supported, guardian, family member) give The Arc of Monroe medical administrative team permission to designate MyChart access to the medical staff assigned to me/my charge/family member.

I am aware that this medical coverage may change periodically through attrition and that a different Arc employee will be assigned and given access.

_____ _____

Person, Guardian, Family Signature Date

Jennifer Carey, RN DON _____

Arc Administrative Team Member Date

2060 Brighton-Henrietta Townline Road, Rochester, NY 14623
(585) 271-0660 Fax (585) 442-1911 www.arcmonroe.org

To allow another adult to view your MyChart, please review this important information <u>before</u> submitting the proxy sign-up form:

1. You must be at least 18 years of age to request that another adult be allowed to view your account (this is called **proxy access**).
2. Your proxy will view your MyChart through his/her own MyChart account. If your proxy does not currently have a MyChart account, and is a UR patient (i.e., he/she sees doctors affiliated with Strong, Highland or UR), then he/she must first **<u>establish a MyChart account before we can fulfill your proxy request.</u>**
3. Your proxy can sign up for MyChart in the following ways:
   - Phone or visit his/her UR doctor's office to sign up at an upcoming appointment.
   - Submit a request for a MyChart account by visiting mychart.urmc.rochester.edu, and click on "**Access for Kids/Family**."

If your proxy is **NOT** a UR patient, then we will establish a MyChart account for him/her.

Thank you for your understanding and cooperation in this matter.

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UR Medicine MyChart Proxy Authorization: 18 and Over

Please read this form carefully before signing. This authorization will permit care provided by this facility or by my treating professionals to release portions of your electronic medical information to the person listed on page 2 of this form.

- **Type of Information to be Disclosed:** I understand that this authorization may cover disclosure of information relating to **ALCOHOL or DRUG ABUSE, PREGNANCY, SEXUALLY TRANSMITTED DISEASES, GENETIC TESTING, PSYCHIATRIC CARE** and/or **CONFIDENTIAL HIV* RELATED INFORMATION**. In the event the medical information described below includes any of these types of information, I specifically authorize release of such information to the person named below. *(*Human Immunodeficiency Virus that causes AIDS)*
- **Method of Disclosure:** My medical information will be disclosed to the person listed below through MyChart.
- **Redisclosure:** I understand that if I authorize the release of HIV related information, the recipient is prohibited from redisclosing such information without my authorization, unless permitted to do so under federal or state law. I understand that I have a right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclosure of HIV related information, I may contact the **NY State Division of Human Rights at 1-800-523-2437** or the **NY City Commission of Human Rights at (212) 306-7500**. These agencies are responsible for protecting my rights. I understand that once my information is released pursuant to this Authorization, it could be redisclosed to others and would no longer be protected by federal privacy regulations.
- **Expiration:** This authorization for release of information will expire only upon my revocation or when the hospital is notified of my death or the death of the person I have authorized to access MyChart.
- **Submitting your Proxy Form:** Give this form to your **Doctor's Office** or **Fax form to UR Medicine Customer Service: (585) 426-8058**. Allow at least 2 weeks for processing; you will receive a message once the proxy form has been processed.
- **Revocation:** I can change my mind and revoke this authorization at any time, except to the extent that anyone has already taken action based on this authorization. I can revoke my authorization online through MyChart, or I can send a written request to: Health Information Management Dept, ATTN: Release of Information, 601 Elmwood Avenue, Box 616, Rochester, NY 14642. I understand that care provided by this facility or by my treating professionals can also revoke access to MyChart (for patients or proxies) at any time and for any reason.
- **Legal Guardianship:** If you are a legal guardian of patient, please include a copy of legal guardianship paperwork.

Please make sure to complete page (2) of this document.

Authorization for Access: I, or my legal representative, request that medical information regarding my past, present and future care and treatment at provided by this facility or by my treating professionals be released through online access to MyChart to the person named below.

▶**PATIENT Information:** (All sections required — please print clearly)

▶Name: *(Last)* _____ *(First)* _____ *(Middle Initial)*_____

Date of Birth *(MM/DD/YY)*: ____/____/_____ Patient Medical Record#:_____
Street Address:_____
City: _____State: _____ Zip:_____
Name of UR Medicine Physician: _____

▶**PROXY Information (the Person you would like to have access to your MyChart):**

Refer to Attached for Current staff requiring Proxy Access

Name: *(Last)* _____ *(First)* _____ *(Middle Initial)*_____

Date of Birth *(MM/DD/YY)*: Phone # :(585)
E-mail (needed if proxy MyChart inactive):
_____
Relationship to
Patient:_____ Street
Address:_____ City:
_____ State: _____ Zip: _____

▶**Access Level (choose ONE):** ☐ Full Access (recommend) or ☐ Full Access without Notes*

▶**Reason for Release of Information:** Access to MyChart

▶**Information to be Released:** MyChart (Electronic Health Record)

Information may include: *Pregnancy, STD Treatment, Reproductive Health Care, Alcohol/Drug Abuse Treatment, Genetic Testing, Mental Health or HIV-related information.*

My questions about this form have been answered. By signing this form, I also agree to the Terms and Conditions for use of MyChart, which can be found on the MyChart website. I know that I do not have to allow release of medical information, and I will still receive care provided by this facility or by my treating professionals.

▶Signature of Patient or Authorized Representative: *(required)* ▶Date:

X

▶If signed by **Authorized Representative**, Print Name: ▶Relationship to Patient:

**This means your proxy will be unable to view any Visit Notes. UR Medicine is providing access to many visit notes made by your providers. By referring to these notes, you can gain a better understanding of your health, take more active steps to improve your health and build a closer relationship with your care team.*