

Eat Well Center Physician Eligibility Certification

□ **Main:** 2056 N Dixie Hwy, Wilton Manors, FL 33305 FAX 954-361-2786

□ **Pompano Beach:** 172 N Powerline Road, Pompano Beach, FL 33069 FAX 954-361-2786

□ **Palm Beach:** 7721 N Military Trail, Palm Beach Gardens, FL 33410 FAX 561-805-3669

Program Participant Information:

Last Name First Name Middle Initial Date of Birth

Phone Number Email @

Physician Information:

Physician Name: Phone Number:

Program Participant Signature: Date:

This letter certifies that is currently my patient and was last seen

Program Participant

in my office on . My Patient is living with as a critical

Office Visit Date Diagnoses

and/or chronic illness(es).

Physician Signature: Date:

Office Stamp:

Please provide this certification to the patient. [www.poverello.org](http://www.poverello.org/)

Updated: 01/24/2023

CHRONIC CONDITIONS INTAKE FORM Participant Number:

Please provide the following information:

Today’s Date: Participant Full Name:

Race:

* White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
* Black or African American – A person having origins in any of the Black racial groups of Africa.
* American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
* Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
* Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
* Describe your race: Ethnicity:

***Poverello Intake Office Notes:***

Residency: Income: ID MD Note: PE AH SC Poverello Client Number Assigned:

Pin:

* Hispanic or Latino
* Not Hispanic or Latino
* Haitian/Creole
* Describe your ethnicity: Marital Status Gender:
* Single
* Married How Many Children under 18 in your household?
* Separated How many total adults in your household who you’re responsible for?
* Divorced
* Widowed

Address:

City: Florida Zip: Phone Number:

Emergency Contact: Relationship:

Permissions: Do we have permission to leave a message(s)? Yes or No?

Do we have your permission to text you? Yes or No?

Do we have your permission to email you? Yes or No? Does your emergency contact know about your medical condition (s)? Yes or No?

Program Participant’s Signature: Date:

# Rights and Responsibilities

## As a program participant of the Poverello Center, Inc., you have the right to:

* Participate in food distribution programs as well as other assistance programs offered here according to program rules and eligibility.
* Courteous and respectful service from all staff and volunteers.
* Fair treatment without regard to age, race, color, religion, gender, sexual orientation, national origin, marital status, physical or mental challenges, and/or citizenship status.
* Confidential and private consultations upon request.
* An orientation to services offered including the food pantry, wellness center, volunteer opportunities and thrift store.

Any disregard of your rights may result in staff or volunteer disciplinary action.

## As a program participant of the Poverello Center Inc., you have the responsibility to:

* Be truthful.
* Respect each other.
* Maintain the confidentiality of those who come here.
* Respect all rules, policies, and procedures.
* Always supervise your children.
* Drive safely.
* Respect parking guidelines.
* Use respectful language and behaviors.
* Be thoughtful of other program participants.
* Respect the environment.
* If you Smoke, do so only off site. <https://tobaccofreeflorida.com/>
* Eat or Drink off site.
* Leave after program hours.

Disregard for your responsibilities may result in a sanction which may include discontinuation of services.

**Confidentiality:** The Poverello Center, Inc. recognizes the importance of confidentiality for persons with chronic/critical illnesses including HIV and specifically the stigma associated with having the HIV virus. Since the Poverello Center Inc serves people with different types of conditions, staff, volunteers, guests, and clients will uphold the trust engendered by receiving services from Poverello and keep each person’s information confidential. The Poverello Center, Inc. respects the rights of individuals it serves and expects its staff, volunteers, and visitors to abide by the rights and responsibilities of the center.

**Grievance Procedure:** We welcome all suggestions and recommendations. Please put your written recommendations in the suggestion box (located outside the intake office) or speak with the Live Well Center Manager. If you experience a problem with the food pantry, please ask to speak with the Eat Well Center Manager. If the matter remains unresolved, you have the right to file a grievance with the Administration by filling out the grievance form. Please provide your completed form to the Live Well Center Manager. We will do all reasonably possible to resolve your issues.

Program Participant’s Signature: Date:

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Poverello Center Inc. (TPC) can act as each of the above business types. This medical information is used by TPC in many ways while performing normal business activities.

Your protected health information may be used or disclosed by TPC for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or food pantries to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. TPC may use or disclose your health information for case management and services. TPC may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.

Your information may be used by certain department personnel to improve TPC’s health care operations. TPC also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

* Reporting abuse of children, adults, or disabled persons.
* Investigations related to a missing child.
* Internal investigations and audits by the department’s divisions, bureaus, and offices.
* Investigations and audits by the state’s Inspector General and Auditor General, and the
* legislature’s Office of Program Policy Analysis and Government Accountability.
* Public health purposes, including vital statistics, disease reporting, public health
* surveillance, investigations, interventions, and regulation of health professionals.
* District medical examiner investigations.
* Research approved by the department.
* Court orders, warrants, or subpoenas.
* Law enforcement purposes, administrative investigations, and judicial and administrative
* proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Poverello. This authorization will have an expiration date that can be revoked by you in writing.

### INDIVIDUAL RIGHTS

You have the right to request the Poverello Center to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Poverello Center will contact you in the manner and at the address or phone number you select. You may be asked to put your request in writing.

If you are responsible for paying for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by Poverello within 30 days of the TPC’s receipt of your request.to obtain a copy of your protected health information. You must complete TPC’s Authorization to Disclosure Confidential Information form and submit the request to the administrative office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If TPC cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

TPC cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time TPC is required to keep the record, the information may no longer be available. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by TPC.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. TPC may deny your request, in whole or part, if it finds the protected health information:

* Was not created by TPC.
* Is not protected health information.
* Is by law not available for your inspection.
* Is accurate and complete.

If your correction is accepted, TPC will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. TPC may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures Poverello may have made of your protected health information. This summary does not include:

* Disclosures made to you.
* Disclosures to individuals involved with your care.
* Disclosures authorized by you.
* Disclosures made to carry out treatment, payment, and health care operations.
* Disclosures for public health.
* Disclosures to health professional regulatory purposes.
* Disclosures to report abuse of children, adults, or disabled.
* Disclosures prior to April 14, 2003. This summary does include disclosures made for:
* Purposes of research, other than those you authorized in writing.
* Responses to court orders, subpoenas, or warrants.
* You may request a summary for not more than a 6-year period from the date of your request.

If you receive this Notice of Privacy Practices electronically, you have the right to a paper copy upon request. Poverello may mail or call you with health care appointment reminders.

### POVERELLO DUTIES

The Poverello Center Inc. (TPC) is required by law to maintain the privacy of your protected health

information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. TPC has the responsibility to notify you following a breach of your unsecured protected health information.

As part of TPC’s legal duties this Notice of Privacy Practices must be given to you. TPC is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Poverello may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Poverello website at https://poverello.org/notice-of-privacy-practices-clients/ and will be available by email and at all Poverello buildings.

Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

### COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with: Poverello’s Inspector General at 2056 N Dixie Hwy, Wilton Manors, FL 33305. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Poverello will not retaliate against you for filing a complaint.

### FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Poverello facility where you received the notice.

### EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning 01/24/2023 and shall be in effect until a new Notice of Privacy Practices is approved and posted.

### REFERENCES

“Standards for the Privacy of Individually Identifiable Health Information; Final Rule.” 45 CFR Parts 160 through 164. Federal Register 65, no. 250 (December 28, 2000).

“Standards for the Privacy of Individually Identifiable Health Information; Final Rule” 45 CFR Part 160 through 164. Federal Register, Volume 67 (August 14, 2002).

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

Program Participant’s Signature: Date:



## EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP) CERTIFICATION OF ELIGIBILITY TO TAKE FOOD HOME 7 CFR 251

Name: Address:

Number of People In Household: County:

The following shows a yearly gross income for each family size. If your household income is at or below the income listed for the number of people in your household, you are eligible to receive food. **The chart below is effective July 1, 2022 - June 30, 2023.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Household Size** | **Annual Income** | **Monthly Income** | **Twice per Month** | **Every two Weeks** | **Weekly Income** |
| 1 | $17,667 | $1,473 | $737 | $680 | $340 |
| 2 | $23,803 | $1,984 | $992 | $916 | $458 |
| 3 | $29,939 | $2,495 | $1,248 | $1,152 | $576 |
| 4 | $36,075 | $3,007 | $1,504 | $1,388 | $694 |
| 5 | $42,211 | $3,518 | $1,759 | $1,624 | $812 |
| 6 | $48,347 | $4,029 | $2,015 | $1,860 | $930 |
| 7 | $54,483 | $4,541 | $2,271 | $2,096 | $1,048 |
| 8 | $60,619 | $5,052 | $2,526 | $2,332 | $1,166 |
| For each additional family member add: | $6,136 | $512 | $256 | $236 | $118 |

## The chart details eligibility criteria for monthly income, income received twice monthly (24 payments per year), income received every two weeks (26 payments per year) and weekly income.

You are eligible to receive food from TEFAP if your household meets the income guidelines above or participates in any of the following programs. Please place a checkmark in the space next to the category that applies.

Income eligibility

Supplemental Nutrition Assistance Program (SNAP) (aka Food Stamps)

Temporary Assistance to Needy Families (TANF)

Supplemental Security Income (SSI)

Medicaid

Please read the following statement carefully and then sign the form and write in today’s date. You only need to meet one of these requirements to be eligible to receive USDA foods.

*I certify that my yearly household gross income is at or below the income listed on this form for households with the same number of people* ***OR*** *that I participate in the program(s) that I have checked on this form. I also certify that as of today, I reside in the State of Florida. This certification is being submitted in connection with the receipt of Federal assistance.*

*Program officials may verify what I have certified to be true. I understand that making a false certification may result in having to pay the State agency for the value of the food improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.*

Signature: Date:

## Designated Individual signing on behalf of client or designated proxy

Signature: Date:

**THIS CERTIFICATION IS VALID FOR A PERIOD OF ONE YEAR and may be renewed as needed. Any changes in the household’s circumstances must be reported to the distributing agency immediately.**

**OPTIONAL:** I authorize to pick up USDA foods on my behalf.

06/2022

“In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online

at: [https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-](https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf) [28-17Fax2Mail.pdf,](https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf) from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

# mail:

U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW

Washington, D.C. 20250-9410; or

# fax:

(833) 256-1665 or (202) 690-7442; or

# email:

[program.intake@usda.gov](mailto:program.intake@usda.gov)”

This institution is an equal opportunity provider.

DACS-06XXX

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