SUNY Downstate STAR PROGRAM SPECIAL TREATMENT AND RESEARCH

Welcome to the STAR Health Center (SHC) - Your Medical Home!

At SHC you can expect state-of-the art medical care with staff that will treat you with respect and kindness. Please read the following to learn what you can expect at SHC, your Patient Centered Medical Home.

An introduction....

Health Care Team

Once your provider is chosen, a case manager will be assigned to you. A team of medical providers, nurses, case managers, adherence counselors, mental health counselors, a nutritionist and clerical staff will be working with you to provide your complete care at SHC. During your first visit to the health center, you will be given the opportunity to choose a provider based on your reference of language, gender, and time. Please get to know your case manager's names and write down their phone numbers so you can reach them when needed.

Medical Information

You will be asked to sign a release of medical records form so we can get your medical information from other health care providers. This medical information is essential for continuity of care. Please let your case manager know if you are working with outside case managers and medical providers so we can communicate with them to ensure you receive all of the services you need.

Contact Information

The clerical staff will ask you for your contact information during the first visit and at EVERY visit. We ask you to please give us the **BEST** number to contact you. It can be a cell or home number or a text number. It is important you always give us a working phone number, so your medical provider can contact you for issues such as follow-up of test results and appointment reminders. Please make sure to let us know right away if you have changed your address or phone number.

Insurance

If you do not have medical insurance your case manager will work with you to get a suitable insurance. Please provide the necessary papers needed for processing the insurance on time in order to avoid delay in getting medical care. It may be difficult to get some services and medications without medical insurance.

Languages and Special Needs

Staff in the SHC speak several languages including Spanish, French, and Haitian Creole as well as others. Please let the clerk at the front desk know of any special needs you require when you register. We will make every effort to accommodate special needs. If we feel we are unable to provide you with the best care, we will help you find a provider that is better able to provide you with the special services you need.

MetroCard

For your travel, a MetroCard is given on the days of your lab work, medical or mental health appointment. You will be given a paper slip, and you will go to the Cashier Office located in the elevator banks on the first floor near the Lenox Avenue entrance to get the MetroCard. The **office closes at 4.30pm**, so remember to collect your MetroCard before the office closes. The distribution of MetroCards is a special service of the SHC. **Metrocards are not given for any other clinic visit or for prescription pick up.**

Case Management

Your personal case manager will help you to get the services you need. It is important to speak to your SHC case manager about what you need to improve your life and family situation. **The case manager will refer you to organizations for services such as housing and legal counseling as well as food services plus other social services**. Your SHC case manager can also help you fill out forms for benefits and others concerns. Most often, these forms take a few days to complete. **The processing time for any forms is 5 business days for non urgent forms and 2 business days for urgent forms**. It is important for you to plan accordingly when you require form completion.

Peer Services

Our trained peer educators would be glad to talk to you if you feel you would benefit from their experience. Peers are people who understand what you are going through and can be a big help in developing a plan to keep you healthy. If you would like to talk to someone about how you can play a bigger role in developing your own health care plan or if you need help with all of your medications, please ask to speak with a Peer Leader.

Support Groups

SHC has a variety of groups to support your health care such as acupuncture, relapse prevention, nutritional education, and medication education. Please talk to your provider, case manager or counselor for information on current groups.

Policies of the SHC you need to know....

Confidentiality

At SHC, we strive to maintain your **privacy and confidentiality. SHC requires written permission from you to share medical information with other facility pertaining to your care.** When we call you for appointment reminders or abnormal test result or for any other reasons, we will be discreet and will only mention your doctor's office. We will not divulge any other information. We will not talk to any family members unless you have given permission.

Waiting Room

A waiting room is provided for your comfort. There is water daily in the waiting room. Please be respectful to others so everyone can enjoy their privacy and be comfortable in the waiting room, so please refrain from loud cell phone conversation.

Lateness Policy

SHC allows a **30-minute** grace period for arrivals to appointments. If you are late by more than **30 minutes** to your appointment you may not be seen on that day. You will be given another appointment. In order to avoid not being seen, please call the clinic at 718-270-3745 to inform us of your expected arrival time. Also, please note our hours of operation.

Monday:	9:00AM – 12:00PM	1:30PM – 8:00PM
Tuesday:	9:00AM – 12:00PM	1:30PM – 5:00PM
Wednesday:	9:00AM – 12:00PM	2:00 PM – 8:00PM
Thursday:	***Not in Session***	1:30PM – 5:00PM
Friday:	9:00AM – 12:00PM	1:30PM – 5:00PM

Grounds for Discharge

At SHC we treat our patients with respect and dignity and hope our patients will treat the staff and other patients the same way. We want to provide the very best care in a safe environment. If specific actions or new situations render us unable to provide excellent care, we will discharge you from the SHC and work with you to find another health care provider who can meet your needs. Below are reasons why you may be discharged from the SHC.

- Threatening or violent behavior towards any person in the clinic; patient and staff
- Arriving to the clinic under the influence of alcohol or illegal drugs
- Carrying weapons of any kind
- Stealing from the clinic, staff, or another patient.
- Repeated rude behavior
- Insurance fraud
- Misusing medicines given to you for your care
- Not following the plan of care your provider gives you.
- Receiving care from another primary care clinic at the same time
- If SHC is unable to provide the specific type of care you need

Filing a Complaint.

If you feel that any of the SHC staff has not treated you well, you may ask to speak to their direct supervisor. If the supervisor is unavailable, you can ask to speak with the Behavioral Health Director or the Assistant Director of Care Management of the clinic. You can also file a complaint with Patient Relations. Your complaint will be taken seriously and you will get a verbal or a written response.

Thank you for choosing STAR Health Center for your care. We hope to be your partner in your medical care so you get the most benefit from our services.

SUNY DOWNSTATE Medical Center

By Automobile

From Manhattan:

Manhattan Bridge: exit onto Flatbush Avenue. Continue approximately three and one-half miles to Parkside Avenue. Turn left onto Parkside Avenue and travel four blocks to New York Avenue. Turn right at New York Avenue and continue one block to Clarkson Avenue.

Brooklyn Bridge: stay to the left at the end of the bridge, following the ramp to Boerum Place, which becomes Adams Street. Continue along Adams Street to Atlantic Avenue. Turn left onto Atlantic Avenue and continue to Flatbush Avenue. Turn right onto Flatbush Avenue and continue approximately two and one-half miles to Parkside Avenue. Turn left onto Parkside Avenue and travel four blocks to New York Avenue. Turn right at New York Avenue and continue one block to Clarkson Avenue.

Brooklyn-Battery Tunnel (toll): exit onto the Brooklyn-Queens Expressway. Continue approximately one mile, staying to the left, and exit onto Prospect Expressway. Note: Currently, the Prospect Expressway is closed weekdays from 5:00 A.M. until 11:00 A.M. for repairs. If you are traveling to Downstate earlier than 11:00 A.M., please take one of the other routes described on this page. Travel three exits to the Fort Hamilton Parkway exit. Continue through two traffic lights to Caton Avenue. Turn left onto Caton Avenue, and continue sixteen blocks to Flatbush Avenue. Turn left onto Flatbush Avenue and continue two blocks to Parkside Avenue. Turn right onto Parkside Avenue and travel four blocks to New York Avenue. Turn right at New York Avenue and continue one block to Clarkson Avenue.

From Staten Island and Newark International Airport:

Verrazano Narrows Bridge (toll): follow bridge to Route 278, the Gowanus Expressway. Travel approximately five miles to the Prospect Expressway exit. Continue on the Prospect Expressway three exits to the Fort Hamilton Parkway exit. Travel along East 5 Street through two traffic lights to Caton Avenue. Turn left onto Caton Avenue, and continue sixteen blocks to Flatbush Avenue. Turn left onto Flatbush and continue two blocks to Parkside Avenue. Turn right onto Parkside Avenue and travel four blocks to New York Avenue. Turn right at New York Avenue and continue one block to Clarkson Avenue.

From Long Island and Airports:

Southern Long Island and JFK: West on Belt Parkway to North Conduit Boulevard exit (Exit 17W). Continue on North Conduit Boulevard for about 3/4 mile. Fork left onto Linden Boulevard, and take Linden Boulevard to New York Avenue. Right two blocks on New York Avenue to Clarkson Avenue.

Northern Long Island and LaGuardia: Take Grand Central Parkway to Jackie Robinson Pkwy (formerly Interboro Pkwy). Continue to Pennsylvania Avenue exit. Follow Pennsylvania to Linden Boulevard, turn right onto Linden. Take Linden Boulevard to New York Avenue. Right two blocks on New York Avenue to Clarkson Avenue.

Valet Parking

Valet Parking is available Mondays through Fridays from 6am to 6pm, located in front of the 445 Lenox Road hospital entrance at the valet parking booth. The fee is $20.00 / day. (This service is not available on weekends or holidays.) When the valet parking service is not available, a limited number of spaces for visitors are available at a nominal cost. There are also several private parking lots in the area.

Pay any time before you leave at one of the Parking Kiosks located at:

Hospital: **445 Lenox Rd Main Lobby**

Public Health Building: **450 Clarkson Ave Lobby** Alcove

Please Report any **Kiosk Machine problem to 718-270-2900**.

When leaving, call 10 minutes in advance Ext 8800 (718-270-8800) to expedite the retrieval of your vehicle.

SUNY Downstate

By Public Transportation

BY RAILROAD

Long Island Railroad

Take any train to the Jamaica station. Change to Brooklyn-bound train (track 3). Take to the Flatbush Avenue terminal. Follow subway directions from there.

Metro-North Railroad

Take any train to Grand Central Terminal. Change to Brooklyn-bound 4 or 5 trains. Follow subway directions from there.

BY SUBWAY

Take the IRT Flatbush Avenue Line (#2 Seventh Avenue or #5 Lexington Avenue) trains to the Winthrop Street station. [Take any IRT Brooklyn-bound train (#2, 3, 4, or 5) to Nevins Street in Brooklyn, changing there for a #2 or #5 marked "Flatbush Avenue"]. Stay toward the front of the train.

Exit at Nostrand and Parkside avenues. Cross Nostrand Avenue and walk one block east on Parkside Avenue until it ends at New York Avenue. Cross New York Avenue. Turn right onto New York Avenue. Cross Clarkson Avenue and walk south until the entrance at 430 Clarkson Avenue.

Nights and outside of rush hours, take the subway to Church Avenue. Walk three short blocks east on Church Avenue to New York Avenue, left three blocks to Clarkson Avenue, right to 450 Clarkson Avenue. Or transfer to an eastbound B-35 bus to the northbound B-44 at Church and New York avenues.
(Downstate students and employees can call 718-270-2626 to arrange for transportation from Church Avenue.)

BY BUS

The B-12 and northbound B-44 buses stop at the corner of Clarkson and New York Avenues.

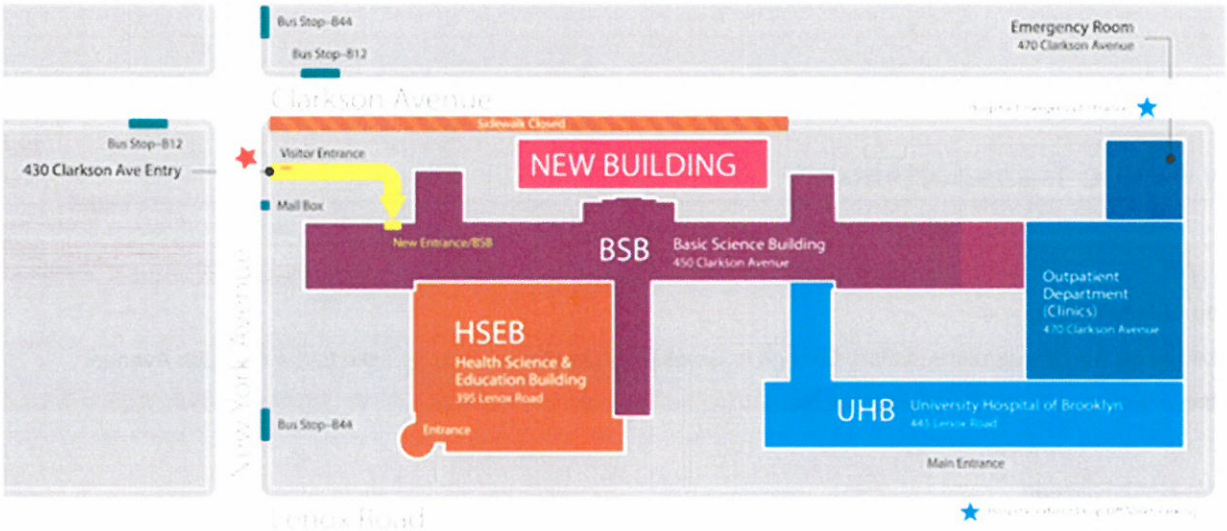
The following lines connect with the B-12 along Clarkson Avenue: B-41, B-44, B- 46, and B-49.

Notice:

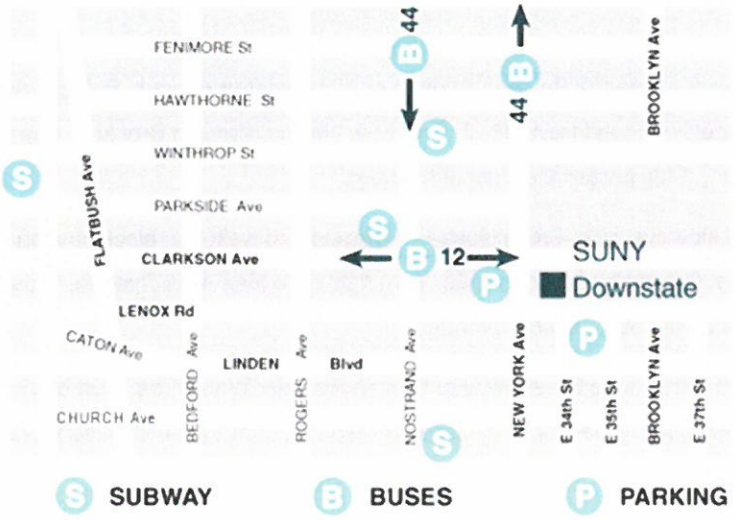
During the construction of our new facility the entrance at 450 Clarkson Avenue will be closed.

Please use the alternate 430 Clarkson Avenue entry.

Please follow diagram below. The 430 Clarkson Avenue Visitor Entrance is off of New York Avenue.



SUNY Downstate



SUNY DOWNSTATE Medical Center

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Your Right to Decide About Treatment

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment. Our Constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started, and to have treatment stopped once it has begun.

Planning in Advance

Sometimes because of illness or injury people are unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long time period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes. In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy are available from your health care provider. If you have no one you can appoint to decide for you, or do not want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written, and often referred to as a Living Will. You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. For example, if you just write down that you do not want "heroic measures", the instructions may not be specific enough. You should say the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition when you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or other close to you. Putting things in writing is safer than

simply speaking to people, but neither method is as effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you, when needed. If you appoint someone and also have instructions about treatment in a Living Will, in the space provided on the Health Care Proxy form itself, or some other manner, the person you select can use these instructions as guidance to make the right decision for you.

Deciding About Cardiopulmonary Resuscitation & DNR

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stop. Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR order). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family, members, or others close to you can decide. A brochure on CPR and your rights under New York State Law is available from your health care provider.

Deciding About DNI

Do not Intubate (DNI) means that no breathing tube will be placed in the throat in the event of breathing difficulties or respiratory arrest. If you stop breathing, you will not be placed on an artificial breathing machine, and the insertion of a tube or mechanical ventilation will not be initiated. The DNI order can be a separate Advance Directive from the DNR order, but in most cases, they are ordered together.

Patients' Bill of Rights in a Hospital

As a patient in a hospital in New York State, you have the right, consistent with law, to:

(1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.

(2) Receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment.

(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

(4) Receive emergency care if you need it.

(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

(6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.

(7) Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.

(8) Receive complete information about your diagnosis, treatment and prognosis.

(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."

(11) Refuse treatment and be told what effect this may have on your health.

(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.

(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

(15) Review your medical record without charge and, obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

(16) Receive an itemized bill and explanation of all charges.

(17) View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.

(18) Challenge an unexpected bill through the Independent Dispute Resolution process.

(19) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.

(20) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

(21) Make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as a health care proxy, will, donor card, or other signed paper). The health care proxy is available from the hospital.

Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?
If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?
Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?
All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?
Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?
Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?
Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?
Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

Frequently Asked Questions, *continued*

How will my health care agent know my wishes?
Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?
No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?
All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?
You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?
It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?
No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Frequently Asked Questions, *continued*

Is a Health Care Proxy the same as a living will?
No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you decide in advance decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?
Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?
Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

Can my health care agent make decisions for me about organ and/or tissue donation?
Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?
It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; a guardian appointed by a court prior to the donor's death; or another person authorized to dispose of the body.

Health Care Proxy Form Instructions

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)
You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse , if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

HEALTH CARE PROXY

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Department of Health

SUNY DOWNSTATE Medical Center

WHAT I NEED TO KNOW ABOUT THE STAR HEALTH CENTER

I received a copy of the "What I need to know about the STAR Health Center". I have been given an opportunity to have all my questions about this information answered on today's date.

Name: _____

Signature: _____

Date: _____

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ My non-HIV health information
- ☐ Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released: _____

_____

Describe information to be released: _____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any:

_____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits
(Note: Federal privacy regulations may restrict some consequences):

_____

_____

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

Name and address of facility/person to be given general health and/or HIV-related information:

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

Name and address of facility/person to be given general health and/or HIV-related information:

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

Name and address of facility/person to be given general health and/or HIV-related information:

_____

_____

Reason for release, if other than stated on page 1:

_____

_____

If information to be disclosed to this facility/person is limited, please specify:

_____

_____

If any/all of this page is completed, please sign below:

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

STAR PROGRAM SPECIAL TREATMENT AND RESEARCH

APPENDIX 2

Ryan White HIV/AIDS Program

APPLICATION FOR
SLIDING FEE DISCOUNT & CAP ON CHARGES

1. NAME: _____
   FIRST MIDDLE LAST Suffix (I, II, III, Jr, Sr. etc)

   ADDRESS: _____
   NUMBER AND STREET CITY STATE ZIP CODE

   TELEPHONE NO: _____

2. OCCUPATION: _____ RATE OF PAY: $_____/HOUR/WEEK/MONTH

   EMPLOYER: _____ ADDRESS: _____

3. HOSPITAL INSURANCE:_____POLICYNO:_____
   (NAME OF INSURANCE CO./GROUP PLAN)

4. DATE OF SERVICE:

   _____
   _____
   _____

5. TYPES & FREQUENCY OF SERVICES:

   _____
   _____
   _____

6. INCOME: LIST COMBINED INCOME FOR YOURSELF, SPOUSE AND OTHER DEPENDENTS:
   (PLEASE SUBMIT DOCUEMTATION)

	TOTAL BY MONTH	TOTAL FOR LAST 12 MONTHS
WAGES.....	_____	_____
FARM OR SELF EMPLOYMENT.....	_____	_____
PUBLIC ASSISTANCE.....	_____	_____
UNEMPLOYMENT/WORKERS COMP.....	_____	_____
STRIKE BENEFITS.....	_____	_____
ALIMONY/MAINTENANCE.....	_____	_____
CHILDSUPPORT.....	_____	_____
MILITARY FAMILY ALLOTMENTS.....	_____	_____
PENSIONS.....	_____	_____
INVESTMENT INCOME (Dividends, Interest, etc)_____		_____
SOCIAL SECURITY DISABILITY(SSD).....	_____	_____
SOCIAL SECURITY INCOME (SSI).....	_____	_____
OTHER.....	_____	_____

TOTAL INCOME BY MONTH $_____ **YEARLY**_____

7. FAMILY SIZE: (USE BACK OF FORM IF MORE SPACE IS REQUIRED)

NAME	AGE	RELATIONSHIP

Patient Signature _____ Date _____

Witness (if patient is unable to sign) _____

Review of Application

Based on the information provided, the above named patient is eligible for:

- ☐ Medicaid
- ☐ ADAP
- ☐ Medical Insurance through the New York Health Plan Marketplace
- ☐ Ryan White Sliding Fee Schedule (**indicate one below**)
  - ☐ Pending application for other insurance
  - ☐ Ineligible for other coverage

Please Explain _____

_____

_____

_____

Signature of CAC _____ Date _____

Print Name & Title _____

Screening for Hepatitis C

If you think you are at risk for Hepatitis C infection, you may consider getting tested. Your primary care provider can order two tests, an antibody test and a viral load test, to see if you have Hepatitis C. If you are concerned about Hepatitis C, talk to our staff and ask to be screened.

For more information, please contact:

Georgene Servio, LPN
718.270.3221

Tracy Griffith, MHA
718.270.1715

Program Phone: 347.831.3280
Fax.718.270.4155

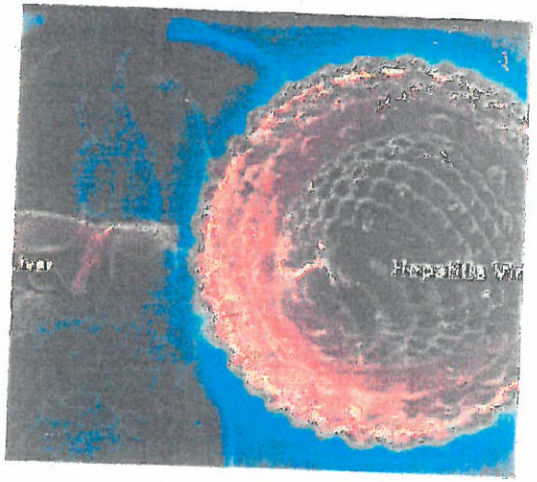
STAR Health Center
SUNY Downstate Medical Center
450 Clarkson Avenue
1st. Floor Suite J
Brooklyn, NY 11203
Main Ph. 718.270.3745
Main Fax. 718.270.2298

SUNY DOWNSTATE Medical Center

STAR Health Center
450 Clarkson Avenue, Suite J
Brooklyn, NY 11203

STAR Health Center at SUNY Downstate Medical Center

Hepatitis C Care Program



STAR PROGRAM

SPECIAL TREATMENT AND RESEARCH

Hepatitis C virus (HCV) infection is the most common chronic blood-borne infection in the United States, affecting about 4 million persons. Due to shared risk factors for HIV and HCV, all HIV-infected persons should be screened for HCV infection.

What is Hepatitis C?

Hepatitis C virus is an infection of the liver caused by a small RNA virus. It goes into liver cells and reproduces very quickly, slowly damaging cells.

What are common symptoms?

Keep in mind that most people who get Hepatitis C have no symptoms at all when they are first infected. Once the liver is seriously damaged, symptoms include:

- Fatigue
- Muscle and joint aches
- Loss of appetite
- Vomiting
- Diarrhea
- Dark urine
- Pale stool
- Jaundice (yellowing of skin or eyes)

How do you get Hepatitis C?

Hepatitis C can pass from one person to another if blood is exchanged through:

- Sharing needles (for drugs, tattooing, piercing or any other reason)
- Sharing personal items that might contain blood (e.g. toothbrushes, razors, snorting straws)

Our professional staff work together as a team, to keep you in good health.

Infectious Disease Specialists

Comprehensive primary care, including gynecological care and family planning.

Hepatologist

On-site Hepatitis C screening and treatment;

Take comfort in care by a licensed liver specialist

Psychiatrist

Medication and care coordination with psychotherapist to help you better manage your feelings

Psychotherapists/ Mental Health

Individual, group and family counseling to help you discover positive ways to solve problems and build on your strengths

Substance Use Counselors

Education on how drugs and alcohol affect your body and your immune system and how to reduce the harm they can do

Adherence Counselor

Information to help you in making decisions about your care and education to make it easier to stick with your medications

Nutritionist

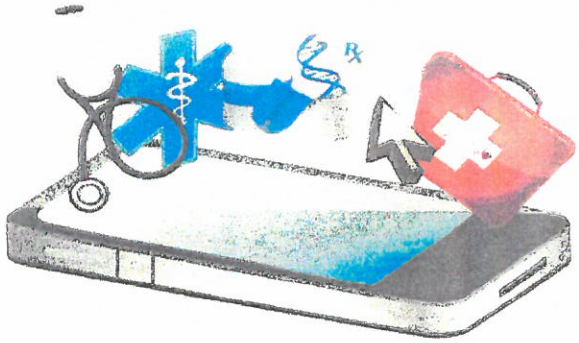
Learn how to maintain good health and reduce medication side effects by using basic guidelines

Case/Care Managers

Work with you to make sure that you have the services that you need to live a healthy life

Hepatitis C Program Services Include:

- Hepatitis C screening , education, and treatment
- A licensed Specialist provides medical evaluation for chronic liver disease and coordinates your care with other Providers
- One-to-one education on reducing the risk of transmission to others and with available treatments to help you manage your health better
- On-going personal support from trained professionals that speak your native language
- Supportive social services
- Peer Support
- Support Groups



Care Managers and Medical Providers share up to date information to help you make informed decisions regarding your health.

STAR PROGRAM SPECIAL TREATMENT AND RESEARCH

STAR Health Center

CONSENT TO ELECTRONIC COMMUNICATION

STAR Health Center (SHC) offers its patients the opportunity to communicate via email or text message. Although we use the most advanced software to ensure that transmitted messages are encrypted and secure, transmitting information by email or text messaging has a number of risks to be considered. This form provides information about these risks, how we will use this information and guidelines for you on communicating via email or text.

WHAT WE DO TO PROTECT YOUR PRIVACY IN ELECTRONIC COMMUNICATIONS

- Emails and text messages are sent only from cell phones, smart phones, other mobile devices, or computers which are issued by the SHC and have HIPAA compliant encryption software installed.
- Our computers and mobile devices used to send emails and text messages are all password protected.
- Staff must double check that the email or cell phone number of each client is recorded correctly by repeating the number back to the client.
- Staff must delete emails/text messages after communication is completed and necessary information is recorded.
- Text messages sent from SHC devices will be automatically deleted after 14 days (on our device and yours).
- Staff with SHC-issued mobile devices must ensure that these devices are secure at all times, including after work and at home in accordance with SUNY-DMC's Mobile Device Policy.
- Every SHC employee must sign the Workforce Confidentiality of Protected Health Information Attestation and, if issued a mobile device, must sign agreement to comply with the Mobile Use Policy.
- Upon termination of employment with the SHC, staff must return his/her DMC-issued device and the content is erased by a qualified technician.
- If a SHC-issued device is lost or stolen the device is remotely erased to ensure information is not accessed.

RISKS OF ELECTRONIC COMMUNICATION

- Senders can misaddress an email or text message which can be received by unintended recipients.
- Email and text messages can be circulated, forwarded or stored in electronic files.
- Backup copies of emails or texts may exist even after the sender or recipient has deleted his/her copy.
- Email can be used to introduce viruses into computer systems.
- The sender may assume that a message was sent when it was not.
- There is a possibility of misinterpretation of the message due to nonverbal feedback.
- Backup copies may exist even after sender and/or recipient has deleted their copies.
- Email and text messages can be lost in transmission.

POTENTIAL COSTS OF TEXT MESSAGING

- Many mobile phone users pay for each message they receive.
- Message & data rates may apply to your communications with SHC.

HOW WE WILL USE ELECTRONIC COMMUNICATION

- In general, we will initiate electronic communication with you only about non-sensitive issues such as appointment reminders; scheduling, canceling and rescheduling appointments; routine forms; and benefit information. However, we have put protections in place in the event we need to contact you with emergent information or when we need to respond to your question that includes sensitive information, SHC will use reasonable means to protect the security and confidentiality of emails and text messages sent and received; however, because of the risks outlined above, we cannot guarantee the security and confidentiality of email or text messaging communication and will not be liable for improper disclosure that is not caused by our intentional misconduct.
- There might be other individuals such as administrative staff who have access to these materials.
- We will not disclose your email to researchers or others unless allowed by Federal or State law.
- Please refer to our Notice of Privacy Practices for information as to the permitted uses of your health information and your rights regarding privacy matters. Our notice of Privacy Practices can be located at http://www.downstate.edu/policy/patient.html

PATIENT GUIDELINES FOR EMAIL COMMUNICATION

- If communicating via email, include the general topic of the message in the "Subject" line of your email. For example, "Prescriptions," "Advice," "Appointment," or "Billing Question."
- Include your name and phone number in the body of the communication.
- Review your message to make sure that it is clear and concise and that all relevant information is included before sending.
- The email or text communication should not be time-sensitive. While we try to respond to messages daily, it may take up to 3 working days for us to respond to your message. If your message requires a response from us and you have not heard back from us in 3 working days, call the phone number for the staff person you are trying to reach or 718-270-3745. **Urgent messages or needs should be relayed to us using regular telephone communication.** It is your responsibility to follow up to determine whether the intended recipient received the email or text message and when a response might be expected.
- You are responsible for protecting your own device, your password, or other means of access. We are not liable for breaches of confidentiality caused by a client or other third party.
- Take precautions to protect the confidentiality of your messages such as password protecting your phone or computer.
- Inform us of changes in your email, cell phone, address or landline phone number.
- **You must withdraw consent to discontinue electronic communications.**

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. I further waive any and all claims that may arise against STAR Health Center (SHC) or University Hospital of Brooklyn (UHB), its employees, contractors, interns, and practicum students resulting from the use or misuse of text messaging.

I may want to communicate with SHC by text or email. I understand that SHC has taken all possible precautions to protect my confidentiality, but cannot guarantee the security and confidentiality of email and text communications. I release and hold harmless SHC, UHB, its physicians and staff from any and all expenses, claims, liabilities damages and losses that may result from email or text communication between me and

SHC/UHB including technical failures beyond the control of SHC/UHB such as system crashes power outages and network overloads.

I understand that I may also communicate with SHC by telephone or during a scheduled appointment and that email or texting is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

I understand that either I or SHC may stop using email or texting as means of communication.

I understand that I may revoke this consent at any time be advising SHC in writing by mail or in person at either of the following addresses:

Mailing Address:

STAR Health Center
SUNY Downstate Medical Center
450 Clarkson Avenue, MSC 1240
Brooklyn, NY 11203

Physical Address:

STAR Health Center
University Hospital of Brooklyn
470 Clarkson Avenue – Suite J
Brooklyn, NY 11203

My revocation of consent will not affect by ability to obtain future health care, nor will it cause the loss of any benefits to which I am otherwise entitled.

I understand that failure to comply with the guidelines delineated in this form may result in SHC's termination of the email or texting relationship.

I have read this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I agree to comply with the information outlined in this communication to and from STAR Health Center and University Hospital of Brooklyn.

_____

:

I agree to communication from STAR Health Center as follows:

☐ **Text** Cell phone number: _____

☐ **Email** Email address: _____

Patient Name: _____

Signature: _____

Date: _____

SUNY Downstate Medical Center | STAR Program | Special Treatment and Research

Patient's Name: _____ **MR#:** _____ **Date received by patient:** _____

STAR Health Program Documentation Cover Sheet

Please check off items collected

Verification of Income

At least one of these:

___Two recent pay stubs
___Social Security statements
___Their most recent tax return
___Unemployment check stubs
___Proof of child support
___A letter from their employer stating hours of work per week/pay per hour
___A letter from someone providing financial support
___Other: _____

Proof of Address

___Utility Bills
___Postmarked Mail
___A letter from patients' social worker
___A letter from patient's shelter manager
___Driver's License/ Government ID/ Learner's Permit
___Other: _____

Medical Coverage (If they have it)

As many of these as they have:

___Insurance Card
___Medicaid Card
___Medicare Card
___ADAP Card
___Benefit Card
___Other: _____

Completed Forms

___Sliding Scale & Cap on Charges application

Staff Name (Print): _____ Date Received by Staff: _____

Please email a photo of the circled documents to

_____

(Providing written consent for email communication has been attained). Thank You!

Please text a photo of the circle documents to 1-347- 831-3670

(Providing written consent for text communication has been attained). Thank You!

Proof of Address

- Driver License
- Letter from you shelter manager
- Letter from your social worker
- Postmarked mail
- State ID
- Utility bill
- Other: _____

Proof of Income

- Child support payment document
- Recent tax return
- Social Security Statement/SSD award letter/ SSI award letter
- Two recent pay stubs
- Unemployment Check stub
- Letter from your employer stating of hours worked each week and pay per hour
- Letter from person providing you with financial support
- Bank statement
- Other: _____

Proof of Medical Coverage

- ADAP Card
- Benefit Card
- Insurance Card
- Medicaid Card
- Medicare Card
- Other: _____

Staff Name (Print): _____Date Received by Staff: _____

Sign up and start saving money today!

The Ryan White program is a federal grant designed to protect you from being overwhelmed by healthcare costs. It not only helps to fund the STAR Health Center; it can help you!

No insurance? No problem!

If you don't qualify for Medicaid, Medicare or ADAP, our Ryan White-grant funded sliding scale discounts and cap on charges can keep your clinic visit costs low, **regardless of your immigration status**, savings or assets. The lower your income, the less we charge!

Do you have insurance? With our cap on charges, once you hit your 12-month maximum – which includes your insurance premiums, medical visits, home healthcare, and the cost of drugs – your STAR Health Center copays for the rest of that year are $0. That's right, SHC and SUNY Downstate visits for FREE.

What do I need to bring?

1

Proof of address:

Utility bills, postmarked mail, or a letter from your social worker or shelter manager

2

Verification of income ONE of these:

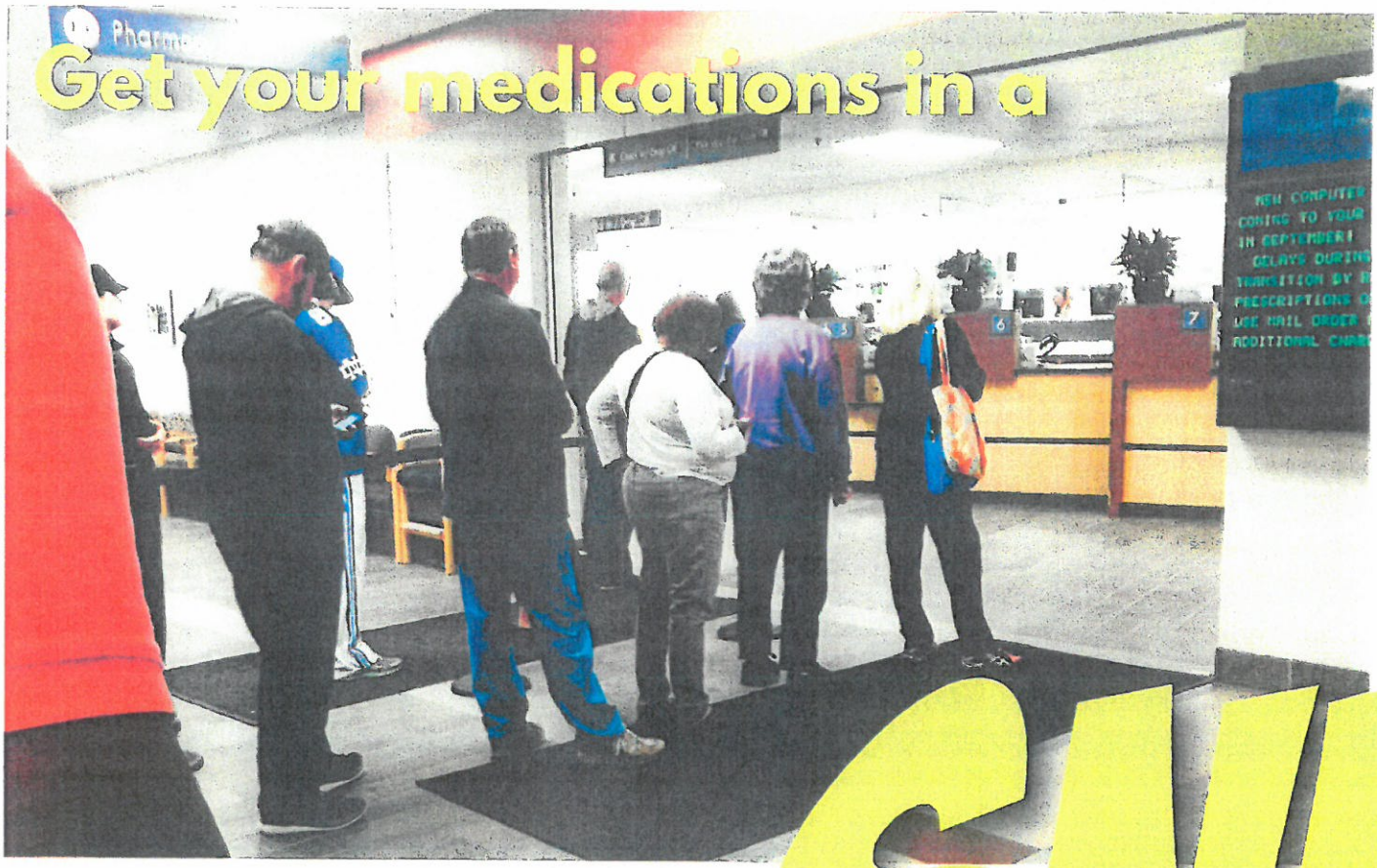
Two recent pay stubs
Social security statements
Your most recent tax return
Unemployment check stubs
Proof of child support
A letter from your employer stating hours worked per week/pay per hour

3

Medical coverage (If you have it), and AS MANY of these as you have:

Insurance card
Medicaid card
Medicare card
ADAP card

Ask your STAR Program health provider about the Ryan White program today!



SNP

Sign up for a Special Needs Plan (SNP) today!

DID YOU KNOW?

Certain insurance plans need pre-authorization before prescriptions can be filled.

There's a way to avoid this: sign up with a SNP

AGAIN!

Please speak with a STAR case manager for more