INSTRUCTIONS FOR COMPLETING APPLICATION

-SEE FREQUENTLY ASKED QUESTIONS IN YOUR KEEP AT HOME PACKET FOR MORE INFORMATION -
PLEASE ALLOW UP TO TWO WEEKS FOR YOUR APPLICATION TO BE PROCESSED

Completed applications may be scanned and emailed to: bchserap@bradfordco.org or mailed or dropped off to: Bradford County Human Services, 220 Main St., Unit 1, Towanda, PA 18848

- Release of Information
  - PRINT your name in the blank space at the top of the page
  - Check off any unchecked boxes that may apply to your specific situation
  - Write the name and phone number for your landlord where indicated
  - Write in the names of any utility companies you are requesting help with
  - Write in the names of any other involved agencies (Probation, CVS, etc.)
  - Date and sign next to the star (where indicated)
- Housing Assistance Application - Page 1
  - Write the head of household's name, address, email, and phone number where indicated in the first box. IF YOU ARE HOMELESS WITHOUT A PLACE TO STAY, instead of an address, please write the zip code where you slept last night.
  - Please circle if you are a homeowner, tenant or street homeless
  - In the next box, please list the names of all household members, starting with the head of household.
  - Write in the date of birth for all household members
  - Write in the social security numbers for all household members
  - Write in the relationship of all household members to the head of household
  - Fill in the gender, race, and ethnicity for all household members, or write DECLINED
  - Check all types of assistance that you are requesting help with. In the amount box, write any known amounts that are currently owed. Write in the name of the landlord and utility companies for any checked boxes.
  - Answer the question about alternative heat sources. Examples might be if you have a fire place, wood or pellet stove to supplement a furnace.
  - Answer the question about Section 8 vouchers. If the answer is yes, please write in what the amount is that you are responsible for.
  - Write in Yes or No for each of the listed agencies to indicate if you have received any funding from them at all (including emergency shelter) during the past 2 years. If you know the amount, please write that in as well.
- Housing Assistance Application - Page2
  - Monthly Income -you MUST list the amounts, frequency, and sources of all household income. Please refer to the list of acceptable proofs of income in your "keep at home" packet to ensure that you provide all of the documentation that is required. While SNAP benefits do not count as income, we are required to gather this information for our reporting and eligibility determinations.
  - On the lines provided, please write a description of why you are asking for help. Please be specific. For example, do not just say "I'm behind on my rent." A better example would be to explain WHY you are behind on your rent. **NOTE: YOU MAY BE REQUIRED TO WORK WITH OTHER AGENCIES AND MAY BE HELD RESPONSIBLE FOR A PORTION OF YOUR RENT AND/OR UTILITIES AS A CONDITION OF RECEIVING ASSITANCE.**

INSTRUCTIONS FOR COMPLETING APPLICATION

PLEASE DO NOT SEND SCREEN SHOTS OR CELL PHONE PHOTOS OF APPLICATIONS OR DOCUMENTS.PLEASE ALLOW UP TO 30 DAYS FOR YOUR APPLICATION TO BE PROCESSED

- Please read the three questions at the bottom of the page CAREFULLY and select the appropriate answer.
  - Examples of financial hardship may include, having unexpected medical bills, car repairs, or other LARGE bills, having less work or losing a job, reduction in SSI/SSD benefits, etc.
  - Examples of housing instability or homelessness include but are not limited to:
    - being behind on electric, water/sewer or other utilities,
    - being behind on rent,
    - experiencing a recent job loss or receiving a large unexpected bill that is going to make it hard to pay your rent or utilities in the future

- Housing Assistance Application - Page 3
  - Utility Certification - please choose if you are asking for help with utilities instead of or in addition to rent. **IF UTILITIES ARE INCLUDED IN YOUR RENT, PLEASE CHECK THAT YOU ARE DECLINING ASSISTANCE.**
  - Attestation/Certification - when you sign this block, you are saying that you agree that everything in your application is true and correct, and that you understand that you can go to jail, and/or be required to pay back any money way (plus interest and fees) if we later determine that information you provided was false.
- Self declaration of Income:
  - Please be sure to list any income for ALL household members is identified on this form and then have them sign to confirm the information provided. It is okay to estimate how much the monthly income is, however you must use the GROSS (pre tax) amount.
  - Please have any adults who do not have an income indicate this in the correct section and sign where indicated.
  - WE WILL ATTEMPT TO VERIFY THE INFORMATION YOU PROVIDE WITH EMPLOYERS, SOCIAL SECURITY, AND OTHER APPLICABLE AGENGIES OR BUSINESSES.
- Acknowledgement of Receipt of Privacy Practices
  - The privacy practices are in your "keep at home" packet. You are signing that you received them, not that you read them.
  - Please PRINT your name on the first line, write your complete address in the second line, and sign and date where indicated. If you are street homeless, your address will be the zip code where you slept last night.
- Rights & Responsibilities
  - Please read, print your name, then sign and write the date in where indicated.
- LANDLORD CERTIFICATION FORMS- these forms only may be faxed TO 570-265-8541 or emailed to: bchserap@bradfordco.org.

  - Please give this form to the landlord to complete and remind them that we will need a detailed statement if there are arrears owed. It explains how to do this in the black box on the form
  - W - 9: Please give this form to the landlord as well. This form is necessary for us to generate a 1099 form for the landlord's taxes.

BRADFORD COUNTY HUMAN SERVICES
HOUSING PROGRAM
CONSENT FOR OBTAINING CONFIDENTIAL INFORMATION

- Main Link HAP Program
- The Bridge (Sayre, PA)
- Salvation Army (all locations)
- TREHAB
- Probation/Parole
- All law enforcement
- Bradford County Assistance Office
- My landlord (current/future)
- Northern Tier Counseling
- Children & Youth Services

- Main Link Certified Peer Support Program
- Grace Connections (Towanda, PA)
- Bradford County MH/ID/Drug & Alcohol/ID/Autism
- Endless Mountains Mission Center
- Bradford County Sheriff's Office
- Local food pantries
- LIHEAP/LIWAP
- Any utility companies I request assistance with
- Allied Services
- Any hotel providing emergency shelter (if applicable}

- Other: ______________________________
- Other: ______________________________

I fully understand the nature of this consent and that this authorization shall remain effective for one year from the date of my signature; however, I may revoke this authorization at any time by written, dated communication to the Administrator or his/her designee.
By signing below, I authorize Bradford County Housing program staff to contact any of the following on behalf of all household members registered on my application to facility approval of my housing application and to assist my household with getting and/or keeping stable housing.
I hereby release the Bradford County Housing Program and said person or facility from all legal responsibility and liability for acting upon this authorization, and I intend to be legally bound hereby.

_______________ ______________________________
DATE **SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO CONSENT FOR CLIENT**

_______________ ______________________________
DATE SIGNATURE OF STAFF MEMBER OBTAINING CONSENT

To be completed if client is physically unable to provide a signature but has indicated verbally or behaviorally, that he/she consents to obtaining information.

We affirm that,____________________________was physically unable to provide a signature, understands the nature of the consent and freely gave his/her verbal or behavioral consent. This Authorization shall remain effective from this date to___ (60 days hence); however this may be revoked by verbal or behavioral communication to the Administrator or his/her designee.

_______________ ______________________________
DATE WITNESS

_______________ ______________________________
DATE WITNESS

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED.

BRADFORD COUNTY HUMAN SERVICES - HOUSING ASSISTANCE APPLICATION

Name: ____________________

Address: ____________________

City: State: Zip:

Mailing Address:
(If different than above) ____________________
City: State: Zip:

For Homeless Only - Zip Code where you slept last night: ____________________

EMAIL: ____________________ Phone: ____________________

IMPORTANT: Please select one of the following: HOMEOWNER TENANT STREET HOMELESS

PLEASE COMPLETE NEXT SECTION FOR YOURSELF AND ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN-ATTACH ADDITIONAL PAGES IF NEEDED

Name	DOB	Age	Soc. Security#	Relationship	Gender*	Race**	Ethnicity***
				SELF			

	Check all that you are asking for help with	Amount	Landlord	Utility Phone Number	Account Number
	Rent				
	Security Deposit				
			Utility Company		
	Fuel Oil				
	Natural Gas / Propane				
	Electric				
	Water				
	Sewer				
	Emergency Shelter				
	Other(Explain Below)				

DOES THE FAMILY HAVE ALTERNATE HEAT SOURCES?

Have you received any help with rent and/or utilities from any of the following in the past 2 years?

Program Name	Check all that apply
Main Link or Futures HAP Program	
Grace Connection	
The Bridge	
Endless Mountain Mission Center	
TREHAB	
ERAP 1	
ERAP 2	
Other	
Explain (If Yes)	

Do you receive any subsidy to help pay your rent from another source

YES / NO

If so, what is the amount you are responsible for?
$

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED

Monthly Income					
SOURCE	**Employer Name**	**Type**	**Phone Number**	**AMOUNT RECEIVED**	**HOW OFTEN**
Adult 1					
Adult 2					
Adult 3					
Adult 4					
Adult 5					
CHILD SUPPORT/ALIMONY					
SNAP BENEFITS (FOOD STAMPS) NOTE: Does NOT count as income, but may help verify income eligibility					
OTHER (PLEASE DESCRIBE BELOW):					

PLEASE WRITE A BRIEF SUMMARY EXPLAINING WHY YOU NEED HELP ... PLEASE USE AS MUCH DETAIL AS POSSIBLE. Use additional paper if needed.

Please select "YES" or "NO" from the following options:

	Yes	**No**
Are you currently experiencing or have you recently experienced a FINANCIAL HARDSHIP, such as a decrease in income or increase in expenses?		
If yes, was the hardship due to COVID		
Are you at risk of housing instability or homelessness?		

YOU MUST PROVIDE DOCUMENTATION THAT VERIFIES THE INFORMATION PROVIDED IN YOUR STATEMENT ABOVE

I certify, under penalty of perjury, that I do not have any income from any source at this time.

Applicant Signature: Date:

PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED

UTILITY CERTIFICATION-ERAP 2 APPLICANTS ONLY

_ I am requesting assistance with the following utilities (please provide bills):

_ I am DECLINING assistance with my utilities, OR my utilities are included in my rent. I understand that If I change my mind later, assistance will not be provided for any utilities that pre-date my authorized funding period.

NOTE: YOU MUST HAVE APPLIED FOR AND USED ANY CASH/CRISIS LIHEAP BENEFIT FOR HEATING BILLS, AS WELL AS LIWAP FOR WATER/SEWER BILLS BEFORE WE WILLASSISTWITH THEM. YOU CAN APPLY FOR LIHEAP AND LIWAP THROUGH THE PA COMPASS WEBSITE.

ATTESTATION/CERTIFICATION

I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is being submitted by someone acting on my behalf. I certify that all information that has been entered is true under penalty of perjury. I understand that the information entered in this application will be kept confidential and used only to administer benefits. I understand that I may be required to work with other agencies as a condition of my receiving assistance. I agree to provide upon request any additional documentation required (pay stubs, lease, recent bills, etc.) to aid in determining eligibility. I understand that future funding is not guaranteed, and that I may be asked to be responsible for a portion of my rent/utilities should assistance be approved.

PLEASE REFER TO YOUR "KEEP AT HOME" PACKET FOR A LIST OF REQUIRED DOCUMENTATION TO SUBMIT WITH YOUR APPLICATION.

Applicant Date

WHAT'S NEXT?

- ALL APPLICATIONS ARE PROCESSED IN THE ORDER IN WHICH THE APPLICATION AND SUPPORTING DOCUMENTATION IS RECEIVED. IT CAN TAKE UP TO 30 DAYS FOR AN APPLICATION TO BE PROCESSED, EVEN IN CASES WHERE THERE IS AN EVICTION OR SHUT OFF NOTICE.
- WE ENCOURAGE YOU TO CONTINUE TO REACH OUT TO OTHER LOCAL AGENCIES FOR ASSISTANCE WHILE YOUR APPLICATION IS UNDER REVIEW.

BRADFORD COUNTY HUMAN SERVICES
HOUSING PROGRAM
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is being provided to acknowledge your receipt of our **Notice of Privacy Practices.**

What is the Notice of Privacy Practices?

The **Notice of Privacy Practices** explains how your patient health information may be used or disclosed by us. In addition, it explains your rights with regard to your patient health information, as well as our legal responsibilities.

Acknowledgement of Receipt

By signing below, you are acknowledging that the Notice of Privacy Practices has been provided to you,

I,____(client's name) residing at ____

(Client's address) have received the Notice of Privacy Practices from Bradford County Human Services, Housing Department.

___________________________________ ________________________

Signature Date

Rights & Responsibilities

RIGHT TO NONDISCRIMINATION
This institution is prohibited from discriminating on the basis if race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

Person with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American sign language, etc.) Should contact the agency (State or Local) where they applied for benefit. Additionally, program information may be available in languages other than English.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S Department of Health and Human Services (HHS):

(1) Mail U.S. Department of Health and Human Services
HHS Director, Officer for Civil Rights, Room 515-F
200 Independence Avenue, S.W.
Washington, D.C. 20201;or
(2) Call (202 619-0403 (Voice) (800) 637-7697 (TTY)

This institution is an equal opportunity provider.

RIGHT TO CONFIDENTIALITY
We will keep your information private. It will only be used to decide which programs you may be eligible for. Any person knowingly violating any of the rules and regulations of this department shall be guilty of a misdemeanor and, upon conviction shall be sentenced to pay a fine not exceeding one hundred ($100) dollars, or to undergo imprisonment, not exceeding six months, or both (62 P.S. section 4863)

RESPONSIBILITY TO PROVIDE INFORMATION
You must give true, correct, and complete information. You must help in proving the information you give. Benefits may be denied if you fail to provide certain proof. If you are contact by Department of Human Services (DHS) or the Office of State Inspector General, you must fully cooperate with those persons or investigators.

PRIVACY ACT STATEMENT
The collection of this information, including the Social Security number (SSN) of each household member is authorized under 42 U.S.C. § 405(c)(2)(C)(J-iv) and 62 P.S. § 432,2(b)(3),
The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Emergency Rental Assistance Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.
This information may be disclosed to other federal and state agencies for official explanation and to laws enforcement officials for the purpose of apprehending person fleeing to avoid the law. Failure to provide an SSN may result in the denial of Emergency Rental Assistance to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members If someone wants help getting an SSN

(1) Call: 1-800-772-1213 or 1-800-325-0778 (TTY); or
(2) Visit: www.ssa.gov

RIGHT TO APPEAL
You have the right to ask for a DHS hearing to appeal a decision if you believe it is unfair or incorrect or if the provider fails to act on your application for benefits. You may file the appeal at:

DHS Office of Hearing and Appeals
PO Box 2675
Harrisburg, PA 17105

If you appeal, you may also request a conference before the hearing by contacting the Emergency Rental Assistance Program (ERAP) program manager via email at :
RA-PWERAPOIM@pa.gov
At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative, may represent you.

Authorization of Release of Information (Tenant Only)

☐	**By checking this box I am confirming that I have read & understood the above information**

I hereby authorize and request the disclosure to the county office any information concerning the age, residence, citizenship, employment, income, and any additional information involving eligibility for the rental and utility assistance programs for myself. It is understood that the information obtained will only be used for determination of rental/utility assistance or other housing assistance programs.

Signature of Tenant	**Date**

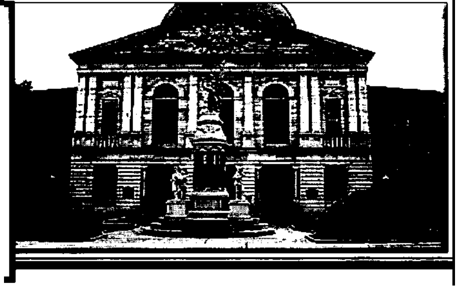
Name Printed-Tenant

PLEASE REFER TO THIS PACKET AS YOU COMPLETE YOUR APPLICATION.

IT CONTAINS IMPORTANT INFORMATION YOU MAY NEED:

- Frequently Asked Questions
- Documentation checklist {submit these with your application)
- Acceptable Proof of Income list
- ERAP 2 Income Guidelines
- Privacy Practice Notice
- Right to Appeal Notice
- Housing Assistance Sheet with other resources

Bradford & Sullivan County
Mental Health/Intellectual Disabilities/Autism
Early Intervention
220 Main St. Unit #1
Towanda, PA 18848
570-265-1760 Fax: 570-265-8541
bchousing@bradfordco.org



DOCUMENTATION CHECKLIST FOR HOUSING ASSISTANCE APPLICATIONS

PLEASE PROVIDE COPIES OF THE FOLLOWING DOCUMENTS AT THE TIME YOU DROP OFF YOUR APPLICATION. DO NOT FAX OR EMAIL THE REQUESTED DOCUMENTS.

- Photo ID for all adults
- Social Security Card or acceptable alternative for all household members including children
- Proof of **SNAP** eligibility
- Proof of Income (see separate sheet for acceptable proof of income)
- Lease/Renters Agreement (preferred but can waive under some circumstances)
- Completed and signed letter of circumstance (attached)
- Documents to support letter of circumstance
- Completed and signed release of information (attached)
- Complete the missing information and/or signatures on application (attached)
- Eviction or Shut off Notice
- Proof of Bradford County residency
- Copies of all utility bills
- Tenant Utility Certification Form
- W-9 from landlord
- Completed and signed Landlord Certification

Documents must be clear and legible.
WE CANNOT ACCEPT CELL PHONE PHOTOS OR SCREENSHOTS.

Requested documents may be dropped off along with your completed application at our office located at 220 Main Street, Unit 1 (upstairs), Towanda or mailed to:

BRADFORD COUNTY HUMAN SERVICES
ATTN: HOUSING
220 MAIN STREET, UNIT 1
TOWANDA, PA 18848

PLEASE ALLOW UP TO 14 DAYS FOR YOUR APPLICATION TO BE PROCESSED ONCE WE RECEIVE ALL NECESSARY DOCUMENTATION FROM ALL PARTIES.

If you have any questions, please call (570) 265-1760 during normal business hours.

PROOF OF INCOME

** Other Income form provided by counselor

TYPES OF INCOME	ACCEPTABLE PROOF
Cash Gifts and Contributions	Use other income form provided by counselor
Child/Spousal Support	Court Award letter, domestic relations printout
Department of Public Welfare (TANF)	Benefits letter, Notice to Applicant Letter
Foster Care	Statement from Social Services
Insurance Proceeds	NOT considered income
Military Pay	Only if household has access to person's wages
Pension	Copy of check & stub or letter from pension board
Recent loss of ANY type of income	Follow No Income Guidelines
Rent paid by HUD	NOT considered Income
Rental Income	Lease or notarized statement
Reverse Mortgage Income	NOT considered income
Room and Board income	Use Other Income form provided by counselor
Salary/Wages	1. Paystubs to cover last 30 day period 2. Newly employed (less than 30 days) *must have at least 1 pay stub *must recertify within 3 months
Self Employed	Current Tax Return Documentation • i.e. Form 1040 and Schedule C
SSI, SS, SSD or Veteran's Benefits	Letter for Social Security Administration Copy of check or direct deposit statement
Student Loans	NOT considered income
"Under the Table"	Use Other Income form provided by counselor
Unemployment	Letter of Determination
Utility Allowances	NOT considered income
Work Study	NOT considered income
Workers Compensation	Statement from Workers Compensation
	If none of the above is available, acceptable proof is Self-Declaration of Income

NOTICE OF YOUR RIGHT TO APPEAL

You have the right to request a hearing to appeal a decision if you believe it is unfair or incorrect.

Step 1 - Request an information review by contacting:

Bradford County Human Services
Attn: Housing
220 Main Street, Unit 1
Towanda, PA 18848
(570) 265-1760

If you still disagree or feel you have been discriminated against, you may request a hearing with the fair housing officer. This request must be in writing, and may be sent to:

Bradford County Fair Housing Officer
Megan Johnson
301 Main Street
Towanda, PA 18848

If you still disagree, you have the right to ask for a DHS hearing to appeal a decision if you believe it was unfair or incorrect. You may file an appeal at:

DHS Office of Hearings and Appeals
PO Box 2675
Harrisburg, PA 17105

If you appeal, you may also request a conference before the hearing by contacting the ERAP program manager via email at: ra-pwerapoim@pa.gov.

At the hearing you may represent yourself, or someone else, such as a lawyer, friend, or relative may represent you.

FY 2022 Income Limits Summary

Selecting any of the **buttons labeled** "Click **for More Detail" will display detailed** calculation **steps** for **each of the various parameters.**

FY 2022 Income Limit Area	Median Family Income	FY 2022 Income Limit Category	Persons in Family							
			1	2	3	4	5	6	7	8
Bradford County, PA	$71,500	Very Low (50%) Income Limits ($)	25,550	29,200	32,850	**36,450**	39,400	42,300	45,200	48,150
		Extremely Low Income Limits($)*	15,300	18,310	23,030	**27,750**	32,470	37,190	41,910	46,630
		Low {80%) Income Limits ($)	40,850	46,650	52,500	**58,300**	63,000	67,650	72,300	77,000

For ERAP applications only, proof of income is not required if the household has a verified open SNAP case.

Client Copy

Bradford County Human Services

HOUSING ASSISTANCE
(Security Deposit, Rent, Utilities, Food, Transportation)

RENTAL ASSISTANCE:
If you are homeless or within 14 days of eviction, the following resources may be available:

- **Call 211 (Dial 211 or 1-855-567-5341 or text your zip code to 898211)-this** is a free service to help you reach local resources. Some programs may REQUIRE a 211 referral for you to qualify for funding.
- **Endless Mountain Mission Center:** **570-297-4489**
  Homeless Shelter and Rapid Rehousing/Homelessness Prevention funds
- **The Main Link:** **570-637-8789**
  Homeless Assistance Program and Emergency Shelter funds
- **Bradford/Tioga Housing Authority:** **570-265-3678**
  Public Low-Income Housing and Section 8 Housing Choice Vouchers **570-638-2151**
- **The Bridge (Valley area only):** **570-888-8826**
  Emergency rent/utility assistance; used furniture
- **Grace Connections:** **570-268-0431**
  Rental & Utility Assistance and food bank, furniture vouchers
  (serves Towanda, Wyalusing, and Northeast School Districts)
- **Salvation Army, Towanda** **570-265-5932**
- **Salvation Army, Sayre** **570-888-2153**

  Both Salvation Army's provide rent and utility assistance for their Respective coverage areas, as well as seasonal needs such as School supplies (back pack program), Christmas for low income Families, etc.

UTILITY **ASSISTANCE:**
If you are facing a shut-off notice, the following resources may be available to you:

- **Bradford County Trehab: (Claverak/UGI/Valley Energy Customers)** **570-255-2072**
  Utility Assistance Program, Celeste Kranick
- **Low Income Energy Bill Assistance Program (LIHEAP)** **866-857-7095**
- **Dollar Energy (Penelec Customers):** **800-375-1388**
  NOTE: On-Hold Wait times are high.

Updated: 9/14/2020

Client Copy

Other agencies that may help with assistance:

Abuse & **Rape** Crisis Center (ARCC)	570-265-5333
Area Agency on Aging, Towanda	570-265-6121
Bradford County Human Services	570-265-1760
Canton Food Pantry, Canton	570-673-7732
Child Hunger Outreach Partners	570-485-5050
Children & Youth Services:	
-Bradford County	570-265-1760
-Sullivan County	570-928-0307
-Chemung County, NY	607-737-5302
Department of Public Welfare (Bradford), Towanda	570-265-9186
Department of Public Welfare (Sullivan), Laporte	570-928-8596
Elmira Homeless Shelter, Elmira, NY	607-732-5954
Helping Hands, Wyalusing	570-726-1384
Housing Authority - Sullivan County, Laporte	570-946-7677
Housing Authority – Bradford/Tioga County	570-638-2151
Open Door Mission Men's Shelter, Tioga County, NY	607-687-1121
Sullivan County Food Pantry, Dushore	570-928-8253
TACO Food Pantry, Wysox	570-265-4422
TREHAB -Affordable Housing Units	570-265-2072
Troy Food Bank, Troy	570-297-1095
Valley Food Pantry, Wave y. NY	607-565-8718
Veterans Affairs, Towanda	570-265-1704

Transportation:

BEST Transit Authority	570-888-7330
Valley Taxi	570-888-2365

Updated: 9/14/2020

Attachment A

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.

Bradford County Human Services –Intellectual Disabilities program has a legal duty to safeguard your protected health information (PHI).

All employees, volunteers, staff, doctors, health professional and other personnel are legally required to and must abide by the policies set forth in this notice to protect the privacy of your health information.

This protected health information, or PHI for short, includes information that can be used to identify you. We collect or receive this information about your past, present, or future health condition to provide health care to you, or to receive payment for this health care.

We must provide you with this notice about our privacy practices that explain how, when, and why we use and disclose (release) your PHI. With some health exceptions, we may not use or release any more of our PHI than is necessary to accomplish the need for information .We must abide by the terms of the notice of privacy practices currently in effect.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy of this notice from the contact person listed at the end of this notice any time.

We may use and release your protected health information for many different reasons. The Commonwealth of Pennsylvania provides a broad range of services through a wide a variety of health and human services programs. If you receive services from Commonwealth program, the Commonwealth program may use your protected health information and disclose it to other Commonwealth health and human series programs and outside the Commonwealth. For some of these reason we will need your permission for a specific signed authorization. Below, we describe the different categories of when we use and release your PHI, give you some examples of each category and tell you when we need your permission.

We may use, or disclose your protected health information for treatment, payment, or health care operations. Your consent is not required for these purposes.

For treatment, we may release your PHI to physicians, nurses, medical students, and other health care personnel and agencies and business associates who provide or are involved in your health care. For example, if you are being treated by one program, which sees a need for other services, we may release your PHI to other county departments/programs in order to coordinate your care.

To obtain payment for treatment. We may use and release your PHI in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date PHI. For example, we may release portions of your PHI with our billing department and your health plan to get paid for the health care services we provided to you. We may also release your PHI to our business associates, such as billing companies, claims processing companies and others.

To run our health care business. We may release your PHI in order to operate our facility in compliance with healthcare regulations. For example, we may use your PHI to review the quality of our services and to evaluate the performance of our staff in caring for you.

We also do not require your consent to use or release your PHI

When federal, state, or local law, judicial or administrative proceedings, or law enforcement agencies request your Protected Health Information.

We release your protected health information only when a law requires that we report information to government agencies or law enforcement personnel. For example. We would notify the appropriate authorities about victims of child abuse, or neglect. We would also notify Law Enforcement officials about the following: for notification and identification purposes when a crime has occurred in missing person cases, or when ordered in a judicial or administrative proceeding.

For public health activities. We report information about births, deaths, and various diseases to government officials in charge of collecting that information and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

For purposes of organ donation. For patients that have previously agreed to organ donation, we may notify organ procurement to assist them in organ, eye or tissue donation and transplants.

To avoid harm. In order to avoid a serious threat to health or safety of a person or the public, we may provide your demographic PHI to law enforcement personnel or persons able to prevent or lessen such harm.

For worker's compensation purposes. We may release your PHI in order to comply with worker's compensation laws. If you do not want worker's compensation notified, alternate insurance or payment information must be supplied.

For appointment reminders and health-related benefits and services. We may use your demographic PHI to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

For fundraising activities. We may use your demographic PHI to communicate with you to raise funds for our healthcare system. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

For health oversight activities. We may use PHI and may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions or other activities necessary for oversight of the healthcare system, government benefit programs, or entities subject to government regulation or civil rights laws.

You have the opportunity to agree to or object to the following.

1. **Patient Directories.** We may include your name, location in our facility, and your general condition in our patient directory, to direct visitors who ask for you by name. We may also include your religious affiliation for use by clergy, unless you object in whole or part. Your choice to object may be made at any time.
2. **Information shared with family, friends, or others**. We may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or part. Your choice to object may be made at any time. You will be notified if one of the persons asks to access your PHI.

Your prior written authorization is required for any uses and disclosures of your protected health information not included above. We will ask for your written authorization before using or releasing any of your PHI except as previously stated, or in an emergency situation. If you choose to sign an authorization to release your PHI, you may later cancel that authorization in writing. This will stop any future release of your PHI for the purposes your previously authorized.

Your rights regarding your protected health information

You have the right to request limits on how we use and release your PHI. If we accept your request we will put any limits in writing and abide by them except in emergency situation. You may not limit PHI that we are legally required or allowed to release.

You have the right to choose how we communicate PHI to you. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, email instead of regular mail). We must agree to your request so long as we can easily provide it in the format you request. Any additional expenses will be passed onto you for payment.

You have the right to see and get copies of your PHI.

You must make the request in writing. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request, if we do, we will tell you in writing why we denied your request. You have the right to have the denial reviewed. We will choose a licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your first request. You can request a summary or a copy of the entire medical record as long as you agree to the cost in advance. If your request to see the medical information is approved, we will arrange this in accordance with established hospital policy. Please submit all request for this information to the supports coordinator.

You have the right to get a list of instances of when and to whom we have disclosed your PHI.

This list will not include uses you have already authorized, or those for treatment payment or operations. This list will not include uses made for national security purposes, to corrections or law enforcement personnel, if you were in custody, or disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list we will provide will include the last six years of activity unless you request a shorter time. The list will include dates when your PHIO was released and why, with whom your PHI was released (including their address if known) and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame,. Please submit all request for this information to the Director of the Intellectual Disabilities Program.

You have the right to correct or update your PHI.

If you believe there was a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will state our reason and explain your right to file a written state of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your PHI. If we approve your request we will make the change to your PHI, tell you that we have done it and tell others that need to know about the change or amendment to your PHI. Please submit all request for amendments to the supports coordinator.

You have the right to get this privacy notice by email

Even if you agreed to receive notice by email you also have the right to request a paper copy of this notice.

How to voice your concerns about our privacy practices: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI you may file a complaint with the person listed below or with the Secretary of the DHHS:

Person to contact for information about this notice or to voice your concerns about our privacy practices:

Director, Intellectual Disabilities Program
(570)-265-1760 – You will not be penalized for filing a complaint.

Effective Date of this notice: This notice went into effect on June 11th, 2003