AGUA SPECIAL UTILITY DISTRICT

Confidentiality of Medical Information
Policy

Policy:	Confidentiality of Medical Information
Scope:	This policy applies to all medical information received by the Agua Special Utility District from any source.
Procedure:	All medical information received by the Agua Special Utility District from any source will be maintained by the District in a locked file in the Office of the District Manager. Medical records will not be maintained in customer files or in personnel files of the District. Access to such medical information is limited to the following individuals: (1) the District Manager, (2) District employees who have a specific, job-related, need to know the information and (3) persons to whom the District is required by law to disclose the information.

Agua Special Utility District
Application for Lifeline Program

Sec. A:
Applicant's Name: _____

Address: _____

Home Phone #: _____ **Other #:** _____ **Account #:** _____

(check the box that applies)

Sec. B: Qualifications

☐ **1.** Permanently disabled **and** receiving benefits from any of the following programs:
(circle program or programs that apply)

- Medicaid
- Food Stamps
- Supplemental Security Income (SSI)
- Federal Public Housing Assistance
- Low Income Home Energy Assistance Program (LIHEAP)
- Disability Compensation from the Department of Veterans Affairs

☐ **2.** **Or** over the age of 65 **and** receiving benefits from any of the following programs:
(circle program or programs that apply)

- Medicaid
- Food Stamps
- Supplemental Security Income (SSI)
- Federal Public Housing Assistance
- Low Income Home Energy Assistance Program (LIHEAP)
- Disability Compensation from the Department of Veterans Affairs

Sec. C: Proof of Eligibility

1. All customers or applicants requesting to be included in the District's Lifeline Program must submit proof that the customer or applicant receives benefits any of the following programs: Medicaid, Food Stamps, Supplemental Security Income (SSI), Federal Public Housing Assistance, Low Income Home Energy Assistance Program (LIHEAP), or disability compensation from the Department of Veterans Affairs.

2. In addition to the information required by subsection C(1), a customer or applicant requesting to be in the District's Lifeline Program based on a permanent disability must submit an original notarized letter from the applicant's or customer's doctor stating the customer or applicant is permanently disabled.

3. In addition to the information required by subsection C(1), a customer or applicant requesting to be in the District's Lifeline Program based on age must present his or her driver's license to the District or provide the District with a copy of his or her birth certificate, and allow them to be copied.

Sec. D

Each customer participating in the District's Lifeline Program shall reapply each year between December 1st and December 31st in order to remain eligible for the program. If a customer fails to reapply as required, the customer's rates shall revert to the standard residential water use rates, unless a new application from the customer is received and approved by the District.

PLEASE READ THE FOLLOWING AGREEMENT, SIGN, DATE AND RETURN WITH YOUR COMPLETED APPLICATION TO ENSURE CONSIDERATION.

DISCLOSURE AND AUTHORIZATION TO OBTAIN INFORMATION

As a customer of Agua Special Utility District ("District"), I hereby claim and make application for the Lifeline Program. I understand that a new application must be completed when there is a change of address, and/or once a year when an update is due.

I hereby grant the right of access to my residence during regular business hours to District employees for verification of information given on this application. I understand that if I refuse access for the purpose of verifying my information or I refuse to provide all documentation requested, the District will deny Lifeline rate assistance. I understand that if I submit false information to the District, the District may deny my application for the Lifeline Program. I agree to notify the District if I no longer qualify for the Lifeline Program.

I understand if my account becomes delinquent I will be subject to the collection process up to and including disconnection of services.

I agree to authorize my doctor to release to the District pertinent information relating to my medical history, diagnosis, and any medical information necessary to update my Lifeline status.

Note: Agua Special Utility District makes every effort to prevent interruption of service. However, water outages may be caused by unforeseen circumstances and continuous service cannot be guaranteed.

AGUA SPECIAL UTILITY DISTRICT RESERVES THE RIGHT TO BACK BILL AN ACCOUNT OF A CUSTOMER IN THE LIFELINE PROGRAM IF HE OR SHE IS FOUND TO HAVE SUBMITTED FALSE INFORMATION IN THIS APPLICATION.

I DO HEREBY SWEAR AND ATTEST THAT ALL INFORMATION CONTAINED IN THIS APPLICATION IS TURE AND CORRECT.

(PLEASE PRINT)

Customer Name: _____ Account #: _____

Address: _____

Phone #: _____ Other #: _____ Driver License #: _____

Customer Signature: _____ Date: _____

SWORN TO AND SUBSCRIBED before me by _____ this __ day of _____, 20___.

_____
Notary Public, State of Texas

AGUA SPECIAL UTILITY DISTRICT
STATEMENT OF CERTIFICATION

This page must be completed by your physician licensed to practice medicine in the State of Texas.

Patient's First Name: _____ MI: __ Last Name: _____

Address: _____ City: _____, TX Zip code: _____

Phone: _____ DOB: _____

PLEASE PRINT ALL INFORMATION LEGIBLY
NOTE: INCOMPLETE OR ILLEGIBILE APPLICATIONS
WILL RESULT IN A DELAY IN PROCESSING.

For purpose of the District's Lifeline Program, "Permanent disability" or "permanently disabled" is defined as having a physical or mental health condition that is expected to last for a continuous period of not less than 12 months or to result in death, and because of that medical condition, the patient is unable to perform a job or any job for which he or she is qualified based on his or her age, education and work experience.

Is the Patient permanently disabled? YES NO

Is "YES", what is your patient's permanent disability? If there is more than one permanent disability, please list them all. DO NOT ABBREVIATE.

I hereby certify the above information is true and accurate as of the date signed. **(Please print legibly or stamp)**

Physician's Name: _____

Address: _____

City: _____ TX, Zip Code: _____ Telephone: _____

Signature of Physician: _____ Date: _____

SWORN TO AND SUBSCRIBED before me by _____ this __ day of

_____, 20___.

_____
Notary Public, State of Texas

YOU MAY REQUEST THAT YOUR PERSONAL INFORMATION CONATIAINED IN AGUA SPECIAL UTILITY DISTRICT'S UTILITY RECORDS BE KEPT CONFIDENTIAL

Agua Special Utility District's ("District") records, including personal customer information, may be subject to disclosure under the Texas Public Information Act (Texas Government Code Chapter 552). Texas Utility Code Section 182.052 allows utilities to keep personal information, such as customer addresses, telephone numbers, account records, social security numbers, and personal medical information, confidential.

Is there a charge for this service?

No. There is no charge to request that your information be kept confidential.

How do I request that my personal information be kept confidential?

Simply complete the form at the bottom of the page and return it to:

In person to: Agua Special Utility District
3120 North Abram Road
Mission, TX78572

By mail to: Agua Special Utility District
P.O. Box 4379
Mission, TX 78573

Your response is required to protect your personal information from disclosure. Your response is not necessary if you do not wish to keep your information confidential.

I request that my personal information, as provided by Texas Utility Code § 182.052, be kept confidential.

Name of Account Holder	Account Number
Address	Area Code/Telephone Number
City, State, Zip Code	Signature

Medical Information Authorization Form

Patient Information:
Patient Name: _____ Patient's Date of Birth: _____
Patient's Address: _____
_____

Federal law requires that your authorization include the following information on your rights under the Privacy Rule. Please read carefully.

- **You may revoke or withdraw this authorization at any time.**
- **Medical information shared by your health plan, your health care providers, and a health care clearinghouse is kept private. If you allow the release of your medical information to someone other than a health plan, health care provider, or health care clearinghouse, the Privacy Rule may no longer protect that medical information. This means there may be nothing to prevent the person you allow to get your personal medical information from giving your information to someone else without your permission.**
- **You may ask for a copy of this authorization.**
- **A photocopy of this authorization is as legal as the original.**

(1) Who do you authorize to release your personal medical information?
Name of Doctor of Health Care Provider: _____
Address of Doctor or Health Care Provider: _____
_____

(2) Who do you want to receive your personal medical information?
Please release or share my personal medical information relating to my permanent disability with ***Agua Special Utility District, 3120 N, Abram Road, Mission TX, 78572, or P.O. Box 4379, Mission, TX 78573, 956-585-2459; 956-585-1516 (FAX).*** Please accurately and completely complete the Agua Special Utility Statement of Certification and provide that document to me or to Agua Special Utility District.

(3) Why do you want your information release?
I am applying for the Lifeline Program of Agua Special Utility District. To be eligible for the program, I must demonstrate that I am permanently disabled. For purpose of the District's Lifeline Program, "Permanently disability" or "permanently disabled" is defined as having a physical or mental health condition that is expected to last for a continuous period of not less than 12 months or to result in death, and because of that medical condition, the patient is unable to perform a job or any job for which he or she is qualified based on his or her age, education and work experience.

(4) What information do you want released or shared?
My personal medical information relating to or evidencing my permanent disability.

(5) When do you want this authorization to end? You *must* give an end date or end event. The latest end date you can give is the end of the current calendar year.

☐ The end of the current calendar year (December 31st of the year you sign this form).

☐ Other (please specify if less than a calendar year): _____

(6) Your signature and date.

I approve the use and sharing of my health information as described in this authorization.

Patient's Signature _____ **Date** _____

If someone other than the patient signs this form, Section 7 *must* be completed.

(7) Personal Representative Information. If you are signing this form for the patient, you must tell us about your legal right to sign. For example, if the patient is less than 18 years old and you are his or her parent, write "Parent of the minor child," below. If you have a power of attorney that allows you to make medical decisions for the patient, write "Medical power of attorney."

_____

_____