VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER: Muslim American Social Services

Section 1

Does the client/patient have insurance that covers the health or dental condition? YES ____ NO ☑

Does anyone in the client/patient's family have an active FL Medicaid card? YES ____ NO ☑

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

Section 2

Family Size: Adults____ Under 18 ____ 18-21--Student ____ Unborn _____ Family Size TOTAL 0

FAMILY MEMBERS NAME (First and Last)	**DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TCA or SSI)
SELF			**$**	**$**
SPOUSE/PARTNER			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
		TOTALS	**$**	**$**
		Add earned and unearned income to determine total		**TOTAL INCOME $**_____

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1. **"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income). (1) $_____ (Above)

Step 2. Subtract $90 for EACH employed member of the family unit. (2) $_____ (Minus)

(2a) $_____ (Total)

Step 3. Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $_____ (Minus)

(3a) $_____ (Total)

Step 4. Subtract up to $50 per month of total child support received. (4) $_____ (Minus)

Step 5. **TOTAL NET INCOME** (5) $_____ (Total)

Section 4 **USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION**

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

_____ _____

SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE

PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE

(VALID FOR ONE YEAR) Expiration date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize **We Care Jacksonville, Inc.,** and its entities, its officers or agents to permit inspection, copying, and/or release of information compiled in the ordinary course of business in connection with the following:

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

_____ Social Security #: _____

I further understand and acknowledge that in complying with my request for release, such disclosure will require **We Care Jacksonville, Inc.,** to disclose, as provided under applicable federal law, Protected Health Information, as defined in 42. C.F.R. § 160 et seq.

Information to be disclosed:

- [x] Complete Health Record
- [ ] Discharge Summary
- [ ] History and Physical Exam
- [ ] Consultation Reports
- [ ] Progress Notes
- [ ] Radiology Reports
- [ ] Abstract/Pertinent Information
- [ ] Emergency Department Record
- [ ] Laboratory Tests
- [ ] Other (Please Specify) _____

I UNDERSTAND THIS MAY INCLUDE INFORMATION RELATING TO THE FOLLOWING UNLESS EXPRESSLY EXCLUDED BY CHECKING THE BOX(ES) BELOW:

- [ ] Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- [ ] Psychiatric Care (Behavioral Health)[1]
- [ ] Treatment for Alcohol and/or Drug Abuse[2]
- [ ] Genetic Testing
- [ ] Sexually Transmitted Diseases (STDs)

This information is to be disclosed to: _____

_____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked in writing, this authorization will expire 1 year from the date of execution. A photocopy or FAX of this document is valid as the original.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein:

Signature of Patient or Legal Representative: _____ Date: _____

Witness: _____ Date: _____

The patient information requested above may not be further disclosed to any party under any circumstances except with the patient's express written consent or as otherwise permitted by law. The information may not be used except for the need specified above.

[1] Except psychotherapy notes as provided under federal and state laws.

[2] **PROHIBITION OF REDISCLOSURE**: This information has been disclosed from records whose confidentiality is protected by federal and state law. Federal Regulations (42 CFR Part 2) prohibit the receiver of these records from making any further disclosure of this information except with the specific written consent of the person who it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Date: Name: Gender ☐ Male / Female ☐

Top 3 Reason / Main Concern for your visit today:

Have you been to a hospital in the past three months? Yes / No	Name:
Lab Preference: LabCorp 5610 W Lasalle St, Tampa, FL 33607	Verified: ___
Preferred Pharmacy:	Verified: ___

Height	Weight(lbs.)	BMI	Blood Pressure	RR	Temp. F	Heart Rate	SpO2	Date of Birth

Additional Notes:	Blood Glucose	HbA1c

Currently taking	Refill Required	Medication(s): strikethrough if stopped.

Intern: _____ Scribe: _____ Provider: _____ PHQ-9 ? Score QA: _____

VOLUNTEER HEALTH CARE PROVIDER PROGRAM
PATIENT REFERRAL FORM

Referral #

NOTICE TO PATIENT

You are being referred to a volunteer health care provider who will provide free care to you or someone for whom you are legally responsible. Depending on the determination of the volunteer health care provider, you may also receive services from pathologists, laboratories, radiologists, and anesthesiologists. Your participation in this referral process is voluntary. The care you receive from the volunteer health care professionals will be provided at no charge to you. However, you may be billed for pharmaceuticals. The health care providers are providing care on behalf of the State of Florida and each serves as an agent of the State. By acceptance of this referral, you acknowledge that the state solely is liable for any injury or damage suffered by you, or someone that you permit to receive treatment, that results from authorized treatment by the volunteer providers and that the State's liability is limited as found in section 768.28, Florida Statutes (copy provided)

I hereby certify that I have read the above notice and understand that I am being referred to a volunteer health care provider who will provide free care for me or someone for whom I am legally responsible. I further understand the volunteer health care provider may also refer me to pathologists, laboratories, radiologists, and anesthesiologists whose specialized services may be needed to treat my health condition. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and whomever she/he may designate as assistants). In addition, I certify that the information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge.

I also acknowledge I am responsible to inform the clinic of any change in my financial or health insurance status.

Signature: _____ Date: _____

If treatment is for a minor, indicate relationship to child

Patient's Name: Date of Birth:

Address: Sex: ☐ Male Female ☐

Race:

Phone: Ethnicity:

Eligibility: *(check one)* DOH client/patient ☑ 200% poverty or less Medicaid eligible *(no provider available)*

Referral Type: ☑ Medical Care Dental Care Other *(specify)*

Notes:

Shah Sayed

Print Name of DOH Referring Person

DOH Referring Person's Signature Date

Referred to: MASS Clinic

Address/Phone:

As needed, the above-named health care provider is referring this patient to the following health care providers who are under contract as outlined in section 766.1115, Florida Statutes, and are agents of the state:

Pathologist Laboratory Radiologist Anesthesiologist

Response to Referral Originator: Date of Initial Service Received _____

(actual services provided)

Estimated Value of Health Care Provided $

Volunteer Health Care Provider Signature Date

☑ In lieu of signature, see progress notes.

PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): Date of Birth:

Address:

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:
OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: **Muslim American Social Services (MASS) and its entities, its officers, its health care partner organizations, or agents located at 2251, St. Johns Bluff Rd. S, Jacksonville, FL 32246.**
Phone / Text : (904) 419-8006 Fax : (904) 830-4404 Email : info@massclinic.org

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

_____ _____
Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____
Print Name of Legal Representative (if applicable)
Check one to describe the relationship of Legal Representative to Patient (if applicable):
☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain :)
NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3. Information created before or after the date of this form.

"From Whom" includes: All information sources including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

CURRENT PATIENT INFORMATION and PATIENT NOTICE ACKNOWLEDGEMENT

Last Name: First Name

Address: Phone:

Patient email: Referred by: Muslim American Social Services

Gender ☐ Male ☐ Female Date of Birth Social Security No:

Language: Race Ethnicity

Muslim American Social Services (MASS) Clinic is a free medical clinic open part-time only and staffed almost entirely by volunteers. This creates some limitations to our services. We desire our patients to be fully aware of our limitations and to understand the responsibility they have for their care. PLEASE READ CAREFULLY.

- By signing this form, I recognize that as a patient of MASS clinic there is no medical care available from clinic staff except during regularly scheduled appointments. I will call 911 for emergencies and I will contact an Urgent Care center / Emergency room for problems that cannot wait until my next scheduled appointment and will notify MASS Clinic within three days of my discharge.
- Due to resource limitations, I understand it is my responsibility to follow up any recommendations that are made to me during this screening.
- MASS Clinic is NOT responsible for patient bills from outside the clinic, including, but not limited, to Emergency Room, Urgent Care and Hospital visits.
- I understand that I should schedule an appointment with MASS clinic three weeks before I need a prescription refills. Refills are provided only at provider discretion.
- I understand that only ONE CALL will be made with my first appointment date, with one automated reminders.
- I am aware that appointments that are NOT confirmed will be cancelled and waiting list patients will receive any appointment slot.
- I authorize the MASS Clinic, to transfer clinical information about me to other health care providers/agencies if needed to carry out my treatment/plan of care.
- I authorize Muslim American Social Service Clinic to obtain/have access to my medical history.
- I authorize my provider's office to contact me and leave the voice message on phone.
- I have read and understand the HIPAA/Privacy Policy / Patient Notice document for Muslim American Social Service Clinic

By signing below, I agree that in exchange for receiving uncompensated health care services, I waive my right to take legal action against any and all medical providers or ancillary personnel at this clinic or owner / tenant of the facility to otherwise seek a monetary recovery from the MASS Clinic and/or its employees and health care volunteers for any alleged professional acts of negligence, except for acts or omissions that are deemed to be grossly negligent or are considered willful and wanton, regardless of where such services are performed. I hereby acknowledge that I have been provided the opportunity to ask questions or request further information from the MASS Clinic regarding the above and I fully understand and accept the rights that I am forfeiting by accepting this provision.

Patient Signature _____ Date:_____

2251, St. Johns Bluff Rd. S, Jacksonville, FL 32246 Telephone: (904) 419 8006 Fax: (904) 830 4404 info@massclinic.org

VOLUNTEER HEALTH CARE PROVIDER PROGRAM
PATIENT REFERRAL FORM

Referral #

NOTICE TO PATIENT

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I hereby certify that I have read the above notice and understand that I am being referred to a volunteer health care provider who will provide free care for me or someone for whom I am legally responsible. I further understand the volunteer health care provider may also refer me to pathologists, laboratories, radiologists, and anesthesiologists whose specialized services may be needed to treat my health condition. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and whomever she/he may designate as assistants). In addition, I certify that the information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge.

I also acknowledge I am responsible to inform the clinic of any change in my financial or health insurance status.

Signature: _____ Date: _____

If treatment is for a minor, indicate relationship to child

Patient's Name: Date of Birth:

Address: Sex: ☐ Male Female ☐

Race:

Phone: Ethnicity:

Eligibility: *(check one)* DOH client/patient ☑ 200% poverty or less Medicaid eligible *(no provider available)*

Referral Type: ☑ Medical Care Dental Care Other *(specify)*

Notes:

Shah Sayed

_____

Print Name of DOH Referring Person

_____ _____ _____

DOH Referring Person's Signature Date

Referred to: MASS Clinic

Address/Phone:

As needed, the above-named health care provider is referring this patient to the following health care providers who are under contract as outlined in section 766.1115, Florida Statutes, and are agents of the state:

Pathologist Laboratory Radiologist Anesthesiologist

Response to Referral Originator: Date of Initial Service Received _____

(actual services provided)

Estimated Value of Health Care Provided $

_____ _____

Volunteer Health Care Provider Signature Date

☑ In lieu of signature, see progress notes.

DH 1032 (12/14), 64I-2.002(5), F.A.C. ORIGINAL-To Patient Medical Record COPY-To Patient at Time of Referral COPY-To Provider as Needed

MCS

Excerpt from Chapter 768.28, Florida Statutes

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(1) In accordance with s. 13, Art. X of the State Constitution, the state, for itself and for its agencies or subdivisions, hereby waives sovereign immunity for liability for torts, but only to the extent specified in this act. Actions at law against the state or any of its agencies or subdivisions to recover damages in tort for money damages against the state or its agencies or subdivisions for injury or loss of property, personal injury, or death caused by the negligent or wrongful act or omission of any employee of the agency or subdivision while acting within the scope of the employee's office or employment under circumstances in which the state or such agency or subdivision, if a private person, would be liable to the claimant, in accordance with the general laws of this state, may be prosecuted subject to the limitations specified in this act. Any such action may be brought in the county where the property in litigation is located or, if the affected agency or subdivision has an office in such county for the transaction of its customary business, where the cause of action accrued. However, any such action against a state university board of trustees shall be brought in the county in which that university's main campus is located or in the county in which the cause of action accrued if the university maintains therein a substantial presence for the transaction of its customary business.

(2) As used in this act, "state agencies or subdivisions" include the executive departments, the Legislature, the judicial branch (including public defenders), and the independent establishments of the state, including state university boards of trustees; counties and municipalities; and corporations primarily acting as instrumentalities or agencies of the state, counties, or municipalities, including the Florida Space Authority.

(3) Except for a municipality and the Florida Space Authority, the affected agency or subdivision may, at its discretion, request the assistance of the Department of Financial Services in the consideration, adjustment, and settlement of any claim under this act.

(4) Subject to the provisions of this section, any state agency or subdivision shall have the right to appeal any award, compromise, settlement, or determination to the court of appropriate jurisdiction.

(5) The state and its agencies and subdivisions shall be liable for tort claims in the same manner and to the same extent as a private individual under like circumstances, but liability shall not include punitive damages or interest for the period before judgment. Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000. However, a judgment or judgments may be claimed and rendered in excess of these amounts and may be settled and paid pursuant to this act up to $200,000 or $300,000, as the case may be; and that portion of the judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole only by further act of the Legislature. Notwithstanding the limited waiver of sovereign immunity provided herein, the state or an agency or subdivision thereof may agree, within the limits of insurance coverage provided, to settle a claim made or a judgment rendered against it without further action by the Legislature, but the state or agency or subdivision thereof shall not be deemed to have waived any defense of sovereign immunity or to have increased the limits of its liability as a result of its obtaining insurance coverage for tortious acts in excess of the $200,000 or $300,000 waiver provided above. The limitations of liability set forth in this subsection shall apply to the state and its agencies and subdivisions whether or not the state or its agencies or subdivisions possessed sovereign immunity before July 1, 1974.

(6)(a) An action may not be instituted on a claim against the state or one of its agencies or subdivisions unless the claimant presents the claim in writing to the appropriate agency, and also, except as to any claim against a municipality or the Florida Space Authority, presents such claim in writing to the Department of Financial Services, within 3 years after such claim accrues and the Department of Financial Services or the appropriate agency denies the claim in writing; except that, if:

1. Such claim is for contribution pursuant to s. 768.31, it must be so presented within 6 months after the judgment against the tortfeasor seeking contribution has become final by lapse of time for appeal or after appellate review or, if there is no such judgment, within 6 months after the tortfeasor seeking contribution has either discharged the common liability by payment or agreed, while the action is pending against her or him, to discharge the common liability; or

2. Such action is for wrongful death, the claimant must present the claim in writing to the Department of Financial Services within 2 years after the claim accrues.

(b) For purposes of this section, the requirements of notice to the agency and denial of the claim pursuant to paragraph (a) are conditions precedent to maintaining an action but shall not be deemed to be elements of the cause of action and shall not affect the date on which the cause of action accrues.

(c) The claimant shall also provide to the agency the claimant's date and place of birth and social security number if the claimant is an individual, or a federal identification number if the claimant is not an individual. The claimant shall also state the case style, tribunal, the nature and amount of all adjudicated penalties, fines, fees, victim restitution fund, and other judgments in excess of $200, whether imposed by a civil, criminal, or administrative tribunal, owed by the claimant to the state, its agency, officer or subdivision. If there exists no prior adjudicated unpaid claim in excess of $200, the claimant shall so state.

(d) For purposes of this section, complete, accurate, and timely compliance with the requirements of paragraph (c) shall occur prior to settlement payment, close of discovery or commencement of trial, whichever is sooner; provided the ability to plead setoff is not precluded by the delay. This setoff shall apply only against that part of the settlement or judgment payable to the claimant, minus claimant's reasonable attorney's fees and costs. Incomplete or inaccurate disclosure of unpaid adjudicated claims due the state, its agency, officer, or subdivision, may be excused by the court upon a showing by the preponderance of the evidence of the claimant's lack of knowledge of an adjudicated claim and reasonable inquiry by, or on behalf of, the claimant to obtain the information from public records. Unless the appropriate agency had actual notice of the information required to be disclosed by paragraph (c) in time to assert a setoff, an unexcused failure to disclose shall, upon hearing and order of court, cause the claimant to be liable for double the original undisclosed judgment and, upon further motion, the court shall enter judgment for the agency in that amount. Except as provided otherwise in this subsection, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 6 months after it is filed shall be deemed a final denial of the claim for purposes of this section. For purposes of this subsection, in medical malpractice actions and in wrongful death actions, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 90 days after it is filed shall be deemed a final denial of the claim. The statute of limitations for medical malpractice actions and wrongful death actions is tolled for the period of time taken by the Department of Financial Services or the appropriate agency to deny the claim. The provisions of this subsection do not apply to such claims as may be asserted by counterclaim pursuant to s. 768.14.

(7) In actions brought pursuant to this section, process shall be served upon the head of the agency concerned and also, except as to a defendant municipality or the Florida Space Authority, upon the Department of Financial Services; and the department or the agency concerned shall have 30 days within which to plead thereto.

(8) No attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement.

(9)(a) No officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. However, such officer, employee, or agent shall be considered an adverse witness in a tort action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. The exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state or any of its subdivisions or constitutional officers shall be by action against the governmental entity, or the head of such entity in her or his official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless such act or omission was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. The state or its subdivisions shall not be liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of her or his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee or agent" includes, but is not limited to, any health care provider when providing services pursuant to s.766.1115; any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, and its employees or agents, when providing patient services pursuant to paragraph (10)(f); and any public defender or her or his employee or agent, including among others, an assistant public defender and investigator.

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests. A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Patient Signature Date

WeCareJax Patient Guidelines

Patient Name _____

We Care Jacksonville, Inc. (WeCareJax) is a non-profit organization whose mission is to help connect patients with specialty health care physicians, medical providers, and services. WeCareJax serves patients referred from Duval County free or charitable clinics. To help ensure that your care and the care of all patients that are referred for service is provided promptly and accurately, we request that each patient agrees to the following operating guidelines:

Eligibility for Referral: there are four basic requirements to be eligible for support through WeCareJax. Each patient must:

- Be a permanent resident of Duval County
- Be uninsured and age 18+
- Be living at or below 300% of the federal poverty level
- Be referred by a primary care physician or provider, and be seen by their primary care provider at least once annually thereafter

Cost of Care: WeCareJax maintains a referral relationship with more than 500 specialty physicians and medical providers who agree to see WeCareJax patients at no cost. Unlike an insurance card, care is provided through the referral process only with the support of our care coordinators. Patients in need of care must have a referral from their primary care provider. Patients may not self-refer. If a patient self-refers, we have no ability to cover the out-of-pocket costs and the patient will be responsible for any charges.

Appointments: Once your primary care provider requests a specialty referral to WeCareJax, our care coordinators will review the referral paperwork. They may have additional questions to help ensure your referral can be processed accurately and promptly.

Once our staff has secured an appointment for you with a specialist or specialty service, you will receive notification from WeCareJax's automated system alerting you to the date and time. Please make arrangements to keep the appointment.

- Because our volunteer physicians and providers have limited availability, it is very important that you keep your appointment.
- If you are unable to keep an appointment, contact our office immediately to request rescheduling. Due to high demand, reschedule requests may be moved to lower priority at the discretion of the Patient Services Director.

Emergency Room Visits

WeCareJax is NOT able to guarantee payment for Emergency Room Visits. From time to time, we can negotiate with a hospital to support emergency care, but only on a case by case basis. If you believe a visit to the Emergency Room is an absolute necessity, please:

- Contact your primary care provider in advance.
- After you have been discharged from an emergency room visit, discharge paperwork and any applicable documents need to be brought to your primary care clinic within one week.
- If you receive a bill, it needs to be sent to your primary clinic right away.
- WeCareJax is not able to negotiate any bill that has already been sent to a collection's agency.

Communications:

- All paperwork sent to WeCareJax (faxes/scans) should be legible and readable to help ensure prompt service.
- WeCareJax staff members will at all times:
    1. Respect the confidential nature of your care.
    2. Communicate with you respectfully and promptly.
    3. Expect respectful communications in return.
    4. Have the right to escalate your case to a director should they feel that progress is impeded by disrespectful or abuse language, failure to provide required information, or other delay in securing your referral promptly due.

Availability: Due to the voluntary nature of the specialty care provided, WeCareJax is not always able to request a certain day or time for an appointment. However, we will make every effort to connect with you to care at the times that are best for you. Please check each time slot that would be easiest for you to make an appointment in the table below.

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
All Day	☐	☐	☐	☐	☐	☐	☐

Patient Bill of Rights and Responsibilities: WeCareJax and its referral partners follow the Patients' Bill of Rights And Responsibilities that is part of Florida law. A copy of those rights is provided as part of your enrollment packet for services to WeCareJax. Those rights include knowing what the rules and regulations for patient conduct may be in for each health care facility. By signing below, you agree to the guidelines set forth above.

Patient Signature _____ Date Signed _____