Magic City Enterprises Inc
Supporting individuals with disabilities to live successfully

Magic City Enterprises, Inc. Admissions Packet

1780 Westland Rd. Cheyenne, WY 82001

Phone: 307-637-8869 Fax: 307-638-0467

Website: www.mcewyo.org

"Supporting individuals with disabilities to live successfully."

Admissions into MCE, Inc. is a three step process. We are here to help you along the way.

1. Introduction: Explore our services and fill out an application, which you may turn into our admissions coordinator.

2. Acceptance: our interdisciplinary team reviews your application and additional material and makes a decision as to whether MCE would be able to serve you.

3. Enrollment: Welcome to our family. We may ask you to fill out additional forms in order to enroll you in the different departments at MCE.

Rev. 11/2/17

Thank you for your interest in Magic City Enterprises. If you have any questions throughout the application process, please call the Admissions Coordinator at 307-637-8869.

In order to process your application, please make sure to include the following:

- ☐ Copy of your Medicare, Medicaid, or other insurance cards
- ☐ Copy of your social security card
- ☐ Completed application with current demographic information
- ☐ All signed released included in the admissions packet
- ☐ Documentation of an intellectual disability from a doctor or psychologist
- ☐ Medical and psychological evaluation completed in the last 12 months
- ☐ Reports and program plans from referring agencies
- ☐ Completed housing application if applying for residential services
- ☐ Sponsorship by fee-paying agency or appropriate private source (such as the Medicaid Home and Community Based Waiver, Department of Vocational Rehabilitation, or School District.)

Please check the services you are applying for:

- ☐ Residential Habilitation
- ☐ Day Habilitation
- ☐ Supported Employment
- ☐ Supported Living

Signature: _____ Date:_____

Magic City Enterprises Inc
Supporting individuals with disabilities to live successfully

Magic City Enterprises Services

It is easy for you to find out about MCE services and how they can best support you in becoming the most independent individual possible. You can contact MCE and the Admissions Coordinator will assist you in receiving the appropriate paperwork, applications and funding information for your needs. You may also visit the MCE web page at *www.mcewyo.org*.

If you are a private paying individual, a fee schedule will be provided to you upon request.

The following criteria must be met for Admission into MCE programs:

- An intellectual, developmental disability or other disability which results in significant restriction in employment and/or independent living skills.
- Sponsorship by a fee-paying agency or appropriate private source
- Funding appropriate for the level of care needed to serve you
- Do not exhibit behaviors which may cause physical damage to yourself or others
- Psychological report within the last five years
- Results of physical evaluation within the past 12 months
- Current Plan of Care
- Reports and program plans from referring agencies
- A person should be able to benefit from MCE services
- Medical care does not require that invasive medical procedures be performed

If at any time you feel that the introduction, acceptance, or enrollment phase is problematic, please contact the Admissions Coordinator and MCE at 307-637-8869

Magic City Enterprises

Application for Services

Magic City Enterprises Inc
Supporting individuals with disabilities to live successfully

Personal Information

Social Security Number:_____

Last Name:_____ First Name:_____MI:_____

Date of Birth:_____ Sex: Male or Female

Address:_____

City: _____ Sate:_____ Zip:_____

Phone: Home:_____ Work:_____ Cell:_____

Legal

Status:_____

(Own guardian, limited guardianship, conservatorship) *need copy of court order

Who is the payee:_____

Ethnic Origin: _____

(White, Black, Native American, Hispanic, Asian American, Other)

Referred By: _____ Contact Name:_____

Educational Information

Place Attended:_____

Programs or grade last completed: _____

Disability Information

Primary: _____ Secondary: _____ Other: _____

(Please enter disability numbers)

1. Autism
2. Seizure Disorder
3. Mental Illness
4. Hearing Impairment
5. Intellectual Disability (mild)
6. Intellectual Disability (severe)
7. Specific Learn Disability
8. Speech Language Impairment
9. Head Injury
10. Orthopedically Impaired
11. Behavior Disorder
12. None
13. Cerebral Palsy
14. Personality Disorder
15. Visual Impairment
16. Diabetes
17. Intellectual Disability (moderate)
18. Intellectual Disability (profound)
19. Speech Language Disability
20. Spina Bifida
21. Organic Brain Syndrome
22. Arthritis
23. Other (specify)

Medical Information

Primary Physcian:_____

Address: _____

Medicaid #: _____ Medicare #: _____

Insurance Company and Policy #: _____

Adaptive Equipment: (Circle all that apply)

Walker Wheelchair Glasses Dentures Hearing Aid Eating Devices Cane
Communication Board Other:_____

Medications: _____

Emotional Problems/Physical Limitations/Allergies: _____

_____

Employment and Financial Information

Current Employer:_____ Position:_____

Past Employer: _____ Position: _____

Income Sources: _____

(Wages, SSI, Social Security, Railroad, Trusts, Other)

Contact

Name:_____

Address: _____

Phone: _____ Relationship: _____

Contact Type: (Circle One) E=emergency, P=primary, G=guardian, C=conservator, O=other

Name:_____

Address: _____

Phone: _____ Relationship: _____

Contact Type: (Circle One) E=emergency, P=primary, G=guardian, C=conservator, O=other

---

****Please Read Carefully and Sign****

I, _____, hereby request admission to the Magic City Enterprises: (circle applicable programs: Supported Employment, Supported Living, Day Habilitation, Residential Habilitation or Occupational Therapy). I agree to abide by MCE rules and regulations and to voluntarily participate in any program of rehabilitation training that best meets my needs and takes place in the least restrictive environment. I understand that this training will be determined by my Individual Plan of Care Team, of which I will be an active participant.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Greenview Apartments

EQUAL HOUSING OPPORTUNITY

Subsidized Housing Program for "people with disabilities"

EEOC Opportunities

Member Affordable Housing Management Association

The Department of Housing and Urban Development

Greenview Apartments
1780 Westland Rd.
Cheyenne, WY 82001
307-637-8869

Greenview apartments are exclusively for non-profit purposes and provides housing to people with developmental disabilities.

- *Accessible Housing Facilities*
- *Services designed to meet physical, social, and psychological needs*
- *Assists and promotes health, safety, and security*

To apply for services with the Wyoming Behavioral Health Division Contact:

Nancy Gordy
Admin and Property Manager
Magic City Enterprises
1780 Westland Rd.
Cheyenne, WY 82001
307-637-8869

State of Wyoming Relay TDD #771 or TTY 1-800-877-9965

In performance of a regulatory agreement with HUD, the Department of Housing and Urban Development

Cheyenne Haven, INC.

EQUAL HOUSING OPPORTUNITY

Subsidized Housing Program for "people with disabilities"

EEOC Opportunities

Member Affordable Housing Management Association

The Department of Housing and Urban Development

Cheyenne Haven, INC
1780 Westland Rd.
Cheyenne, WY 82001
307-637-8869

Greenview apartments are exclusively for non-profit purposes and provides housing to people with developmental disabilities.

- *Accessible Housing Facilities*
- *Services designed to meet physical, social, and psychological needs*
- *Assists and promotes health, safety, and security*

To apply for services with the Wyoming Behavioral Health Division Contact:

Nancy Gordy
Admin and Property Manager
Magic City Enterprises
1780 Westland Rd.
Cheyenne, WY 82001
307-637-8869

State of Wyoming Relay TDD #771 or TTY 1-800-877-9965

In performance of a regulatory agreement with HUD, the Department of Housing and Urban Development

Cheyenne Handicapped Services, INC.

EQUAL HOUSING OPPORTUNITY

Subsidized Housing Program for "people with disabilities"

EEOC Opportunities

Member Affordable Housing Management Association

The Department of Housing and Urban Development

Cheyenne Handicapped Services, INC

1780 Westland Rd.

Cheyenne, WY 82001

307-637-8869

Greenview apartments are exclusively for non-profit purposes and provides housing to people with developmental disabilities.

- *Accessible Housing Facilities*
- *Services designed to meet physical, social, and psychological needs*
- *Assists and promotes health, safety, and security*

To apply for services with the Wyoming Behavioral Health Division Contact:

Nancy Gordy
Admin and Property Manager
Magic City Enterprises
1780 Westland Rd.
Cheyenne, WY 82001
307-637-8869

State of Wyoming Relay TDD #771 or TTY 1-800-877-9965

In performance of a regulatory agreement with HUD, the Department of Housing and Urban Development

Housing Application

Check the box for the housing project that you're applying for:

- ☐ Magic City Enterprises, Inc. (any home other than the ones listed below)
- ☐ Cheyenne Handicapped Services, Inc. (HUD-Cleveland or Wills)
- ☐ Cheyenne H.A.V.E.N., Inc. (HUD-Ridge)
- ☐ Greenview Apartments (HUD-Central)

Please fill out the following information

Date: _____

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Have you ever lived in another state? Yes or No If yes: Where and When: _____

_____

Social Security #:_____ Place of Birth: _____ Date of Birth: _____

Is an accessible unit requested? Yes or No If yes: Specific needs of applicant: _____

_____

In case of an emergency, notify:

Name: _____ Relationship: _____

Telephone: _____ Address: _____

If you have a guardian, please list their name, address, and telephone: _____

_____

Will Magic City serve as payee for the client? Yes or No If no: Where should the bills be sent?

_____

_____

Magic City Enterprises Occupancy Standards

The following standards must be supplied to all applicants applying for HUD housing

Magic City Enterprises (agent for HUD Housing) provides HUD housing for single and double occupancy for the intellectually disabled and related conditions. We do not supply housing for families at this time. Magic City Enterprises also supplies non-HUD housing for single and double occupancy for the developmentally disabled and related conditions.

Information on housing options and availability for you will be provided by the Admissions Coordinator. Determination is dependent upon your choice of housing and your strengths and needs.

Note: if your application is accepted for Magic City Enterprises housing and/or services, you will be given a Services Policy Manual that explains in detail your responsibilities, Magic City's responsibilities, and the rules and procedures for living in Magic City's homes.

MOVE-IN MOVE-OUT Information

Moving In:

1. All forms must be completed as indicated by the Admin and Property Manager.
2. For HUD homes/apartments, all financial documentation must he turned into the Admin and Property Manager at least two weeks prior to the anticipated move-in date.
3. For HUD home and apartments, all leases and additional forms MUST be signed prior to moving in. If the tenant has a guardian, the guardian must sign all forms for HUD homes.
4. The check-in form should be filled out by the Admin and Property Manager and Maintenance (and parent or guardian if applicable) when moving in for the first time OR when moving to a different room, even in the same home.
5. Security deposits are due prior to moving in. The amount is one month's rent, which will vary for the HUD projects. If a tenant is moving from a MCE home to a HUD home (or vice versa), a new security deposit will be necessary and an adjustment will be made.

Moving out: (or moving to a different room/unit)

1. The check-out form is to be completed by the Admin and Property Manager and Maintenance (and tenant, parent or guardian if applicable). The form must be filled out entirely, including an indication of whether the tenant will be held responsible for the cost of any repairs.
2. If a tenant is moving from one unit to another, the same procedure is followed, plus a new move in packet must be done for the new unit.
3. The Admin and Property Manager will send a copy of the forms (and any charges) to the Business Services Director and Maintenance.
4. Any necessary cleaning and repairs should be done within one week of move-out. Admin and Property Manager and Maintenance will provide the Business Services Director with any repair cost that need to be billed to the client. This allows security deposits to be refined within thirty days as required. It also allows the unit to be rented to a new tenant as quickly as possible or vacancy finding to be collected for HUD units.
5. A thirty-day notice must be given for all move-outs. If it is not, the security deposit may be held in lieu of notice.

NOTE: HUD/WCDA units include the Cleveland, Wills, Ridge group homes, as well as the Greenview Apartments.

Employment

Employer/Company Name: _____

Employer Address: _____

Salary: Hourly/ Weekly/ Bi-Monthly/ Monthly

Wage Rate: $_____per _____ Position Held: _____

Assistance Received

Social Security $: _____ SSDI $: _____ SSI $: _____

Veterans Benefits $: _____ Private Pension $: _____ From: _____

Other $: _____ From: _____

Is the applicant currently seeking assistance? Yes or No

(please provide income verification)

Criminal Background

Have you ever been evicted from federally assisted house for drug related criminal activity?

Yes or No If yes: When/Where:_____

Are you currently engaging in illegal drug use? Yes or No

Are you subject to a lifetime registration requirement or are you currently registered under a state sex offender registration program? Yes or No

Have you ever unlawfully obtained government assistance? Yes or No

Assets

Name and address of bank: _____

Savings account #: _____ (copy of current statement) Approximate $: _____

Checking account #: _____ (copy of last 6 months statements) Approximate $: _____

Other assets $: _____(copy of certificate of deposits, trusts, money market funds, stocks etc..)
_____
_____

Medical Expenses:

_____
_____
_____
_____

After acceptance, additional paperwork will be required. This applies to all projects, except MCE.

****

This above application information, is true and complete to the best of my knowledge.

Applicant or Guardian Signature:_____Date:_____

****

I, _____, do hereby authorize Magic City Enterprises to contact any and all individuals, companies, and agencies to obtain any information and materials which is deemed necessary to meet eligibility standards to participate in the 202 project HUD section 8 program, HUD 811 project, Wyoming Community Development Agency or Magic City Enterprises Community Living Program.

Signed:_____ Date: _____

Signature of Hosting Agent: _____ Date: _____

Summary of Allowable Medical Expenses

These include all medical expenses anticipated to be paid in the twelve month period beginning Nov. 1 of this year and that will not be paid by an outside source. The best way for us to calculate this is to give us expenses (please send copies of bills, receipts, etc…) for the previous twelve months and we will estimate based on that, If you know of a major, upcoming medical expense, please give us information on that as well. Allowable medical expenses may serve to reduce the rent to be paid by the tenant

Examples of Allowable Expenses:

- services of recognized health care professionals
- services of health care facilities
- medical insurance premiums
- prescription and non-prescription medicines
- transportation to/from treatment
- dental treatment
- eyeglasses, contact lenses
- hearing aid, wheelchair, walker, artificial limbs
- attendant care or periodic medical care
- payments on accumulated medical bills

Summary of Most Common Assets/Income to Be Included

The following are the most common examples of assets and income that must be included and documented for recertification.

Assets:

- cash held in savings and checking accounts, safe deposit boxes, homes, etc.
  - savings accounts - *copy of statement showing current balance required*
  - checking accounts - *copies of statements for last six months required*
- revocable trusts
- equity in rental property or other capital investments
- stocks, bonds, treasury bills, certificates of deposit, money market accounts
- individual retirement and Keogh accounts
- retirement and pension funds
- lump sum receipts or one-time receipts
- cash value of life insurance policies- if available before death
- personal property held as investment
- real property

Income:

- interest, dividends, other income from assets
- gross wages and/or distributions from a business
- gross amount (before deductions for Medicare, etc.) of social security and/or SSI payments--send copy of most recent notification letter from Social Security Administration giving amount of the current year's payments
- full amount of other periodic receipts (e.g., annuity, retirement find, disability benefits)
- payment in lieu of earnings (including delayed payments)
- welfare assistance
- recurring monetary contributions or gifts regularly received from other persons
- distributions from trust funds

US Department of Housing and Urban Development Office of Housing

Race and Ethnic Data Reporting Form

Name at Property: _____ Project #: _____

Address of Property: _____

Name at Owner/Agent: _____ Type of Assistance/Program Title:_____

Name of Head of Household: _____ Name of Household Member: _____

Date: _____

Ethnic Categories Select One

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

Racial Categories Select All that Apply

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

There is no penalty for persons who do not complete the form.

Signature: _____ Date: _____

Magic City Enterprises Inc
Supporting individuals with disabilities to live successfully

Magic City Enterprises

Public Relations Release

I, _____, give my permission for Magic City Enterprises to use my name, picture or video of me for public relations purposes. This will include printing my name or picture in the following Magic City Enterprises publications (*initial each item to give permission for that usage*):

___ Annual Report ___ Brochures ___ Web site ___ Other PR materials___ Facebook
___ Twitter ___ Pinterest ___ YouTube

If, in the future, I change my mind about allowing Magic City Enterprises to print my name or picture for public relations, I can request that this release be turned over to me for destruction.

_____ _____
Date of release Participant signature
(Expires 5 years from date signed)

_____
Guardian signature

_____ _____
Witness title Witness signature

Magic City Enterprises
1780 Westland Road
Cheyenne, WY 82001
(307) 637-8869

Magic City Enterprises Inc
Supporting individuals with disabilities to live successfully

Magic City Enterprises Medical Release

(required by M.C.E.)

I hereby authorize personnel of Magic City Enterprises, as required by the state of Wyoming, to admit to a medical treatment facility and/or obtain emergency medical treatment for_____ participant of Magic City Enterprises, Inc., (MCE) in the event that any medical and/or psychiatric treatment is recommended by a licensed professional. I also authorize the release of information about medical/psychiatric diagnosis, treatment and discharge directives to MCE personnel. In the event that I am unreachable and medications for immediate treatment and/or health and safely are necessary, (ie: antibiotics), I give permission for MCE to fill these prescriptions until I am contacted and can consult about the treatment.

Release effective dates:

This authorization will be in effect for the duration of the Individual Plan of care dated:_____/_____/_____ through _____/_____/_____.

Signature of Participant: _____ Date: _____

Signature of Guardian: _____ Date: _____

Magic City Enterprises, Inc. - Notice of Privacy Practices Outline and Receipt

A federal regulation, known as the "HIPAA Privacy Rule requires that we provide detailed notice, in writing of our privacy practices. A hard copy of our Notice of Privacy Practice is available for you to review at your request. An outline of the topics covered in the MCE Notice of Privacy Practice is as follows:

1. Our commitment and obligation to protecting health information about you
2. How we may use and disclose protected health information about you
    - Uses and disclosures for treatment, payment, and health care operations
    - Other uses and disclosures we can make without written authorization for which you have the opportunity to agree or object.
    - You have the right to object to us disclosing protected health information about you to a family member, close friend, or any other person identified by you that is involved in your care or payment for your care.
    - Other uses and disclosures we can make without your written authorization or opportunity to agree or object.
    - Other uses and disclosures of protected health information require your authorization.
3. Your rights regarding protected health information about you
4. Complaints and questions

I acknowledge that I was provided with the MCE Notice of Privacy Practices.

Printed Name of Client: _____
Signature of Client: _____
Date: _____
Patient's Date of Birth: _____

For Guardian of Client (If Applicable)

Printed Name of Guardian: _____
Signature of Guardian: _____
Date: _____

Signature of MCE Witness: _____
Date: _____

Magic City Enterprises, Inc.

Participants Rights Pictorial Manual

Magic City Enterprises Inc

Supporting individuals with disabilities to live successfully

Know Your Rights

Know Your Rights

People with intellectual disabilities have the same basic human and legal rights of the United Sates as everyone else. MCE is dedicated to protecting your right and to providing a safe and healthy environment for you. It is important to know your rights.

<u>People with intellectual disabilities have the right to:</u>

Services and Supports:

- Training on how to be safe

- Freedom from restraint

- Choose your service providers and ISC

- Accept or refuses services and treatment

- Choose your own medical services

- Have Services Designed for your needs and desires

- Say “no thank” to being part of research or other treatment

- Know about your treatments and program, exam, test, and treatment results

- Apply for entitlements you have
- Receive services in the least restrictive environment

- The right to eat when and what they want and choose who they eat with and access to food at all times
- Request a preferred staff person and control their daily schedules

Education:

- Services developed just for you as long as they meet state and federal standards
- An education provided by qualified people

Own Property

- Keep and use personal possessions

- Have, choose, and wear your own clothing
- Keep and spend your own money

- Have visitors and talk to the people you choose at any time.

- Say “NO” to unnecessary drugs and abuse

- Choose where you live and who you live with

- Right to keep your records and information private
- Protection from state intrusion except to protect yourself and others

Due Process

- Police Protection

- To make complains without fear of being treated badly

- Vote in elections

- Go to the place of worship you like to

- the right to send and receive unopened mail

Freedom from Discrimination

You have the right to be free from discrimination because of race, age, national origin, sex, religion, disability, color, gender, familial status, genetic information, pregnancy or political affiliation.
You may have been denied the above rights only as a part of your individual plan of care (IPC.) You will be informed in writing and orally of the grounds for denial. The grounds of denial will be entered into the plan of care.

MAGIC CITY ENTERPRISES, INC.
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.

If you have any questions about this Notice please contact our Privacy Officer, Barbara Schutkowski-Fortish at (307-637-8869.)

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by contacting MCE and requesting that a revised copy be sent to you in the mail.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may disclose health information about you to doctors, nurses, psychologists, social workers, direct support staff and other agency staff, volunteers and other persons who are involved in providing health and rehabilitation services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of Magic City Enterprises, Inc.

Following are examples of the types of uses and disclosures of your protected health information that Magic City Enterprises, Inc. is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a physician's office that provides care to you. We will also disclose protected health information to other providers who may be also providing services to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition,

we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Service Operations: We may use and disclose health information about you for our own operations. These are necessary for us to operate Magic City Enterprises, Inc. and to maintain quality health for our participants. For example, we may use health information about you to review the services we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff and volunteers. We also may use the information to study ways to more efficiently manage our organization or for accreditation or licensing activities.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight

agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or

lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Magic City Enterprises, Inc. may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

1. **YOUR RIGHTS**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain

the protected health information. You may obtain your record that contains services provided, medical and billing records and any other records that Magic City Enterprises, Inc. uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, Barbara Schutkowski-Fortish if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Magic City Enterprises, Inc. is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with our Privacy Officer, Barbara Schutkowski-Fortish.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have Magic City Enterprises, Inc. amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer, Barbara Schutkowski-Fortish if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It

excludes disclosures we may have made to you if you authorized us to make the disclosure, for example to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

2. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer, Barbara Schutkowski-Fortish of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Barbara Schutkowski-Fortish at (307) 637-8869 ext 268 for further information about the complaint process.