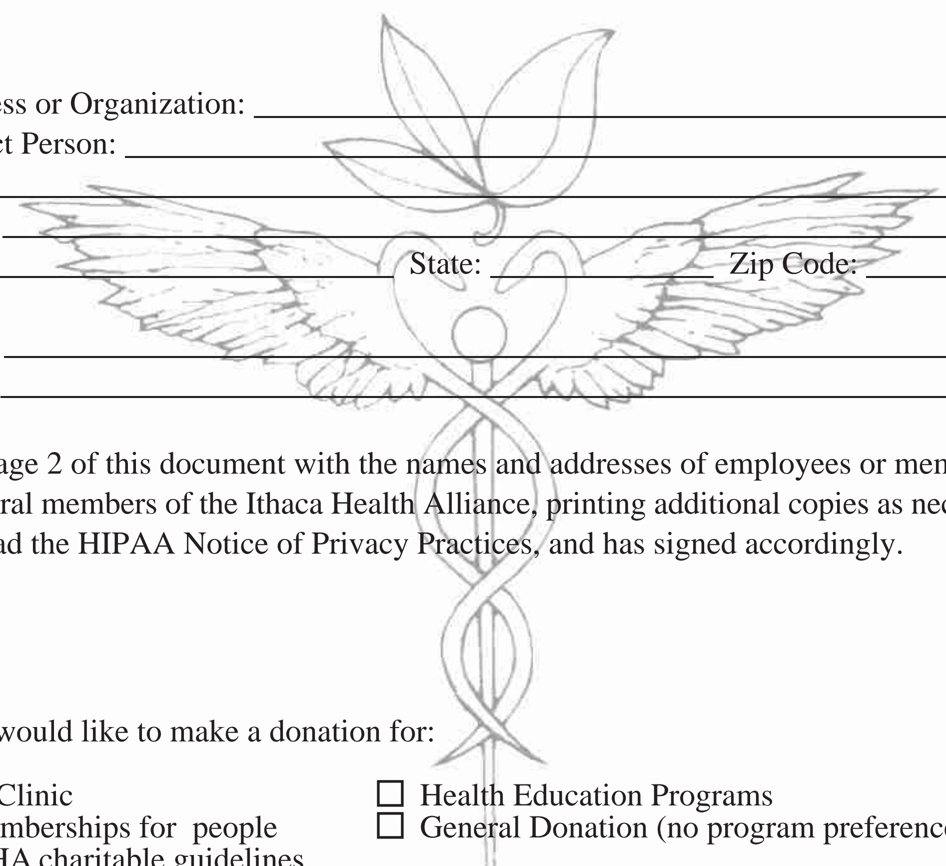
Ithaca Health Alliance

General Membership Application for Businesses and Organizations

Upon payment of an Ithaca Health Alliance membership donation, we hereby agree to all terms of Ithaca Health Alliance membership.

We understand that grants and loans made to members out of the Ithaca Health Fund are done in a discretionary manner by the IHA Board of Directors, in accordance with strict guidelines approved by the membership. We understand that to apply for a grant or loan we need to provide prompt documentation of health services received. We understand that terms of this agreement may be changed by the elected IHA Board of Directors. We have reviewed the HIPAA Statement below. We understand that the Ithaca Health Alliance does not operate under the supervision of the New York State Insurance Department. We hold Ithaca Health Alliance harmless for the effects of any treatment facilitated through its programs. We understand that Ithaca Health Alliance General Membership is available to residents of New York State only, and affirm that the NYS address provided below is our/my residence for a majority of the calendar year.



Name of Business or Organization: ______________________________
Name of Contact Person: ______________________________
Street Address: ______________________________
____
City: ______________ State: __________ Zip Code: __________

Phone Number: ______________________________
Email Address: ______________________________

Please fill out page 2 of this document with the names and addresses of employees or members to be enrolled as general members of the Ithaca Health Alliance, printing additional copies as necessary. Ensure that each has read the HIPAA Notice of Privacy Practices, and has signed accordingly.

(Optional) We would like to make a donation for:

- ☐ Ithaca Free Clinic
- ☐ Donated memberships for people who meet IHA charitable guidelines
- ☐ Health Education Programs
- ☐ General Donation (no program preference)

General Membership Donation Info - Businesses: $80/year per employee or member enrolled $75/year for a spouse/partner $50/year per child 50% payable in Ithaca HOURS for business memberships only		
	Employees / Members:	$
	Partners:	$
	Children:	$
	Other Donation	$
	Total enclosed:	$

Please print and sign this form, include a check payable to “Ithaca Health Alliance”, and any Ithaca HOURS.

Mail to: Ithaca Health Alliance, PO Box 362, Ithaca, NY 14851

http://www.ithacahealth.org office@ithacahealth.org (607) 330-1253

Employees or Organization Members to be enrolled as Ithaca Health Alliance General Members:

Last Name: ______________________ First Name: ______________________
Street Address: ______________________
City: ______________________ State: __________ Zip Code: __________
Phone Number: ______________________
Email Address: ______________________
Number in Household:__________ Annual household income:__________
Insurance Provider, if any: ______________________

Last Name: ______________________ First Name: ______________________
☐ Partner of employee/member ☐ Child of employee/member
Street Address: ______________________
City: ______________________ State: __________ Zip Code: __________
Phone Number: ______________________
Email Address: ______________________
Number in Household:__________ Annual household income:__________
Insurance Provider, if any: ______________________

Last Name: ______________________ First Name: ______________________
☐ Partner of employee/member ☐ Child of employee/member
Street Address: ______________________
City: ______________________ State: __________ Zip Code: __________
Phone Number: ______________________
Email Address: ______________________
Number in Household:__________ Annual household income:__________
Insurance Provider, if any: ______________________

Last Name: ______________________ First Name: ______________________
☐ Partner of employee/member ☐ Child of employee/member
Street Address: ______________________
City: ______________________ State: __________ Zip Code: __________
Phone Number: ______________________
Email Address: ______________________
Number in Household:__________ Annual household income:__________
Insurance Provider, if any: ______________________

Last Name: ______________________ First Name: ______________________
☐ Partner of employee/member ☐ Child of employee/member
Street Address: ______________________
City: ______________________ State: __________ Zip Code: __________
Phone Number: ______________________
Email Address: ______________________
Number in Household:__________ Annual household income:__________
Insurance Provider, if any: ______________________

HIPAA NOTICE OF PRIVACY PRACTICES

Please review this notice carefully. It is our HIPAA Notice of Privacy Practices, summarized for your convenience. A copy of the complete Privacy notice is available for your review upon request.

Summary of HIPAA Notice of Privacy Practices

A. Our Commitment to Your Privacy
Your Individually Identifiable Health Information, further known as "IIHI" is defined as all health information that identifies you. We are required by law to maintain confidentiality of this health information and to provide you with this notice of our legal duties and the privacy practices of Ithaca Health Alliance. We will provide this information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

B. Questions about this Notice to:
Privacy Officer, Ithaca Health Alliance, PO Box 362, Ithaca NY 14851
E-mail privacyofficer@ithacahealth.org

C. We may Use and Disclose your IIHI in the following ways:

1. Treatment
2. Payment
3. Health Care Operations
4. Appointment Reminders
5. Treatment Options
6. Health-Related Benefits and Services
7. Release of Information to Family/Caregivers
8. Disclosure Required by Law

D. Use and Disclosure of your IIHI in Certain Special Circumstances

1. Public Health Risks
2. Health Oversight Activities
3. Lawsuits and Similar Proceedings
4. Law Enforcement
5. Deceased Patients
6. Organ and Tissue Donation
7. Research
8. Serious Threats to Health or Safety
9. Military
10. National Security
11. Inmates
12. Workers' Compensation

E. Your Rights Regarding Your IIHI

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

Policy of the Ithaca Health Alliance:
The Ithaca Health Alliance Board of Directors formally opposes the automatic disclosure of Individually Identifiable Health Information without a member's notification, consent and advice of counsel. It is the intent of the Ithaca Health Alliance to Guard your privacy rights through this notification process if called upon to respond to the use and disclosure of your IIHI in special circumstances as stated in HIPAA law.

Effective date of this notice: 14 April, 2003