Saint Alphonsus Unique Families Program™

# GESTATIONAL CARRIER

## (with court validated Gestational Agreement)

FAMILY TO FAMILY
SUPPORT NETWORK®

Saint Alphonsus
A Member of Trinity Health

PATIENT LABEL

OB/GYN

# SAINT ALPHONSUS UNIQUE FAMILIES PROGRAM™

Thank you for choosing Saint Alphonsus Health System. We look forward to caring for you and your family! **Our Unique Families Program**™ mission is to provide exceptional care for patients and families that may need extra support and care during their stay here.

We have assembled this packet to provide an opportunity for much of the paperwork to be prepared and submitted in advance.

**Attached you will find:**

PHI RELEASE

- This form allows the hospital to release health information to listed parties.

BIRTH PLAN

- This form helps our team know your wishes. This plan is flexible and can be adjusted at any time during your stay.

FINANCIAL FORM.

- This form allows us to bill the correct entity for the infant care.

In addition to these forms, please ensure Saint Alphonsus has received a copy of the court validated Gestational Agreement as outlined by the Idaho Gestational Agreements Act (Title 7, Chapter 16 of the Idaho Code.

**Please print and scan in this packet, and then email to the following:**
SAHSUniqueFamilies@saintalphonsus.org

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# PHI RELEASE

## Request for Access to Health Information in a Designated Record Set SAHS-1317

**Name of Patient:** _____ **Date of Birth:** _____

**Patient's Address:** _____

**City, State, Zip**_____ **Phone:**_____

| **I am requesting records from:** | **Please deliver/direct the records requested below to:** |
|---|---|
| ❑ Saint Alphonsus Regional Medical Center (Boise)<br>❑ Saint Alphonsus Medical Center – Nampa<br>❑ Saint Alphonsus Medical Center – Ontario<br>❑ Saint Alphonsus Medical Center – Baker City<br>❑ Saint Alphonsus Medical Group _____<br>❑ South Nampa Neighborhood Hospital/Emerus | ❑ Patient/Myself (see address above)<br>❑ Other: Name: _____<br>Mailing Address: _____<br>_____<br>Phone:_____ Fax:_____ |

**I would like to receive my health information by the following method (choose one):**

❑ Paper Copy ❑ Electronic–CD ❑ Review Only (by appointment only)

❑ Electronic E-mail Link (personal e-mail address only) _____

*(E-mail from webmaster@mrocorp.com for Records; or noreply@ambrahealth.com for Radiology Images)*

**I am requesting the following information from my designated record set:**

| **TYPE/DATES OF SERVICE**<br>**Date Range:**<br>_____<br>_____<br>❑ Inpatient/Outpatient Procedure<br>❑ Emergency Room<br>❑ Outpatient Diagnostic Visit<br>❑ Clinic Office Notes<br>❑ Other (specify):<br>_____ | ❑ **Pertinent Record Set: (or only as specified):**<br>❑ Discharge Summary<br>❑ History and Physical<br>❑ ER Physician Report<br>❑ Consultations<br>❑ OP/Procedure Note<br>❑ Pathology Report<br>❑ All outpatient diagnostic tests<br>❑ _____ | ❑ **Outpt Diagnostic Test** (or only as specified)<br>❑ Laboratory<br>❑ X-rays/CT Scans/MRI<br>❑ Ultrasound<br>❑ EKG/Vascular Study<br>❑ Echocardiogram<br>❑ EEG<br>❑ Sleep Study<br>❑ Pulmonary Test<br>❑ _____ | ❑ **Complete Medical Record** (Fees may apply)<br>**Please Include:**<br>❑ Radiology Images<br>❑ CD<br>❑ E-mail (see above)<br>❑ Itemized Billing Records<br>**Other Instructions:** |
|---|---|---|---|

**Charges for Access**: We will not charge you for your first copy of your pertinent record set and/or outpatient diagnostic test results**.** If you ask us to copy your complete medical record, we may charge a reasonable fee as permitted by HIPAA Privacy regulations. Health Information Management utilizes a copy service, MRO, to complete most record requests. If MRO handles your request you will be invoiced directly by MRO. You may request to be notified of any charges for approval prior to having your records sent to you.

**Information About Your Access Rights:** Except under limited circumstances, we will provide you with the access your records. We will respond to your request within 3 business days from the time we receive this completed form. In certain situations we may deny your request but if we do, we will tell you in writing of the reasons for the denial and explain your rights to having the denial reviewed.

**I hereby request access to my health information as noted above maintained by Saint Alphonsus. I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.**

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Personal Representative (if not signed by the patient) | Authority to Act as Representative (Documentation required)

☐ Mailed ☐ Pick up ☐ ID verified: Release by:_____ Date:_____


FIN:_____ROI LOG ID:_____

Return Completed form to: Health Information Management Dept
Email: BO-HIM-ReleaseOfInfo@saintalphonsus.org

OB/GYN

# GESTATIONAL CARRIER PLAN OF CARE

**This plan will help our staff better understand your wishes, at this time, during your stay.**
(Can be subject to change per your wishes)

Birthing patient's name:

OB provider chosen:

Anticipated delivery due date: Phone:

- Would you like another person to be in the delivery room with you during birth? ☐ YES ☐ NO

  Who would you like this person to be?

  Relationship:

- If it is medically necessary for you to have a cesarean birth or delivery in the operating room, only one person can accompany you.

  Who would you like this person to be?

  Relationship:

  Agency involved (if applicable): Phone:

  Lawyer involved (if applicable): Phone:

**Are there any other plans you would like to have incorporated into your care, or is there any other information you would like the Labor and Delivery staff to be aware of?**

**Are any mementos desired?** ☐ **NO** ☐ **YES,**

Birthing patient's signature: Date: Time:

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# GESTATIONAL CARRIER FINANCIAL FORM

**Birthing patient's name:** _____

**Expected due date:** _____

**Please note that primary and secondary insurances may exclude surrogacy benefits; but are still required to be listed. If none, please indicate NONE.**

**PRIMARY INSURANCE PLAN NAME:** _____

Subscriber name: _____ DOB: _____

Policy/ID #: _____ Effective date: _____

Group name: _____ Group number: _____

**Does this plan include surrogacy coverage?** ☐ **NO** ☐ **YES**

**SECONDARY INSURANCE PLAN NAME:** _____

Subscriber name: _____ DOB: _____

Policy/ID #: _____ Effective date: _____

Group name: _____ Group number: _____

**Does this plan include surrogacy coverage?** ☐ **NO** ☐ **YES**

By signing below, I agree that all the information is correct to the best of my knowledge.

Name: _____ Date: _____

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# INTENDED PARENTS FINANCIAL FORM

**Birthing patient's name** (last, first, middle):

**Infant's legal name** (last, first, middle):

**INSURANCE INFORMATION**: How will the infant bills be paid for?

- ☐ INSURANCE PLAN (Enter plan information below)
- ☐ SELF PAY
- ☐ ESCROW: ACCOUNT # _____ CONTACT # _____
- ☐ AGENCY: _____ CONTACT PERSON: _____
- CONTACT # _____ ☐ OTHER _____

**GUARANTOR INFORMATION (person responsible for infant's bills):** _____

Name: DOB:

SSN: ☐ NA Sex:

Residence (temporary) address:

Mailing address: ☐ same as above

Home phone: Cell phone:

Email address:

**PRIMARY INSURANCE PLAN NAME:** _____

Subscriber name: DOB:

Policy/ID #: Effective date:

Group name: Group number:

**SECONDARY INSURANCE PLAN NAME:** _____

Subscriber name: DOB:

Policy/ID #: Effective date:

Group name: Group number:

**Will infant have Medicaid Insurance?** ☐ NO ☐ YES

By signing below, I agree that all the information is correct to the best of my knowledge.

Name: Date:

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# — Important Information —

Saint Alphonsus Health System, Inc. honors the sacredness and dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability, or sex.

**Saint Alphonsus Health System, Inc.:**

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic and other formats
- **Provides free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

**If you need these services, contact our Community Services Coordinator at 1-866-727-6248.**

If you believe that Saint Alphonsus Health System, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail, fax or email to:

- Patient Relations Coordinator, 1055 N Curtis Road, Boise, Idaho 83706
- Phone: 208-367-6226 I Fax: 208-367-8181
- Email: BO-PatientRelations@saintalphonsus.org

If you need help filing a grievance the Patient Relations Coordinator is available to help you.

You can also file a civil rights complaint with the US Department of Health & Human Services, Office of Civil Rights electronically via web, by mail or phone to:

- US Department of Health & Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building,Washington, DC 20201
- Web: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1-800-368-1019 I TTY 1-800-537-7697

## Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات الترجمة اللغوية تتوافر لك بالمجان.
اتصل بالرقم: 1-866-727-6248 ، (رقم هاتف الصم والبكم: 1-844-801-7932 )

## Burmese

သတိ။ ။ သင် [ဗမာစကား] ပြောရင် ဘာသာစကားအတွက် အကူအညီပေးတဲ့ဝန်ဆောင်မှု အခမဲ့ရနိုင်ပါတယ်။ 1-866-727-6248 TTY: 1-844-801-7932 ကို ဖုန်းဆက်ပါ။

## Chinese

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-866-727-6248 TTY：1-844-801-7932。

## Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-727-6248 تماس بگیرید. 1-844-801-7932 TTY: 2397-108-448-1.

## French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-727-6248 ATS : 1-844-801-7932.

## Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-727-6248 TTY: 1-844-801-7932 まで、お電話にてご連絡ください。

## Karen

ဟ်သူဉ်ဟ်သး: မ့မ့်နတဲတ်ပှၤကညီကျိာ်အကိးလီတဲစိနိဉ်ဂ်ါ် 8426-727-668-1 TTY: 2397-108-448-1. မၤစၢၤနါသ့ဒီးစ့တလိဉ်ဘဉ်မ့အကလီ.

## Kirundi

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-866-727-6248 TTY: 1-844-801-7932.

## Nepali

ध्यान दनुिहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस्
1-866-727-6248 टटिवाि: 1-844-801-7932 ।

## Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-727-6248 телетайп: 1-844-801-7932.

## Serbo-Croatian

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-727-6248 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-844-801-7932.

## Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-727-6248 TTY: 1-844-801-7932.

## Swahili

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-866-727-6248 TTY: 1-844-801-7932.

## Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں . کال 1-866-727-6248 کریں 1-844-801-7932

## Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-866-727-6248 TTY: 1-844-801-7932.

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