

Saint Alphonus Unique Families Program™

GESTATIONAL CARRIER

(with court validated Gestational Agreement)



FAMILY To FAMILY
- SUPPORT NETWORK -



Saint Alphonus

A Member of Trinity Health

PATIENT LABEL

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 birth of the baby.

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: <input type="checkbox"/> Saint Alphonsus Regional Medical Center (Boise) <input type="checkbox"/> Saint Alphonsus Medical Center – Nampa <input type="checkbox"/> Saint Alphonsus Medical Center – Ontario <input type="checkbox"/> Saint Alphonsus Medical Center – Baker City <input type="checkbox"/> Saint Alphonsus Medical Group _____ <input type="checkbox"/> South Nampa Neighborhood Hospital/Emerus	Please deliver/direct the records requested below to: <input type="checkbox"/> Patient/Myself (see address above) <input type="checkbox"/> Other: Name: _____ Mailing Address: _____ _____ Phone: _____ Fax: _____
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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 Date Range: _____ _____ <input type="checkbox"/> Inpatient/Outpatient Procedure <input type="checkbox"/> Emergency Room <input type="checkbox"/> Outpatient Diagnostic Visit <input type="checkbox"/> Clinic Office Notes <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Pertinent Record Set: (or only as specified): <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> ER Physician Report <input type="checkbox"/> Consultations <input type="checkbox"/> OP/Procedure Note <input type="checkbox"/> Pathology Report <input type="checkbox"/> All outpatient diagnostic tests <input type="checkbox"/> _____	<input type="checkbox"/> Outpt Diagnostic Test (or only as specified) <input type="checkbox"/> Laboratory <input type="checkbox"/> X-rays/CT Scans/MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> EKG/Vascular Study <input type="checkbox"/> Echocardiogram <input type="checkbox"/> EEG <input type="checkbox"/> Sleep Study <input type="checkbox"/> Pulmonary Test <input type="checkbox"/> _____	<input type="checkbox"/> Complete Medical Record (Fees may apply) Please Include: <input type="checkbox"/> Radiology Images <input type="checkbox"/> CD <input type="checkbox"/> E-mail (see above) <input type="checkbox"/> Itemized Billing Records Other Instructions:
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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

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:

Intended Parents Name(s):

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?

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: _____



— 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 | 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 | 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)

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोलुनुहुन्छ भने तपाईंको नमिती भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-866-727-6248 टेलिफाई: 1-844-801-7932 ।

Burmese

သတိ။ သင် [တမာစကား] ခြေရင် ဘာသာစကားအတွက် အကူအညီပေးတဲ့ဝန်ဆောင်မှု အခမဲ့ရရှိနိုင်ပါသည်။ 1-866-727-6248 TTY: 1-844-801-7932 ကို ဖုန်းဆက်ပါ။

Russian

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

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。

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.

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تنه‌ی خدمات زبان‌ی بصورت رایگان برای شماست. تماس بگیرد. 1-866-727-6248 فرام می باشد. 2397-108-448-1.

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.

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.

Swahili

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

Urdu

توجہ: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی ہمد کی خدمات ہمت میں دستیاب ہیں۔ کال 1-866-727-6248 کریں 1-844-801-7932

Karen

တံသ့တံသ့: မုမုနုတံတံပုကညီကိတိ:လီတံစိနီနီဂံ 8426-727-668-1 TTY: 2397-108-448-1. မၤစၢၤနီၤသ့ဒီးစုတလိၣ်တံတံမုဆကလီ.

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.

Kirundi

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

