

Saint Alphonbus Unique Families Program™

# INTENDED PARENTS



**FAMILY To FAMILY**  
- SUPPORT NETWORK -



**Saint Alphonbus**

A Member of Trinity Health

PATIENT LABEL

## SAINT ALPHONSUS UNIQUE FAMILIES PROGRAM™

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Thank you for choosing Saint Alphonius 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.

#### CARE 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 the event you have a gestational agreement that has been validated by an Idaho court under the Idaho Gestational Agreements Act (Title 7, Chapter 16 of the Idaho Code), you will need to provide Saint Alphonius a copy of the gestational agreement and the Idaho court's Order of Validation of the Gestational Agreement. If you would like Saint Alphonius to share your baby's PHI with anyone (e.g., Birth Patient or attorney), please also complete the PHI Release. After the baby's birth, please also provide Saint Alphonius a copy of the Idaho court's Order of Parentage within 14 days of the birth. The court's Order of Parentage can be emailed to Saint Alphonius at [bohshimdocuments@saintalphonius.org](mailto:bohshimdocuments@saintalphonius.org).

**Please print and scan in this packet, and then email to the following:**

[SAHSUniqueFamilies@saintalphonius.org](mailto:SAHSUniqueFamilies@saintalphonius.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:**

- Saint Alphonsus Regional Medical Center (Boise)
- Saint Alphonsus Medical Center – Nampa
- Saint Alphonsus Medical Center – Ontario
- Saint Alphonsus Medical Center – Baker City
- Saint Alphonsus Medical Group \_\_\_\_\_
- South Nampa Neighborhood Hospital/Emerus

**Please deliver/direct the records requested below to:**

- Patient/Myself (see address above)
- Other: Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
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](mailto:webmaster@mrocorp.com) for Records; or [noreply@ambrahealth.com](mailto:noreply@ambrahealth.com) for Radiology Images)

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

<p><b>TYPE/DATES OF SERVICE</b> <b>Date Range:</b> _____ _____</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Inpatient/Outpatient Procedure</li> <li><input type="checkbox"/> Emergency Room</li> <li><input type="checkbox"/> Outpatient Diagnostic Visit</li> <li><input type="checkbox"/> Clinic Office Notes</li> <li><input type="checkbox"/> Other (specify): _____</li> </ul>	<p><input type="checkbox"/> <b>Pertinent Record Set:</b> (or only as specified):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Discharge Summary</li> <li><input type="checkbox"/> History and Physical</li> <li><input type="checkbox"/> ER Physician Report</li> <li><input type="checkbox"/> Consultations</li> <li><input type="checkbox"/> OP/Procedure Note</li> <li><input type="checkbox"/> Pathology Report</li> <li><input type="checkbox"/> All outpatient diagnostic tests</li> <li><input type="checkbox"/> _____</li> </ul>	<p><input type="checkbox"/> <b>Outpt Diagnostic Test</b> (or only as specified)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Laboratory</li> <li><input type="checkbox"/> X-rays/CT Scans/MRI</li> <li><input type="checkbox"/> Ultrasound</li> <li><input type="checkbox"/> EKG/Vascular Study</li> <li><input type="checkbox"/> Echocardiogram</li> <li><input type="checkbox"/> EEG</li> <li><input type="checkbox"/> Sleep Study</li> <li><input type="checkbox"/> Pulmonary Test</li> <li><input type="checkbox"/> _____</li> </ul>	<p><input type="checkbox"/> <b>Complete Medical Record</b> (Fees may apply)</p> <p><b>Please Include:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Radiology Images <ul style="list-style-type: none"> <li><input type="checkbox"/> CD</li> <li><input type="checkbox"/> E-mail (see above)</li> </ul> </li> <li><input type="checkbox"/> Itemized Billing Records</li> </ul> <p><b>Other Instructions:</b></p>
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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](mailto:BO-HIM-ReleaseOfInfo@saintalphonsus.org)

# INTENDED PARENTS PLAN OF CARE

Intended Parents Name(s):

Infant's Name:

Gestational Carriers Name and DOB:

If you are able to be present for the delivery, will the infant be immediately placed in your arms?  YES  NO

If you are not able to be present, place the Infant:  In a warmer  Skin to skin with gestational carrier

The plan is for the infant to be in a separate room with the you.  YES  NO

Infant visitation between the intended parents and birthing patient has been arranged and agreed upon.  YES  NO

The birthing patient plans the following:  see infant  hold infant

Feeding plan:  breastfeeding done by:  pumping/hand expression  formula choice:

Do you plan to circumcise baby in the hospital?  YES  NO  NA  circ. to be done as outpatient at later time

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?

Intended parent signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Intended parent signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



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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: \_\_\_\_\_



# — 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 بگیرید 1-866-727-6248 فرام می باشد. 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.

**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: မုမုနုတံတံပုကညီကိတိကိ:လီတံစိနီနီဂံ 8426-727-668-1 TTY: 2397-108-448-1. မၤစၢၤနီၤသ့ဒီးစုတလိၣ်တၢ်တၢ်မုဆကလီၤ.

**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.

