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To our new patient,

Welcome to Homescripts™. Our team is here to help. We will ship your medicine to your home, and have pharmacists available to talk with you about your medicine.

Remember that talks with you, your doctor and Homescripts are important to your health. We will be sending medicine and supplies to you. Please call us at (888) 239-7690 if you run low before your next shipment, or if you have any other questions.

We are here for you!

Sincerely,
Your Homescripts Team

Homescripts.com
p: 888.239.7690
f: 877.396.5970

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Homescripts Vision, Mission and Core Values

CARING

Caring is the heart of everything we do. Caring motivates our work. We care about our teammates, our patients and our healthcare partners. Caring is the underpinning of our business philosophy, that doing the right thing leads to requisite rewards for everyone.

OUR VISION

Homescripts combines leading pharmacy expertise with a focus on results and caring service, which benefits plan sponsors, patients, and the greater community.

OUR MISSION

Homescripts transforms the pharmacy experience with innovative and flexible solutions, clinically driven programs and data analytics that lead to the best and most cost-effective outcomes for patients.

CORE VALUES

1. **Be driven by caring**
   Caring is at the heart of everything we do and doing the right thing rewards everyone.
2. **Live open, honest, accountable lives**
   We believe in transparency in who we are and how we serve our clients. Integrity and financial performance are inseparable.
3. **Exceed expectations; be passionate**
   We strive to exceed expectations every day. We combine a passion for improving lives with unrivaled expertise to drive results for all.
4. **Embrace creativity and dare to be different**
   We have an independent spirit which gives rise to creative clinical and business solutions, a competitive edge and a strong desire to make a difference.
5. **Be humble**
   Our humble disposition powers our service culture. We promise customized, one-to-one interaction from our team.
6. **Pursue excellence with urgency**
   We work with a sharp sense of urgency and believe our work has an important bearing on the patients we serve.
7. **Reinvent fun; smile**
   We are a diverse and friendly team with positive attitudes. We come to work excited and empowered to make a difference.
8. **Focus on the patient; all else will follow**
   Everything we do is built around the patient. This leads to a positive and measurable difference and ultimately drives the success of our company.
9. **Value the perspectives and differences in others**
   We are motivated by natural curiosity. We support the differences people bring to life because it makes us and our work stronger.
10. **Tackle all jobs big and small**
    We believe in teamwork. We take an all-hands-on-deck approach to everything we do.

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Emergency Management Plan

We are prepared to handle emergencies/natural disasters. In case of severe weather or other disaster, our pharmacies work to ensure you receive your prescription on time. Every effort is made to coordinate care with local healthcare agencies, when needed.

AcariaHealth's procedures for ensuring continuity of care in the event of a disaster include:

- We have plans for meeting your immediate needs, and/or discuss the date the service will be reinstated.
- In the event our pharmacy location is forced to close down as a result of an emergency, your services will be coordinated with an alternate AcariaHealth branch or subcontracted pharmacy.
- If we are unable to deliver your medication on time, we will contact you. We will work with you and your physician to locate the pharmacy closest to you and arrange to have it filled at that pharmacy.

If you have an immediate need for medication, we will supply your needs on a priority basis. We will provide you with enough supply to get through the emergency, whenever possible.

If an emergency occurs and we are unable to reach you, and you are experiencing difficulties administering or obtaining your medication, please go to the nearest emergency room for help. In order to make sure an emergency does not negatively impact your prescription needs, you should take the following precautionary measures:

- Whenever possible, keep a seven- to ten-day supply of your medication on hand and a back-up power supply for your medical equipment and/or supplies.
- Make sure we have accurate contact information, including your emergency contacts.
- In case of an emergency, seek medical attention at an area hospital or by calling 9-1-1.

Remember that preparation is key when facing emergencies – please be safe.

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SHARPS-tainer (stackables)
Instructions for Use and Disposal

Note: Post these instructions near the point of use.

CAUTIONS

1. Inspect sharps container before use for cracks or damage, then assemble lid according to Lid Assembly instructions.
2. Store container out of traffic areas in order to minimize possibility of container being knocked over.
3. DO NOT under any circumstances insert hand or object into sharps container.
4. DO NOT COMPACT CONTENTS OF CONTAINER OR FORCE SHARPS INTO CONTAINER. When contents have reached recommended fill line (approximately ¾ full), the container must be disposed of and replaced. DO NOT OVERFILL.
5. Follow Final Closing and Disposal instructions when container is full.

LID ASSEMBLY INSTRUCTIONS

1. Place lid onto the container before placing any sharps (used syringes/needles) into the container.
2. Make sure the lid is securely on the container by pressing firmly around edges of lid to ensure snap features are fully engaged on container. Listen for clicks. This is for your safety.
3. Now the sharps container is ready for use. Open lid and place sharps into receptacle opening.

FINAL CLOSING INSTRUCTIONS

Once fill level has been reached and sharps container is ready for final disposal:

1. Fold down the permanent locking tabs (if applicable) which are located at the front of the lid opening.
2. Close lid and engage the tabs into the slots provided. For the sliding door design, use the handle to slide the door past the locking posts.
3. Press firmly until a snap is heard for each tab, for all designs except the sliding door. Do not press on the middle of lid or door when closing.
4. Fold tab down and insert into slot, if container is equipped with round trap. Now the sharps container is ready for disposal.

DISPOSAL INSTRUCTIONS

1. Dispose of contaminated sharps containers in compliance with national, state and local regulations and in accordance with institutional policy. You must be in compliance will all regulations and policies.
2. Inspect prior to moving to ensure that no sharps are protruding from container.
3. Contact the local Environmental Protection Agency (EPA) in your area for guidance on waste disposal if container is equipped with round trap.

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How to Dispose of Medicines Properly

Medications are important for treating many conditions and diseases, however they may be harmful if taken by someone that does not need them. To avoid accidental exposure or intentional misuse of prescription and over-the-counter drugs it is important you dispose of them properly.

DON'T: Flush expired or unwanted medications down the toilet or drain unless the label specifically instructs you to do so.

DO: Return unwanted or expired medications to a drug take-back program or follow the steps for household disposal below.

HOW TO DISPOSE OF MEDICATIONS?

Drug Take-Back Events

The preferred way to dispose of unwanted medications is through a local take-back program. For more information call your city or county government's household trash and recycling service and ask if a drug take-back program is available in your community. Some counties hold household hazardous waste collection days, where prescription and over-the-counter drugs are accepted at a central location for proper disposal.

Household Disposal Steps*

If no disposal instructions are provided on the medication's label and no drug take-back program is available in your area, follow the recommended steps below to safely dispose of your medication:

1. Take your medications out of their original containers.
2. Mix drugs with an undesirable substance, such as dirt, cat litter or used coffee grounds.
3. Put the mixture into a disposable container with a lid, such as an empty margarine tub, or into a sealable bag.
4. Remove any personal information from the medication's original container, including Rx number, by covering it with permanent marker or duct tape, or by scratching it off.
5. The sealed container with the drug mixture, and the empty drug containers, can now be placed in the trash.

** Drug Disposal Guidelines, Office of National Drug Control Policy, October 2009*

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How Proper Disposal of Medicines Protects You and the Earth:

- Prevents poisoning of children and pets.
- Prevents misuse by teenagers and adults.
- Avoids health problems from accidentally taking the wrong medicine, too much of the same medicine, or a medicine that is too old to work well.
- Keeps medicines from entering streams and rivers when poured down the drain or flushed down the toilet.

How Improper Disposal of Medicines May End Up in Our Drinking Water Sources

In homes that use septic tanks, drugs flushed down the toilet can leach into the ground and seep into ground water.

In cities and towns where residences are connected to wastewater treatment plants, drugs poured down the sink or flushed down the toilet can pass through the treatment system and enter rivers and lakes. They may flow downstream to serve as sources for community drinking water supplies. Water treatment plants are generally not equipped to routinely remove medicines.

Information provided by the United States Environmental Protection Agency (EPA)
For more information go to www.epa.gov/ppcp/ or call the Safe Drinking Water Hotline at 800-426-4791
April 2011

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Notice of Privacy Practices

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES

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.**

This Notice of Privacy Practices ("Notice") covers an Affiliated Covered Entity ("ACE"). When this Notice refers to the AcariaHealth ACE, it is referring to AcariaHealth, Inc. ("AcariaHealth") and each of the following AcariaHealth subsidiaries and affiliates: Specialty Therapeutic Care, LP, AcariaHealth Pharmacy, Inc., AcariaHealth Pharmacy #11, Inc., AcariaHealth Pharmacy #12, Inc., AcariaHealth Pharmacy #13, Inc., AcariaHealth Pharmacy #14, Inc., and HomeScripts.com, LLC.

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR RESPONSIBILITY

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research

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Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	› You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. › We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	› You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. › We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	› You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. › We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	› You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. › If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a copy of this privacy notice	› You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly
Choose someone to act for you	› If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. › We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	› You can complain if you feel we have violated your rights by contacting us. › You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. › We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: An AcariaHealth Inc. pharmacist may discuss your prescription information with your doctor and/or the doctor's staff members to ensure proper treatment.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

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HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.
Help with public health and safety issues	We can share health information about you for certain situations such as: › Preventing disease › Helping with product recalls › Reporting adverse reactions to medications › Reporting suspected abuse, neglect, or domestic violence › Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: › For workers' compensation claims › For law enforcement purposes or with a law enforcement official › With health oversight agencies for activities authorized by law › For special government functions such as military, national security, and presidential protective services

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OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice
- We must provide you a copy of this notice
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

You may contact the Privacy Office at Privacy@AcariaHealth.com or by writing to:

AcariaHealth, Inc.
Attn: Privacy Officer
8427 Southpark Cir., Suite 400
Orlando, FL 32819

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Notice of Privacy Practices

ACARIAHEALTH ACE
NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the AcariaHealth, Inc. *Notice of Privacy Practices* and its affiliates and subsidiaries (collectively, the "AcariaHealth ACE"). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information.

I acknowledge receipt of the *Notice of Privacy Practices* of the AcariaHealth ACE.

Patient Name: _____

Signature: _____ Date: _____

Print Name: _____
(Patient / Parent or Legal Representative)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed by AcariaHealth only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of AcariaHealth Provider Representative: _____ Date: _____

Reasons why the acknowledgement was not obtained:

_____ Patient Refused to Sign

_____ Other or Comments: _____
(ex: Delivery to patient's home; patient was not able to sign.)

YOU MAY RETURN THIS ACKNOWLEDGEMENT TO

AcariaHealth, Inc.
Privacy Office
8427 Southpark Circle, Suite 400
Orlando, FL 32819

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HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The purpose of this HIPAA Authorization Form is to enable patients to authorize **AcariaHealth, Inc.,** to disclose their Protected Health Information (PHI) for certain purposes. Completing this form will allow AcariaHealth, Inc., to share your health information with the person or organization that you identify below. *You are not required to complete this form if you do not wish to make an Authorization.*

PATIENT INFORMATION		
Patient Name:		Date of Birth:
Address:		
Email address:	Phone:	Last 4 digits of SSN:

1. I authorize AcariaHealth, Inc., and any of its affiliated covered entities[1] to release my personal health information maintained by AcariaHealth to:

   _____

   [Insert full name of person or organization]

   _____

   [Purpose of use/disclosure]

2. Information to be disclosed *(check all that apply)*:
   - ❑ ALL pharmacy related records, OR
   - ❑ Pharmacy billing records
   - ❑ Prescription records
   - ❑ Progress notes
   - ❑ Other _____

   If applicable, I also give permission for the following to be disclosed **(please initial)**:

   _____ Pharmacy records related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

   _____ Pharmacy records related to treatment for alcohol and/or drug abuse

[1] *Affiliated covered entities include Specialty Therapeutic Care, LP, AcariaHealth Pharmacy, Inc., AcariaHealth Pharmacy #11, Inc., AcariaHealth Pharmacy #12, Inc., AcariaHealth Pharmacy #13, Inc., AcariaHealth Pharmacy #14, Inc., and HomeScripts.com, LLC.,*

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3. Covering the periods of health care: FROM (date): _____ TO (date): _____

4. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written request to **AcariaHealth, Inc., Attn: Privacy Officer, 8427 Southpark Circle, Suite 400, Orlando, FL 32819,** or **email to Privacy@AcariaHealth.com**. I understand that the request to revoke this Authorization will not apply to information already released in response to this authorization.

5. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. **If I fail to specify an expiration date, event or condition, THIS AUTHORIZATION WILL EXPIRE IN 12 MONTHS.**

6. I understand that this authorization is voluntary and treatment and/or payment for claims is not conditioned upon the signing of this form.

7. I understand that **AcariaHealth** cannot promise that the person or organization you want to share your health information with will not share it with someone else.

8. AcariaHealth, Inc., its affiliated covered entities, employees and officers are released from any legal responsibility or liability for disclosure of the above information to the extent indicated or authorized herein.

_____ _____

*(Signature of Patient, Parent, or *Legal Representative)* *(Date)*

_____

(Print Name)

*If signing on behalf of a patient please describe your authority and provide related documentation.

_____ _____

(Legal Representative Name and contact information) *(Relationship to patient)*

If you have questions about the use/disclosures of your health information contact the Privacy Officer at 855-422-2742 Ext. 8092904 or email: Privacy@AcariaHealth.com.

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f: 877.396.5970

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PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

You have the right to:

- Considerate and respectful service. Obtain service without regard to race, creed, national origin, gender, sexual preference, age, disability or illness, or religious affiliation.
- Speak with a health care professional.
- Confidentiality of all information pertaining to you, your medical care, and service and to have personal health information shared in accordance with state and federal law.
- A timely response to your request for service and to expect continuity of services.
- Select the home medical equipment supplier of your choice.
- Be privy to information on your treatment outcomes.
- Make informed decisions regarding your care planning.
- Participate in decisions concerning the nature and purpose of any technical procedure that will be performed and who will perform it, the possible alternatives and/or risks involved, your right to refuse all or part of the services, and to be informed of expected consequences of any such action based on the current body of knowledge.
- Agree to or refuse any part of the plan of service or plan of care.
- Be told what service will be provided in your home, how often, and by whom.
- An explanation of charges including policy for payment.
- Voice grievances or complaints regarding treatment of care without fear of termination of service or other reprisals.
- Be treated with respect, consideration, and recognition of client/patient dignity and individuality.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown sources, and misappropriation of client/patient property.
- Have your communication needs met.
- Receive information about the philosophy and characteristics of AcariaHealth's patient management (clinical) programs, including administrative information regarding changes in or termination of the clinical program.
- Identify the staff member of the clinical program and their job title, and to speak with a supervisor of the staff member, if requested.
- Be referred to other health care providers, if desired, within an external health care system (ex. Dietician, pain specialist, mental health services, etc.). You may also be referred back to your own prescriber for follow up.
- Receive assistance with any eligible internal programs that help with patient management services, manufacturer copay and patient assistance programs, and health plan programs (tobacco cessation programs, disease management, pain management, and suicide prevention/behavioral health programs).
- Decline participation, revoke consent, or disenroll from the clinical program at any point in time without jeopardizing access to care, treatment, or other services being provided.

Continued on the back.

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You have the responsibility to:

- Provide accurate and complete information to AcariaHealth regarding your medical history and current condition, any payers which may cover your care, financial information, and to promptly inform AcariaHealth of changes in this information.
- Provide AcariaHealth with a guardian decision-maker if you are unable to make decisions regarding care, treatment, or services, in accordance with state and federal law, if you desire.
- Participate in planning, evaluation, and revising your care plan to the degree that you are able to do so. Adhere to the plan of care, which you participated in developing. Ask questions about any part of the plan of care that you do not understand.
- Ask AcariaHealth what to expect regarding pain and pain management, discuss pain relief options with them, work with them to develop a
  pain management plan, ask for pain relief when pain begins, help the AcariaHealth personnel assess your pain, tell them if your pain is not relieved, and tell them about any worries you have about taking pain medications.
- Arrange for supplies, equipment, medications, and other services, which AcariaHealth cannot provide, that are necessary for provision of care and your safety.
- Protect the equipment from fire, water, theft, or other damage while it is in your possession.
- Use the equipment for the purpose for which it was prescribed, following instructions provided for use, handling care, safety, and cleaning.
- Supply us with needed insurance information necessary to obtain payment for services and assume responsibility for charges not covered. You are responsible for settlement in full of your account.
- Be at home for scheduled service visits or notify us in advance to make other arrangements.
- Notify us immediately of:
  - Equipment failure, damage, or need of supplies.
  - Any change in your prescription or physician.
  - Any change or loss in insurance coverage.
  - Any change of address or telephone number, whether permanent or temporary.
  - Discontinued equipment or services.
- Contact us if you acquire an infectious disease during the time we provide services.
- Accept the consequences for any refusal of treatment or choice of noncompliance, including changes in reimbursement eligibility.
- Submit any forms that are necessary to participate in the clinical program, to the extent required by law.
- Give accurate clinical and contact information and to notify the clinical program of changes in this information.
- Notify your treating provider of your participation in the clinical program, if applicable.

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PATIENT DRUG PROFILE

Please include prescriptions, over-the-counter medications, and supplements.

Patient Name: _____ Patient Phone: _____ Age:_____ Sex:_____

DOB:_____ Diagnosis:_____ Height: _____ Weight:_____

Medication Allergies *(please provide description of reaction)*

_____

_____

Start date	Medication Name	Strength	How often is the medication taken?	How much of the medication is taken at each dose?

Form completed by:_____ Relationship to patient: _____ Date: _____

Reviewed by RPh: _____ Date: _____

NP14_1016

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PATIENT COMPLAINTS & GRIEVANCES FORM

AcariaHealth strives to provide quality products and services that are consistent with our philosophy that caring is at the heart of everything we do. As stated in the Bill of Rights and Responsibilities, you have the right to expect quality customer care and pharmacy services. You also have the right to voice your service issues, grievances, or complaints about our services without fear of discrimination or disrespect.

If you have a complaint or concern about our services, we ask that you contact us immediately by completing this form, calling us at **888.239.7690** or by visiting our website at **AcariaHealth.com**. You may also report concerns about safety or quality of care directly to The Joint Commission (**800.994.6610),** URAC (**www.urac.org/complaint/),** or ACHC (**855.937.2242** or **www.achc.org/complaint-policy-process.html**).

Within 5 calendar days, AcariaHealth will acknowledge all complaints / grievances and advise that an investigation is underway. Within 14 calendar days, AcariaHealth will send the investigation results and response or resolution to you in writing.

Mail form to:
AcariaHealth, Inc.
6923 Lee Vista Blvd., Suite 300
Orlando, FL 32822

Thank you in advance for bringing your concern to our attention as it will assist us in our continuing effort to improve the quality of our services.

Patient's Name: _____DOB: _____

Description of the problem/concern/complaint (include dates, times and names, if possible):

_____

_____

Completed by (signature):_____ Date: _____

Relationship to patient (if applicable): _____

(FOR OFFICE USE ONLY)

Patient ID#:	Received By:
Date Received:	Date Submitted to Quality Department:
Date of Initial Patient Notification:	Issue Type:
Date of Resolution:	Resolution Completed By:

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Language Assistance / Nondiscrimination Notice

Nondiscrimination Notice

AcariaHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AcariaHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AcariaHealth:

- 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 (large print, audio, accessible electronic formats, 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, please call 1-800-511-5144, TTY: 711.

If you believe that AcariaHealth 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 with:

Civil Rights Coordinator

6923 Lee Vista Blvd., Suite 300

Orlando, FL 32822

Telephone Number: 1-800-511-5144, TTY: 711

Fax: 1-877-541-1503

You can file a grievance in person or by mail, or by fax. If you need help filing a grievance, AcariaHealth is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building, Washington, D.C. 20201

Telephone Number: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-511-5144 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-511-5144 (TTY: 711).

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 1-800-511-5144 (TTY：711）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-511-5144 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-511-5144 (TTY: 711)번으로 전화해 주십시오.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-511-5144 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-511-5144 (телетайп: 711).

Arabic
إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل ملحوظة: برقم 1-800-511-5144 (رقم هاتف الصم والبكم: 711).

French Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-511-5144 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-511-5144 (ATS : 711).

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-511-5144 (TTY: 711).

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-511-5144 (TTY: 711).

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-511-5144 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-511-5144 (TTY: 711).

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。1-800-511-5144（TTY:711）まで、お電話にてご連絡ください。

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-511-5144 (TTY: 711) تماس بگیرید.