Notice of Privacy Practices August, 2021

This notice describes how Protected Health Information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

This notice is provided on behalf of Tempus Unlimited, Inc. herein named the Agency.

PURPOSE: This notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out payment for Fiscal Intermediary program services, required by the contract entered into between the Massachusetts Executive Office of Health and Human Services and Tempus Unlimited, Inc. Protected Health Information is information that may identify the Consumer and that relates to the consumer's past, present or future physical or mental health, and may include name, address, phone numbers and other identifying information.

We are required by law to give you this notice and to maintain the privacy and security of your protected health information.

We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, may be obtained from the Agency website, www.tempusunlimited.org, and will be posted in our offices. You may also request a current copy by sending a written request to the Agency Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your Protected Health Information. We create a record of the care and services you receive at the Agency. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your protected health information.

If you believe your Privacy Rights have been violated, you may make a complaint to us or to the US Secretary of Health and Human Services at: http://www.hhs.gov/. To file a complaint with us, you may send a letter describing the violation to Tempus Unlimited, Inc. Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072. You also may email a complaint to Grievance@TempusUnlimited.org.

There will be no retaliation for filing a complaint.

WHO WILL FOLLOW THIS NOTICE: This notice describes the practices of Agency health care professionals, employees, volunteers and others who work in any of the Tempus Unlimited, Inc. Programs that you may participate in.

Your Privacy Rights:

You have the following rights relating to your Protected Health Information and may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of Agency created documents. Your request to obtain a copy of these documents must be in writing or in a format that allows us to verify the requestor as the Consumer or Guardian or other designated individual.
- Request that we amend your Protected Health Information (PHI), if you feel the information is incomplete or incorrect.
- Obtain a record of certain disclosures of Protected Health Information.
- We will obtain your written permission for uses and disclosures of your Protected Health information sent to you by alternative means or at alternative locations.
- We will obtain your permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing or in a format that allows us to verify the requestor as the Consumer or Guardian or other designated individual.

Our Responsibilities:

We are required by law, to maintain the privacy and security of your protected health information and to abide by the terms of this Notice. We will let you know promptly if an incident occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can. If you tell us we can, you may change your mind at any time. We will request that you submit that request in writing. We will offer an accommodation to document your request if needed.

Examples of Uses and Disclosures

We will use your Protected Health information to provide services.

- Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and is required by law.
- Communicable Disease: We may disclose your Protected Health information to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.
- Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law.
- As Required by Law: We must disclose your protected health Information when required by federal, state or local law.
- Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight Agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.
- Abuse or Neglect: we must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.
- Legal Proceedings: We may disclose your protected Health information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.
- Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.
- To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- For Specific Government Functions: In certain situations, we may disclose Protected Health Information of veterans. We may disclose your Protected Health Information for national security activities required by law.

Consent to the Use and Disclosure of Protected Health Information

I hereby give my consent for Tempus Unlimited, Inc. to use and disclose protected health information (PHI) on my behalf to enable billing and reimbursement for services provided by the Tempus Unlimited Fiscal Intermediary program. I understand that Tempus Unlimited, Inc. staff may have access to the following types of PHI and may use this information to either approve or deny timesheets and/or to submit billing for reimbursement or for other program billing and reimbursement. Types of PHI that we may share could be a MassHealth ID, other payer Insurance IDs, admit and discharge paperwork for inpatient stays, and information of your stay at a long term care facility. We only use this information to provide documentation to MassHealth and other payers for reimbursement for FI services. We also use this information to ensure that timesheets are not submitted fraudulently and that we are billing MassHealth for actual work done by PCA or worker that you have authorized. We also use this information for staff training and for conducting quality assurance, (monitoring the need, appropriateness, and quality of services provided).

I have been given a Notice of Privacy Practices that fully explains the uses and disclosures that Tempus Unlimited, Inc. will make with my protected health information (PHI). I understand and have been given the right to review the *Notice of Privacy Practices* before signing this consent. Tempus Unlimited, Inc. has given sufficient time for me to review the *Notice of Privacy Practices* and has answered any questions I may have had to my satisfaction.

I understand that I do not have to consent to the use or disclosure of my protected health information for payment, and health care operations, but that if I do not consent, Tempus Unlimited, Inc. may refuse to provide me Fiscal Intermediary services unless applicable state or federal law requires Tempus Unlimited, Inc. to provide such services. If Tempus Unlimited, Inc. does agree to my requested restrictions, it is bound by this agreement.

The following person(s) have my consent regarding my protected health information. **You have my permission** to release information to them or **I am adding the access** of the following persons:

Name_____Relationship_____

Name_____Relationship_____

I understand that I have the right to object to the use and/or disclosure of my protected health information to family members. **You do not have my permission** to release information to them or **I am revoking the access** of the following persons:

Name_____Relationship_____

Name_____Relationship_____

Password: I would like to have a password added to my account. Information will not be disclosed over the phone unless the following password is used:

Password_____Effective Date: _____

Permission to leave detailed voicemails on my home or cell phone voicemail:

☐ Yes, you have my permission ☐ No, you do not have my permission

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Tempus Unlimited, Inc. has already taken action based on my earlier consent. **This consent will be in effect, if not revoked, until one month after the termination date of your Program**.

_____	Consumer Name	_____
Signature of Consumer/Surrogate Legal or Personal Representative	**Printed Name**	**Date**

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) 0 1 – 2 3 4 5 6 7 8

2 Employer's or payer's name (not your trade name) Consumer Name

3 Trade name (if any)

4 Address Address

Number Street Suite or room number

City State Zip Code

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (*Check all that apply.*)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☑	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☑	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

✗ **Sign your name here**

Print your name here Consumer Name

Print your title here HCSR

Date

Best daytime phone (413) 214-5888

Now give this form to the agent to complete.

Part 3: **Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

6 Agent's employer identification number (EIN) 04-3770718

7 Agent's name (not trade name) Tempus Unlimited, Inc.

8 Trade name (if any)

9 Address 600 Technology Center Drive
Number Street Suite or room number

Stoughton | MA | 02072
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X **Sign your name here**

Print your name here

Print your title here Intake Coordinator

Date / /

Best daytime phone 1-877-479-7577