



## APPLICATION CHECKLIST

We have received your request for an application for clinic services. In order for us to schedule an appointment for you all the following is required for eligibility determination. Please use this checklist to make sure you have enclosed all the information requested.

Entire New Patient Application including:

\_\_\_\_\_ Patient Information Form – Please remember to complete and sign the front page, and read, initial, and sign the back page.

\_\_\_\_\_ Social Services Inventory Form - Complete all areas of the form, and sign at the bottom of the page.

\_\_\_\_\_ Informed Consent/Participant Rights Form - Read and sign the front and back of page.

\_\_\_\_\_ Authorization to Release Medical Information - Complete all applicable areas and sign at the bottom of the page.

\_\_\_\_\_ Proof of Residency - Please provide **one** of the following current documents indicating residency within our service area. Utility Bill (electric, telephone, water, or cable), Apartment Association lease agreement or rental verification form.

\_\_\_\_\_ Proof of Income- Please provide Federal income tax documents with W2 forms and **one** of the following current documents indicating household income. Last 4 paycheck stubs showing date, name, employer and gross earnings, Bank statements if living off of savings, SSI/SSDI award letter with the amount payable per month.

\_\_\_\_\_ Copy of Medicare card or Medicaid letter, if you do not qualify for Medicare or Medicaid, please obtain a Medicaid Denial Letter. In order to get a Medicaid denial letter you must apply with the Department of Human Services, if you're application is denied, please request that they send you a letter of denial. We must have a copy of this letter on file.

Your application is complete after the above information has been received. Your application will be screened if you meet the eligibility requirements an appointment will be scheduled for you. Please send the above information as soon as possible. If we do not receive the requested information within 30 days, your application will be deleted from our files. If you have questions or need more information regarding the requested information please call our office at (210) 653-5353 in the San Antonio area or outside of the San Antonio area please call toll free 1-888-606-5353.

Sincerely,

Stefanie Noska, CMA  
Patient Specialist



### THE FOLLOWING ITEMS ARE MANDATORY

The Epilepsy Foundation Central & South Texas clinic is sponsored in part by the Department of State Health Services (DSHS). In order to be eligible to receive services from the Epilepsy Foundation Central & South Texas (EFCST) you must meet Federal Poverty Income Guidelines as specified by DSHS as well as meet all additional agency requirements. DSHS requires all patients to provide all of the following documents in order to qualify for EFCST services and if applicable, the Medication Assistance Programs:

- **Proof of Income** (last three pay check stubs, or award letter, and current income tax return or W-2) IF paid in cash you must provide, a Notarized Letter confirming type and amount of monthly support.
- **Proof of Residency** (any current utility bill or bill statement, or rent receipt with current address)
- **Proof of Insurance** (private insurance card, Medicaid, Medicare, or CIDC card)
- **Denial of Benefits Letter** for Medicaid Benefits from the Medicaid office at 1-800-252-8263, you may also apply in person at your local food stamps office.

All items are mandatory and must be provided for verification. Failing to comply will result in inability to process application and request for services, subsequently active clinic patients failing to provide updated yearly information may also disqualify for services and be terminated and/or delay any clinic services provided by EFCST. **REMEMBER ALL PAPERWORK MUST BE IN OUR OFFICE BEFORE YOUR CLINIC APPOINTMENT.**

EFCST provides medical care and diagnostic services to **QUALIFIED, ELIGIBLE** patients that do not have insurance. However, there may co-pay for all services provided. Please come prepared to pay for your visit at your next appointment. Please contact clinic staff if you need to make PAYMENT arrangements. The following co-pays will be charged for services: **NEW PATIENT VISITS- \$40.00, FOLLOW UP VISITS- \$20.00, LAB/DIAGNOSTIC TESTS-FEES VARY**

Please do not waste appointment slots by missing your appointment. If you are not able to keep your appointment, please call the office at least 24 hours before your appointment date to cancel or reschedule your appointment. **MISSING THREE APPOINTMENTS WITHOUT NOTICE WILL RESULT IN SUSPENSION AND POSSIBLE DISCHARGE FROM CLINIC.**

Medication refill policy: A week before you finish your last dose, you must call your pharmacy to request a refill. After your pharmacy has faxed us a refill request the clinic staff will respond within 48-72 hours. EFCST clinic staff will not authorize same day refills. For individuals on the medication assistance programs we request that you contact the office when you are opening your last bottle of medication. Most medication assistance programs take 4 weeks to ship the next order. **RESPECTFULLY WE ASK THAT YOU COMPLY WITH THIS RULE, NO EXCEPTIONS WILL BE MADE!**



# EPILEPSY FOUNDATION

## CENTRAL & SOUTH TEXAS

10615 PERRIN BEITEL ROAD, SUITE 602  
SAN ANTONIO TEXAS 78217-3142

### PATIENT INFORMATION

**Patient's Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Nombre de Paciente) (Fecha De Nacimiento) (Seguro Social)

**Address:** \_\_\_\_\_ **City (Ciudad)** \_\_\_\_\_ **State (Estado)** \_\_\_\_\_ **Zip Code (Código Postal)** \_\_\_\_\_  
(Dirección)

**Telephone #:** (\_\_\_\_\_) \_\_\_\_\_ **Sex: F / M** \_\_\_\_\_ **E-mail/Correo Electrónico:** \_\_\_\_\_  
(Teléfono de casa) (Sexo)

**Work #:** (\_\_\_\_\_) \_\_\_\_\_ **County where you live?** \_\_\_\_\_ **Preferred Language? /Idioma? English/Spanish**  
(Teléfono del trabajo) (Condado donde vive?)

**Spouse/ Parent Name:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_  
(Esposo/ Padre) Numero alternativo

**Please provide name and phone number of an individual that we may contact should you not be available/Nombre de persona y numero de teléfono a quien pudiéramos dejarle un mensaje encaso que no este disponible:** \_\_\_\_\_

### PATIENT INSURANCE INFORMATION / INFORMACION DE SEGURO MEDICO

**Do you currently have insurance? /Tiene Seguro medico? Yes / No Si / No**  
Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_  
(Nombre de Seguro) (Numero de Póliza)

### PATIENT HEALTH INFORMATION (INFORMACION DE LA SALUD DEL PACIENTE)

**ALLERGIES:** \_\_\_\_\_  
(Tiene Alergias)

**First Medical Condition:** \_\_\_\_\_ **Second Medical Condition:** \_\_\_\_\_  
Condición Medico) (Otro Condición Medico)

**Primary Doctor:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
(Doctor) (Dirección)

**City (Ciudad)** \_\_\_\_\_ **State (Estado)** \_\_\_\_\_ **Zip Code (Código Postal)** \_\_\_\_\_ **Telephone (Telefono)** \_\_\_\_\_

**Primary Neurologist:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
(Neurólogo) (Dirección)

**City (Ciudad)** \_\_\_\_\_ **State (Estado)** \_\_\_\_\_ **Zip Code (Código Postal)** \_\_\_\_\_ **Telephone (Telefono)** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_  
(Medicamentos)

**Seizure diagnosed at age:** \_\_\_\_\_ **With fevers only? (Yes / No)** \_\_\_\_\_ **Seizure Family History? (Yes / No)** \_\_\_\_\_ **Have any Auras? (Yes / No)** \_\_\_\_\_  
Edad que fue diagnosticado su epilepsia? Con Fiebre? Historia en la familia con epilepsia? Si / No Tiene Auras?

**Seizure Frequency:** \_\_\_\_\_ **Seizure Average Duration:** \_\_\_\_\_  
Frecuencia de ataques? Cuanto duran los ataques?

**Please Describe Auras,** \_\_\_\_\_  
(Descripción de sus Auras)

**Seizure Description** \_\_\_\_\_  
(Descripción de sus ataques)

**NEW PATIENT ONLY! - WHO WERE YOU REFERRED BY? OR HOW DID YOU HEAR ABOUT US? (Por quien fue referido? O Como Oyó De Nuestros Servicios?)** Name of Individual or Agency \_\_\_\_\_

**ADDRESS/ Dirección** \_\_\_\_\_ **PHONE/ Telefono** \_\_\_\_\_

*PLEASE COMPLETE BACKSIDE OF APPLICATION!!!! Favor de leer y firmar el lado detrás de esta pagina, es muy importante!!!*

## INFORMED CONSENT

**Please read and initial on the following lines: (Por favor de leer estos párrafos y apuntar sus iniciales)**

1. \_\_\_\_\_ On the advice of my treating physician, I request the Epilepsy Foundation Central & South Texas provide diagnostic procedures and hospital care, including medical and surgical treatment as prescribed by my attending physician(s), their assistants and designees. I acknowledge that the practice of medicine and surgery is not an exact science and that no guarantees have been made as to the hospital care and medical treatment hereby authorized. / **Por consejo de mi Doctor, yo solicito que la Clinica de Epilepsia de South Texas proveer servicios diagnosticos y cuidado de hospitalizacion, incluyendo tratamiento medico y surigia recitado por el doctor que me cuida y sus asistentes. Yo reconozco que la ciencia medica y practica de surigia no es exacta y no hay garantias del cuidado y tratamiento medico que se autorizado por mi doctores.**

2. \_\_\_\_\_ I understand that the physicians on staff of this hospital, including the attending physician(s) are not employees or agents of the hospital, but rather are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. / **Yo entiendo que los doctores de este hospital y los que me atienden no son empleados o agentes de este hospital, pero son contratistas independientes que tienen privilegios de usar el hospital para el cuidado y tratamiento medico de sus pacientes.**

### RELEASE OF INFORMATION

3. \_\_\_\_\_ I hereby authorize the hospital and all physicians involved with my care to release information from my medical records, as may be required, to any person, corporation, or agency which is legally responsible or which the Epilepsy Foundation Central & South Texas has good cause to believe is legally responsible for processing, and/or paying all or part of the hospital's charges and/or professional fees, and, to any entity which has contracted with an insurer to conduct utilization review or performance reviews. / **Yo autorizo el hospital y todos los doctores envoltos en mi cuidado, de compartir informacion de mi archivos medico, como se requiere, a cualquier persona, agente, que es legalmente responsable o agentes responsables para procesar o pagar los cargos del hospital o honorarios profesionales o cualquier entidad que a contratado con una seguridad para revisar los archivos.**

### ASSIGNMENT OF BENEFITS

4. \_\_\_\_\_ I hereby assign to Epilepsy Foundation Central & South Texas and the physician's involved with my care all hospital and medical benefits to which may be entitled by virtue of insurance or public funding, including Medicare, Medicaid, or other coverage providing major medical insurance, surgical and medical benefits and authorize Epilepsy Foundation Central & South Texas and physicians to file claims for treatment provided on my behalf. / **Yo asigno la Clinica Epilepsia de South Texas, y todos los doctores envoltos en mi cuidado y tratamiento medico que reciban todo beneficios y honorarios por derecho de la seguridad o fondos publicos como Medicare, Medicaid o otro entidad proviendo seguridad medica y hospitalizacion, y yo autorizo la clinica Epilepsia de South Texas y sus doctores que solicitan beneficios por mi tratamiento.**

### GUARANTEE OF PAYMENT

5. \_\_\_\_\_ I further understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities. The guarantor of each account is ultimately responsible for payment in full of the account. If insurance does not pay on a timely manner, the insured will be expected to pay the balance and then pursue the matter with the insurance company. / **Yo entiendo que yo soy totalmente responsable de pagar todo honorarios y servicios proveidos para mi tratamiento medico, independiente de proteccion de seguridad o otros agentes responsables. (El fiador de cada cuenta es ultimamente responsable por pagar. Si la seguridad no paga, el fiador pagara el balance de la cuenta y resolvera su cuenta con la seguridad el mismo.)**

### REFILL POLICY

6. \_\_\_\_\_ I understand that the Epilepsy Foundation Central & South Texas does not give same day refills. As a patient, I must call the pharmacist at least a week before I finish my medication. The pharmacist must call and request a refill, requests from patients or relatives will not be taken from patients or their relatives. Refills will be authorized within 48-72 hours. No Exceptions! / **Yo entiendo que la Clinica de Epilepsia de South Texas no sortira medicamentos ese mismo dia. Como paciente, yo tengo que hablarle al farmacético por lo menos una semana antes que se me termine la medicina. El farmacético necesita llamar a la clinica de epilepsia y pedir que me surten la medicina, ni el paciente o sus familiares pueden sortir medicinas. Todo medicamentos seran sortidos dentro de 48-72 horas. No Habra Excepciones!**

\_\_\_\_\_  
Signature of patient or parent/guardian, if a minor  
Firma de paciente o padre, si es menor de edad

\_\_\_\_\_  
Date (Fecha)

\_\_\_\_\_  
Witness (Testigo)



# EPILEPSY FOUNDATION

CENTRAL & SOUTH TEXAS

10615 PERRIN BEITEL ROAD, SUITE 602  
SAN ANTONIO, TEXAS, 78217-3142

## SOCIAL SERVICES INVENTORY

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Race: \_\_\_\_\_ Education or Highest Grade Completed: \_\_\_\_\_ Marital Status: M / S

**Patient Income Information** Is patient employed? (Y/N) If yes, where? \_\_\_\_\_  
How long? \_\_\_\_\_ Full time/Part time? \_\_\_\_\_ Work Phone # \_\_\_\_\_ Fax#: \_\_\_\_\_

Do you have any of the following? (Please write the balance)  
Cash \$ \_\_\_\_\_ Savings \$ \_\_\_\_\_ Checking \$ \_\_\_\_\_ IRA \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

Do you own a car? Yes or No Approximate Value \$ \_\_\_\_\_

Average monthly medical expenses not covered by **insurance** or Medicaid/Medicare? \$ \_\_\_\_\_

**Household Income** (Please write the amount you receive, circle if weekly or monthly, indicate who, and provide copies of income.)

Wages \$ \_\_\_\_\_ weekly or monthly who? \_\_\_\_\_  
Unemployment \$ \_\_\_\_\_ weekly or monthly who? \_\_\_\_\_  
Social Security \$ \_\_\_\_\_ weekly or monthly who? \_\_\_\_\_  
SSDI \$ \_\_\_\_\_ weekly or monthly who? \_\_\_\_\_  
Child Support \$ \_\_\_\_\_ weekly or monthly who? \_\_\_\_\_  
TANF (AFDC) \$ \_\_\_\_\_ weekly or monthly who? \_\_\_\_\_  
Other Source of Income \_\_\_\_\_ \$ \_\_\_\_\_ weekly or monthly who? \_\_\_\_\_

**Household Members** Number of people in the household including the patient \_\_\_\_\_ Number of children 18 and under \_\_\_\_\_

Patient: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship \_\_\_\_\_

**Family Services:** Please answer the following questions:

Do you need employment services/ training? Yes or No if you said yes, what kind of job would you like to do? \_\_\_\_\_

Do you need daycare services? Yes or No Explain: \_\_\_\_\_

Do you need home provider services? Yes or No Explain: \_\_\_\_\_

Do you need medication assistance? Yes or No If yes, please Explain \_\_\_\_\_

Where do you get your medications? \_\_\_\_\_

Do you need any legal services/assistance? Yes or No If yes, explain: \_\_\_\_\_

Do you need any disability equipment/services? Yes or No If yes please: \_\_\_\_\_

**Community Services:** Do you need any other services like:

Utility Assistance: Yes or No Clothing: Yes or No  
Transportation: Yes or No Food: Yes or No Other Needs: \_\_\_\_\_  
Please Explain: \_\_\_\_\_

The above information is true and correct to the best of my knowledge: \_\_\_\_\_ (initial) Date: \_\_\_\_\_



### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_  
SSN \_\_\_\_\_  
DOB \_\_\_\_\_

Receive Records from:  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Release Records to:  
Name EFCST  
Address 10615 Perrin Beitel Ste. 602  
San Antonio, TX 78217

Please mail or fax copy (210) 653-5355 medical records as indicated below:

\_\_\_\_\_ All Records \_\_\_\_\_ Lab Reports \_\_\_\_\_ History/Physical \_\_\_\_\_ EEG/MRI  
\_\_\_\_\_ X-Ray Reports \_\_\_\_\_ Hospital Records \_\_\_\_\_ Other

Purpose for release of medical information \_\_\_\_\_

Signature of Patient, Parent, or Guardian

Witness

Date

Date

I understand that my expressed consent is required to release any health information relating to testing, diagnosis, and /or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases, and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Signature of Patient, Parent, or Guardian

Witness

Date

Date

Permission to fax records in the event of a medical emergency?  Yes  No

This authorization will be honored for one year from date of signature



# EPILEPSY FOUNDATION

CENTRAL & SOUTH TEXAS

10615 PERRIN BEITEL ROAD, SUITE 602  
SAN ANTONIO, TEXAS, 78217-3142

## CLIENT GRIEVANCE PROCEDURE EL PROCEDIMIENTO DE LA QUEJA DEL CLIENTE

It is the intent of the Epilepsy Foundation Central & South Texas (EFCST) Client Grievance Procedure to provide fair and equal consideration to all client complaints and grievances. Clients and/or guardians are encouraged to communicate complaints or grievances to the program staff as soon as they become known. Clients are encouraged to use face-to-face meetings to resolve issues dealing with individual program plan(s). The procedure for obtaining a resolution meeting is as follows **/Es la intención del Procedimiento del sur de la Queja de Cliente de Dispensario Fundación de Epilepsia de Tejas (EFCST) para proporcionar justamente y para igualar la consideración a todas quejas del cliente y quejas. Los clientes y/o los guardianes son alentados a comunicar las quejas o las quejas al personal del programa en cuanto ellos lleguen a ser sabe. Los clientes son alentados a usar las reuniones de la cara a cara para resolver los asuntos tratando con el plan (s) individual del programa. El procedimiento para obtener una resolución que reúne es como seguir:**

1. To obtain a resolution meeting, a client must file a grievance in writing to the Executive Director/**Para obtener una cita de resolución, un cliente debe de escribirle una queja ala directora ejecutiva. (Sindi J. Rosales, Executive Director) Epilepsy Foundation of Central and South Texas at 10615 Perrin Beitel, Suite 602 San Antonio, TX 78217**
2. An informal or formal (at the discretion of the Executive Director) resolution meeting to resolve the written grievance will be held during normal business hours as soon as practicable (and in most cases, at least within ten (10) working days of receipt of written grievance) with the client (and guardian, if appropriate), the Executive Director and, at the Executive Director's sole discretion, the employee in attendance. If the client fails to attend the resolution meeting, the grievance will be dismissed and become final with no written decision. **/Un junta formal o informal (a la discreción del Director Ejecutivo) de resolución sera formado para resolver la queja escrita se tendrá durante horas normales de negocio en cuanto practicable (y en la mayoría de los casos, por lo menos dentro de diez (10) días de trabajo del día que la queja escrita fue recibida) con el cliente (y el guardián, si apropiará), el Director Ejecutivo y, en el Director Ejecutivo's única discreción, el empleado en la asistencia. Si el cliente falla de estar presente a la cita de resolución, la queja se despedirá y llegará a ser final sin la decisión escrita**
3. A written response will be forwarded to the client and employee, from the Executive Director within three (3) working days of the resolution meeting(s). All the decisions of the Executive Director are final. **/ Una respuesta escrita será adelantada al cliente y el empleado, del Director Ejecutivo dentro de tres (3) jornada de trabajo de la resolución reuniendo (s). 'Todas las decisiones del Director Ejecutivo son finales.**
4. Those not satisfied may address grievance to/ **Esos no satisfecho pueden dirigir la queja a**

Department of State Health Services  
1100 W. 49<sup>th</sup> St.  
Austin, TX 78756-3199



## **STATEMENT OF COMPLIANCE/ LA DECLARACIÓN DE LA CONFORMIDAD**

**Services provided by Epilepsy Foundation Central & South Texas shall satisfy any obligations to comply with the Civil Rights Act of 1964, Title VI (Public Law 88-352); 45 Code of Federal Regulations Part 80 so that no person will and Section 504 of the Rehabilitation Act of 1973 (subparts A, D, and E of CRF part 32). Furthermore, services provided satisfy any obligations to comply with subparts B and C and appendix A of 29 CFR part 32, which pertain to employment practices and employment related training program accessibility and accommodations under section 504. / Atienden a proporcionado por la base satisfará cualquier obligación de conformarse con el Título VI (Public Law 88-352), el Acto Civil de Derechos de 1964 y la Sección 504 del Acto de Rehabilitación de 1973 (partes menor, A, D, y E de la parte de CRF 32). Además, atienden a proporcionado satisface cualquier obligación de conformarse con subparts B y C y el apéndice UN de 29 CFR despide 32, que pertenece a prácticas de empleo y empleo accessibility relacionado de programa de capacitación y alojamientos bajo la sección 504.**

**Services provided by Epilepsy Foundation Central & South Texas shall satisfy any obligations to comply with Executive Order 11246, Section 503 of the Rehabilitation Act, the Age Discrimination in Employment Act, and Title IX of the Education Amendments respective regulations. / Atienden a proporcionado por la Base satisfará cualquier obligación de conformarse con la Orden Ejecutiva 11246, la Sección 503 del Acto de Rehabilitación, la Discriminación de la Edad en el Acto del Empleo, y en el Título IX de las Enmiendas de la Educación las regulaciones respectivas.**

**Epilepsy Foundation Central & South Texas will also satisfy any obligations to comply with Title 8 of the Texas Human Resources Code, Article 5221K from the Texas Commission on Human Rights Act of 1983, Public Law 101-121 on lobbying, The Clean Air Act, The Clean Water Act, and all EPA regulations. / La base satisfará también cualquier obligación de conformarse con el Título 8 del Código de recurso humanos de Tejas, el Artículo 5221K de la Comisión de Tejas en el Acto Humano de Derechos de 1983, la Ley Pública 101-121 en el lobbying, en El Acto Aéreo Limpio, en El Acto Limpio de Agua, y en todas regulaciones de EPA.**

**Finally, services provided by Epilepsy Foundation Central & South Texas are in compliance with the Texas Health and Safety Code. Chpt.40; Title 25 Texas Administrative Code 37.211-37.222, Texas Family Code, 231.006, and all Texas HIV/AIDS in the Workplace Guidelines. / Finalmente, servicios de esta organizacion el están de acuerdo con Texas Health and Safety Code. Chpt.40; Title 25 Texas Administrative Code 37.211-37.222, Texas Family Code, 231.006, igual que con las leyes de Tejas que pertenecen al HIV/ y el SIDA en el area de trabajo.**



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CENTRAL & SOUTH TEXAS

10615 PERRIN BEITEL ROAD, SUITE 602  
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## CLIENT RIGHTS/ DERECHOS DEL CLIENTE

The Epilepsy Foundation Central & South Texas (EFCST) recognizes the human and civil rights of our clients, their families and other persons with disabilities in the community. These rights include those freedoms identified in the Constitution of the United States of America and the Constitution of the State of Texas, laws adopted by applicable legislative bodies of both the United States and Texas, as well as applicable judicial orders at all levels. **EFCST reconoce el humano y los derechos civiles de nuestros clientes, sus familias y otras personas con incapacidades en la comunidad. Estos derechos incluyen esas libertades identificadas en la Constitución de los estados unidos de América y la Constitución del Estado de Tejas, las leyes adoptivas por cuerpos legislativos aplicables de ambos los estados unidos y Tejas, las órdenes judiciales así como también aplicables en todo nivelan.**

- EFCST endeavors to treat all clients with dignity as evidenced by the attitudes displayed by staff members in the fulfillment of their responsibilities as well as in policies and procedures. **EFCST intenta en tratar a todos clientes con la dignidad como evidenciado por las actitudes demostradas por miembros de personal en el cumplimiento de sus responsabilidades así como también en políticas y procedimientos.**
- EFCST strives to protect its clientele from exploitation, neglect and abuse while on EFCST premises and while participating in EFCST sanctioned activities. All staff members are required to report all incidences of abuse to authorities, whether the abuse is physical, sexual or chemical. **EFCST se esfuerza para proteger su clientela de la explotación, el descuido y el abuso mientras en el local de EFCST y mientras tomando parte en actividades sancionadas por EFCST. Todos miembros del personal son requeridos a informar todas incidencias del abuso a autoridades, si el abuso es físico, sexual o químico.**
- EFCST encourages an individualized treatment and habilitation plan for its clients and encourages each client to participate in the planning and decision-making processes, which lead to the development of a program plan. EFCST policy is to review each client's treatment/program plan based on progress toward goals. **EFCST alenta un plan individualizado del tratamiento y habilitación para sus clientes y alenta a cada cliente a tomar parte en los procesos de la planificación y la toma de decisiones, que dirigen al desarrollo de un plan del programa. La norma de EFCST deberá revisar a cada cliente el plan de tratamiento de/el programa basado en el progreso hacia metas.**
- EFCST strives to place its clients in agency programs, which will be the least restrictive to the client. EFCST staff assists in locating and facilitating a client's placement in appropriate programs or settings when EFCST's own services might be too limited for a client's growth and success. In the event an applicant for EFCST services or an existing client is deemed ineligible for services provided by EFCST, a staff member will inform them of their ineligibility. Clients may voluntarily terminate their involvement in EFCST programs and/or services at anytime. **EFCST se esfuerza para colocar sus clientes en programas de agencia, que será el arrendamiento restrictivo al cliente. El personal de EFCST participa en localizar y facilitar a un cliente la colocación de s en programas o colocaciones apropiados cuando EFCST's posee que los servicios quizás sean demasiado limitados para un cliente el crecimiento de s y éxito. En el caso un solicitante para servicios de EFCST o un cliente existente es creído ineligibile para servicios proporcionados por EFCST, un miembro del personal los informará de su ineligibility. Los clientes pueden terminar voluntariamente su involucramiento en programas de EFCST y/o servicios en en cualquier momento.**
- EFCST clients may request a review of treatment or placement decisions with which they disagree utilizing EFCST grievance policies in effect at the time the disagreement arises. Clients are advised to review EFCST grievance policies and procedures, which are available from EFCST staff members. Unless EFCST has actual notice of the appointment of a guardian or personal representative, each client over the age of eighteen (18) years will be presumed to be able to make decisions for himself or herself and EFCST will look only to such client. A copy of a court order appointing a guardian or other personal representative shall be conclusive evidence of such appointment. Natural or court appointed guardians of the person of any minor client are entitled to be notified of all policies and procedures applicable under this client policy statement. **Los clientes de EFCST pueden solicitar una revisión de decisiones de tratamiento o colocación con que ellos no convienen las normas de la queja de EFCST que utilizan vigente en el tiempo que el desacuerdo surge. Los clientes son avisados a revisar las normas de la queja de EFCST y procedimientos, que están disponibles de miembros de personal de EFCST. A menos que EFCST tenga nota verdadera de la cita de un guardián o representante personal, cada cliente sobre la edad de diez y ocho (18) años será presumido de ser capaz de tomar decisiones para él mismo o para ella misma y EFCST mirarán sólo a tal cliente. Una copia de un designar de la orden del tribunal un guardián o a otro representante personal serán la evidencias conclusivos de tal cita. Natural o el tribunal guardianes designados de la persona de algún cliente secundario son permitidos para ser notificado de todas normas y procedimientos aplicables bajo esta declaración de la norma de cliente.**



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SAN ANTONIO, TEXAS, 78217-3142

## **EXTENT OF OUTPATIENT CLINIC SERVICES/ GRADO DE LOS SERVICIOS DE LA CLÍNICA**

**The Epilepsy Foundation Central & South Texas (EFCST) clinic is not intended to serve as a primary source of medical care therefore the following explanation on the extent of services is provided for your records/**

La clínica de EFCST no se piensa para servir como fuente primaria de la asistencia médica por lo tanto que la explicación siguiente en el grado de servicios se proporciona para sus expedientes

- 1. EFCST clinic physicians will provide outpatient services to clinic patients at designated facilities only, and do not serve as attending physicians in hospitalization situations.** / Los médicos de la clínica de EFCST proporcionarán servicios del paciente no internado a los pacientes de la clínica en las instalaciones señaladas solamente, y no sirven como atender a médicos en situaciones de la hospitalización
- 2. EFCST clinic physicians can advise ER doctors of ongoing acute seizures and medical management, in the ER. However, if admission is necessary the on-call hospital neurologist will be called.** / Los médicos de la clínica de EFCST pueden aconsejar a doctores asimientos agudos en curso y gerencia médica, en ER. Sin embargo, si la admisión es necesario en-llame a neurólogo del hospital será llamado
- 3. EFCST clinic patients can phone the clinic for questions and additional outpatient management./** Los pacientes de la clinica de EFCST para puede telefonar la clinica de EFCST las preguntas Y la gerencia adicional del paciente no internado.

## **SERVICE TERMINATION/ LA TERMINACIÓN DE SERVICIO**

**Occasionally, an individual may be dismissed from services, situations that would cause this to happen are:/**

De vez en cuando, un individuo puede ser despedido de los servicios, las situaciones que harían esto suceder son:

- 1. Patients who are taking illegal or non-prescribed drugs will be counseled on the effects of use and may be discharged.** / Aconsejarán en los efectos del uso y pueden ser descargados los pacientes que son el tomar ilegal o las drogas no-prescritas
- 2. Patients noncompliant with treatment & medication regime and/or suspected use of non-prescribed medication will be counseled on effects and may be discharged./** pacientes noncompliantes con régimen de la medicamento y/o el uso sospechado de la medicación no-prescrita será aconsejado en efectos y puede ser descargado de servicios
- 3. Danger to self or others/** peligro de ser un dano a uno mismo u otros
- 4. Relocating out of our service area /**cambio de hogar de area de servicio
- 5. Physician has the right to discharge a patient if patient is determined inappropriate for medical services (i.e. pseudo seizures, etc.)/** el doctor tiene el derecha de descargar a un paciente si el paciente es inadecuado determinado para los servicios médicos (es decir pseudo asimientos, etc.)

**In the event that a person is terminated from services, the individual has a right to appeal this decision as specified by Department of State Health Services (DSHS) guidelines and observed by EFCST Program Rules. If a client is terminated from services EFCST staff will make every attempt to refer the individual to service providers and/or programs that may be better able to meet their needs.** / A en caso que terminen a una persona de servicios, el personal de EFCST hará cada esfuerzo de referir al individuo a otros abastecedores de servicio y/o los programas que pueden poder mejor resolver sus necesidades.



# EPILEPSY FOUNDATION

CENTRAL & SOUTH TEXAS

10615 PERRIN BEITEL ROAD, SUITE 602  
SAN ANTONIO, TEXAS, 78217-3142

## INFORMED CONSENT/PARTICIPANT RIGHTS FORM EI CONSENTIMIENTO INFORMADO y los DERECHOS de PARTICIPANTE

I \_\_\_\_\_ have been fully oriented to the Epilepsy Foundation Central & South Texas clinic program and have been provided information on the following/**Yo he sido orientado completamente al programa del Dispensario de STEC y se ha proporcionado información en lo Siguiente:**

- The Participant Bill of Rights and Statement of Compliance/**La Cuenta del Participante de Derechos y Declaración de la Conformidad**
- The Participant Grievance procedure/**El procedimiento de la Queja del Participante**
- The Program Rules and Service Termination Procedure/**Las órdenes del Programa y Procedimiento de la Terminación de Servicios**
- The Limits of confidentiality/**Los Límites de confidencialidad**

Orientation by: \_\_\_\_\_ Correspondence: \_\_\_\_\_ In Person: \_\_\_\_\_

I understand and have received an explanation and a copy of the Rules and Responsibilities relating to the **Epilepsy Foundation Central & South Texas** participant rights, and grievance procedures and after being fully informed of all of the above, voluntarily consent to intervention./ **Entiendo y he recibido una explicación y una copia de las Ordenes y Responsabilidades que relacionan a la CLINICA de FOUNDACION DE EPILEPSIA DEL SUR de TEJAS/los derechos de participantes de el clinica, y los procedimientos de la queja y después de siendo tal informado completamente de todo el arriba, voluntariamente consentimiento a la intervención.**

Participant Signature: \_\_\_\_\_  
**Firma de Participante**

\_\_\_\_\_  
**Date/ Fecha**

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



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## LIMITS OF CONFIDENTIALITY/LOS LÍMITES DE LA CONFIDENCIALIDAD

The contents of a counseling, intake, or assessment session are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian and without a signed release of information. Noted exceptions are as follows: / **El contenido de un aconsejar, la cita inicial, o la sesión de la evaluación son considerados confidenciales. Ambas información verbal y los registros escritos acerca de un cliente no se pueden compartir con otro partido sin el consentimiento escrito del cliente ni el clientes guardián legal y sin una liberación firmada de información. Las excepciones notadas son como seguin:**

**Duty to warn and protect-** When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities, In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client./ **Cuando un cliente revela las intenciones o un plan para dañar a otra persona, el profesional del cuidado de la salud es reembolsado por advertir la víctima destinada e informar esta información a autoridades legales, en caso de que en que el cliente revele o implique un plan para el suicidio, el profesional del cuidado de la salud es requerido a notificar las autoridades legales y hacer las tentativas razonables para notificar la familia del cliente.**

**Abuse of Children and Vulnerable Adults-** If a client stated or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. Professional misconduct by a health care professional must be reported by other health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns. / **El abuso de Niños y Adultos Vulnerables- Si un cliente expresó o sugiere que él o ella abusan a un niño (o el adulto vulnerable) o han abusado recientemente a un niño (o el adulto vulnerable), o un niño (o el adulto vulnerable) está en peligro del abuso, el profesional del cuidado de la salud es reembolsado por informar esta información al servicio social apropiado y/o autoridades legales. La mala conducta profesional por un profesional del cuidado de la salud debe ser informada por otro profesional del cuidado de la salud. En caso de que en que un profesional o la reunión disciplinaria legal se tengan considerando el profesional del cuidado de la salud las acciones de s, los registros relacionados se pueden liberar para justificar disciplinario concierne.**

**Court Orders/ Órdenes de Corte -** Health care professionals are required to release records of clients when a court order has been placed./**El profesional del cuidado de la Salud es requerido a liberar los registros de clientes cuando una orden del tribunal se ha colocado.**

**Minors/Guardianship/ Los menores/Padres de tutela -** Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. **Padres o guardianes legales de clientes secundarios no emancipados tienen el derecho de conseguir acceso a al cliente' los registros des**

I agree to the above limits of confidentiality and understand their meanings and ramifications. / **Conuerdo al encima de límites de confidencialidad y entiendo sus significados y las ramificaciones**

Client's Name (please print): \_\_\_\_\_  
El nombre de el cliente'

Client's or guardian's Signature: \_\_\_\_\_ Date/ la Fecha: \_\_\_\_\_  
El clientes (o el guardianas) Firma

## NOTICE OF BENEFIT DENIAL:

## AVISO DE NEGACION DE BENEFICIOS:

Case/App No.:  
Date: 12/15/03

Worker:  
Phone:  
Fax:  
Toll Free Number:

MEDICAL ASSISTANCE

ASISTENCIA MÉDICA

# Sample - Medicaid Denial

Work today for a better tomorrow!

¡Trabaja ahora y le irá mejor mañana!

On the basis of information received by this office and the policy found in SECTION(S) A900 of the Texas Works Handbook, the following action is being taken: (All DHS offices have the Texas Works Handbook available for you to read.)

Debido a la información recibida en esta oficina y según las reglas de la SECCIÓN(ES) A900 del Texas Works Handbook, se está iniciando la siguiente acción: (Todas las oficinas tienen el Texas Works Handbook disponible para que lo lea.)

Your application for current Medicaid has been denied.

Su solicitud de Medicaid para beneficios corrientes fue negada.

**REASON:**

You no longer have children in your home who are eligible for assistance.

**RAZÓN:**

Usted ya no tiene niños en su casa que califican para asistencia.

Your family may still be eligible for Medicaid, even if you cannot get TANF, you are making more money, or other things have changed. Contact your local office for information.

Es posible que su familia sea elegible para Medicaid, aunque no reciba TANF, gane más dinero o, haya habido otro cambio. Para más información, comuníquese con su oficina local.

If there is a pregnant woman in the household she may be potentially eligible for another Medicaid program.

Si hay una mujer en su casa que esta embarazada, ella puede ser elegible para Medicaid.

DENIED MEDICAID RECIPIENTS: The Texas Department of Health will send you a Certificate of Coverage. You can use this Certificate to prove how long you had Medicaid coverage if you

CLIENTE A QUIÉN LE HAN NEGADO MEDICAID: El Departamento de Salud de Texas le enviará un Certificado de Cobertura. Puede usar este Certificado como prueba cuánto tiempo recibió Medicaid si se

— Sample —