



## Epilepsy Society of Southern New York Capabilities Partnership Inc.

450 West Nyack Road, Suite 9  
West Nyack, New York 10994

845.627.0627 or 800.640.0371  
845.627.0629 fax

[www.mycapabilities.org](http://www.mycapabilities.org)

### Family Empowerment Fund

#### **Instructions:**

1. Complete the following application. **Incomplete applications will not be processed.**
2. Attach a copy of the bill or estimate, if applicable
3. Complete the attached DDP-1 form, sections 3-6 & 11-18
4. Sign the last page (page 6) of the Notice of Privacy Practices
5. Include documentation of the applicant's disability
6. Submit to ESSNY & CPI by mail or fax

### **Our Policy\***

#### **Purpose:**

The Epilepsy Society of Southern New York (ESSNY) & Capabilities Partnership, Inc. (CPI) have been awarded special monies to assist families in the lower Hudson Valley region who are in need of temporary financial help. This money is not to be used to meet ongoing financial obligations, but to help families who are in need of emergency funds to recover from a unique financial hardship.

#### **Eligibility:**

The individual for whom the request is made must have a developmental disability. Documentation of the disability must be submitted with the application. Examples of such documentation may be: an IEP, an ISP, a medical report, a psychological report, etc. If the nature of the request warrants immediate action and such documentation is not readily available payment will be made with the promise that such documentation will be received within 7 business days.

#### **Nature of Request:**

It is our policy to reserve and prioritize the monies for emergency situations. Emergency situations may include, but are not limited to, assistance purchasing medications; assistance to prevent eviction; utility bill payments; purchasing food, baby formula etc. Please note, however, that ESSNY & CPI do consider additional requests and will do our best to meet each individual's need based on the monies in the fund.

#### **Application Process:**

In order to be considered for this fund, you must first complete the attached application and include copies of any bills that payment is requested for. In addition you must complete a DDPI form and include documentation that demonstrates the applicant has a developmental disability.

#### **Payment Policy:**

If your request has been approved, ESSNY & CPI will pay the bill directly. Please be aware that it is not our usual procedure to submit payment to an individual. For example: If the request is for medication, payment will be made directly to the pharmacy. Therefore in order to process payments accurately we require copies of bills, pharmacy numbers etc.

\* The Epilepsy Society of Southern NY & Capabilities Partnership Inc. reserve the right to change this policy without notice  
Document Date: 9-30-13

# Family Empowerment Fund Application

## **\*Applicant's Information:**

Consumer's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Names (if child): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Seizures:  Yes  No Seizure Type & Frequency: \_\_\_\_\_

Physician and/or Neurologist: \_\_\_\_\_

Medications: \_\_\_\_\_

Medicaid:  Yes  No Number: \_\_\_\_\_

Medicare:  Yes  No Number: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

Does applicant have a Service Coordinator?  Yes  No TABS ID# \_\_\_\_\_

Name & Agency of Service Coordinator: \_\_\_\_\_

## **\*Monthly Income/Savings:** (If applicant is a child, list families' information)

Annual Income \_\_\_\_\_

Monthly Income \_\_\_\_\_

Employed (who): \_\_\_\_\_ Unemployed (who): \_\_\_\_\_

Savings account?  Yes  No If so how much: \_\_\_\_\_



**\*Nature of Request:**

\_\_\_\_\_

Amount Requested: \$ \_\_\_\_\_

Please make check payable to: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Explain the reason for the request and why it is an urgent or emergency situation (Please attach additional sheets if necessary)

\_\_\_\_\_

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Is this the first time applying to ESSNY & CPI's Family Empowerment Fund?  Yes  No

- 1) Please complete the attached DDP-1 form, sections 3-6 & 11-18.
- 2) Please submit documentation that the individual has a disability (IEP or ISP or medical report, etc.)
- 3) Sign and submit the HIPAA Notice of Privacy Practices Acknowledgement Form

Completed by: \_\_\_\_\_

Print Name Relationship

Signature: \_\_\_\_\_

**Internal Use Only**

Approval: \_\_\_\_\_ Amount Approved: \_\_\_\_\_



# Putting People First

## DEVELOPMENTAL DISABILITIES PROFILE REGISTRATION / MOVEMENT FORM

Fill out items 1 through 7, and 18 including "completed by" and "phone number" on every DDP-1. Complete other items as required.

1	PURPOSE: <input type="checkbox"/> 1 Demographic Data Change <input type="checkbox"/> 2 Add <input type="checkbox"/> 3 Moved Out of State <input type="checkbox"/> 4 Remove <input type="checkbox"/> 5 Died <input type="checkbox"/> 6 Transferred within agency		
2	TABS ID: (if known)		
3	PERSON'S NAME	LAST	FIRST MI
4	SEX: <input type="checkbox"/> 1 MALE <input type="checkbox"/> 2 FEMALE	5	DATE OF BIRTH: MO DAY YR
6	COUNTY OF RESIDENCE:		
7	AGENCY NAME:		PROGRAM NAME:
8	REMOVE PROGRAM CODE:		9 ADD PROGRAM CODE:
10	REMOVE / ADD DATE:	MO DAY YR	
11	RESIDENTIAL ADDRESS: (please print)	%	
	NAME		
	STREET		
	CITY	STATE	ZIP
12	INDIVIDUAL'S RESIDENCE TYPE: (mark only one)		
	<input type="checkbox"/> 1 Alone	<input type="checkbox"/> 4 Department of Social Services Residence or Foster Care Home	<input type="checkbox"/> 7 OPWDD / Agency Operated Residence
	<input type="checkbox"/> 2 With Friends / Housemates	<input type="checkbox"/> 5 Nursing Facility	<input type="checkbox"/> 8 Other (specify)
	<input type="checkbox"/> 3 With Member of His / Her Own Family	<input type="checkbox"/> 6 Homeless or Shelter	
13	SOCIAL SECURITY NUMBER:	14	PERSON'S MEDICAID NUMBER (CIN):
15	ETHNICITY / RACE:		
	<input type="checkbox"/> 1 White	<input type="checkbox"/> 3 Hispanic	<input type="checkbox"/> 5 American Indian / Alaskan
	<input type="checkbox"/> 2 Black	<input type="checkbox"/> 4 Asian or Pacific Islander	<input type="checkbox"/> 6 Other
16	DISABILITIES: Indicate "1" for Primary (mark only one) and "2" for All Other Disabilities: (mark as many as apply)		
	<input type="checkbox"/> 1 Developmental Delay	<input type="checkbox"/> 8 Psychiatric Disability	<input type="checkbox"/> 15 Fetal Alcohol Syndrome
	<input type="checkbox"/> 2 Mental Retardation	<input type="checkbox"/> 9 Chronic Physical / Medical Condition	<input type="checkbox"/> 16 Narcolepsy
	<input type="checkbox"/> 3 Autism	<input type="checkbox"/> 10 Sensory Impairment	<input type="checkbox"/> 17 Neurofibromatosis
	<input type="checkbox"/> 4 Cerebral Palsy	<input type="checkbox"/> 11 Undetermined	<input type="checkbox"/> 18 (Code Not Valid at this Time)
	<input type="checkbox"/> 5 Epilepsy / Seizure Disorder	<input type="checkbox"/> 12 Other (specify)	<input type="checkbox"/> 19 Spina Bifida
	<input type="checkbox"/> 6 Learning Disability	<input type="checkbox"/> 13 Traumatic Brain Injury (TBI)	<input type="checkbox"/> 20 Tourette Syndrome
	<input type="checkbox"/> 7 Other Neurological Impairment	<input type="checkbox"/> 14 Prader-Willi Syndrome (PWS)	<input type="checkbox"/> 21 Toxic Substance Exposure
			<input type="checkbox"/> 22 Child Under 5 Unable to Diagnose
17	PREFERRED LANGUAGE:		
	<b>Spoken</b>	<b>Nonverbal</b>	<b>Understood</b>
	<input type="checkbox"/> 1 English	<input type="checkbox"/> 1 Sign	<input type="checkbox"/> 1 English
	<input type="checkbox"/> 2 Spanish	<input type="checkbox"/> 2 Other Symbolic	<input type="checkbox"/> 2 Spanish
	<input type="checkbox"/> 97 None	<input type="checkbox"/> 97 None	<input type="checkbox"/> 97 None
	<input type="checkbox"/> 98 Other	<input type="checkbox"/> 98 Other	<input type="checkbox"/> 98 Other
18	DATE COMPLETED:	MO DAY YR	
	COMPLETED BY: (Print staff name)		PHONE NUMBER:
			( ) -

## Acknowledgement of Receipt of Privacy Notice

I have received a copy of the Notice of Privacy Practices of the Epilepsy Society of Southern New York and Capabilities Partnership, Inc. dated April 14, 2003 / Updated September 23, 2013.

I acknowledge that I have been provided with a copy of this document and have therefore been advised of how medical information about me may be used and disclosed by ESSNY/CPI.

If I have any questions with regard to this notice I understand that I can approach the ESSNY/CPI staff person who provides services to me or I can call (845) 627-0627.

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Signature of Consumer or Personal Representative

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Print Name of Consumer or Personal Representative

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Date

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Description of Personal Representative's Authority

Please mail this form to:

Privacy Officer  
Epilepsy Society of Southern New York  
Capabilities Partnership, Inc.  
450 West Nyack Road Suite 9  
West Nyack, New York 10994  
Or fax: (845) 627 – 0629

# Privacy Notice

## Epilepsy Society of Southern New York Capabilities Partnership Inc.

### Notice of Privacy Practices

**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 was originally effective as of **April 14, 2003** but has been update as of **September 23, 2013**. If you have any questions about this notice, please contact the ESSNY/CPI staff person who provides you service or call the Privacy Officer at 845-627-0627.

#### **Our Privacy Commitment to You**

At the Epilepsy Society of Southern New York and at Capabilities Partnership (hereafter referred to as ESSNY/CPI) we understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information to assure quality services for you. This notice tells you how ESSNY/CPI uses and discloses information about you. It describes your rights and what our responsibilities are concerning information about you.

#### **Who will follow this notice:**

All people who work for ESSNY/CPI in all areas including, but not limited to, vocational services, service coordination services, educational services, services under the TBI waiver, as well as in our administrative offices will follow this notice. This includes all employees, contractors, our Board of Directors, Professional Advisory Board, Consumer Advisory Council, and volunteers/interns who provide services to you either directly or indirectly.

#### **What information is protected?**

All information we create or keep that relates to your health care and/or treatment, including your name, address, birth date, social security number, your medical information including any genetic data, your individualized service plan and other information about your care in our programs will be protected.

#### **ESSNY/CPI Responsibilities Regarding Your Health Information**

ESSNY/CPI is required by law to:

- ❖ Maintain the privacy of your protected health information
- ❖ Give you this notice of our legal duties and practices concerning the health information we have about you. If you received this notice electronically, you have the right to receive a paper copy as well. You may ask an ESSNY/CPI staff member to give you a paper copy or you may call (845) 627-0627 to request one be mailed out to you.

- ❖ Notify you if your unsecured protected health information has been breached.
- ❖ Follow the rules in this notice. ESSNY/CPI will use or share information about you only with your permission except for the reasons explained in this notice.

### **Your Health/Clinical Information Rights**

You have the following rights concerning your health/clinical information. When we use the word “you” in this notice we also mean your personal representative. However, your authorized representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your health/clinical information. ESSNY/CPI also retains the discretion to deny access to your health/clinical information to provide protection to those consumers who depend upon others to exercise their rights under these rules and may be subject to abuse or neglect. Depending on your circumstances and in accordance with state law, this may be your guardian, involved parent, spouse, adult child, or your advocate.

- ❖ You generally have a right to see or inspect your health/clinical information and obtain a copy in hardcopy or electronic format (if such data is kept in electronic format). You also have the right to ask us to send this information to a third party. Your request must be in writing, must be clear, conspicuous and specific and there may be a fee associated with copying, mailing and electronic medium. Some exceptions may apply. If we deny your request to see your health/clinical information, you have the right to request a review of that denial. A professional chosen by ESSNY/CPI who was not involved in denying your request will review the record and decide if you may have access to the record. If ESSNY/CPI does not maintain the health/clinical information but knows where it is maintained, you will be informed of where to direct your request.
- ❖ You have the right to ask ESSNY/CPI to change or amend your health/clinical information that you believe is incorrect or incomplete. Your request must be in writing and must state a reason for the change. We may deny your request in some cases, for example, if the record was not created by ESSNY/CPI or if after reviewing your request, we believe the record is accurate and complete. If ESSNY/CPI denies the request, it will provide you with an opportunity to submit a written statement disagreeing with the denial. ESSNY/CPI may limit the length of that statement as reasonable. ESSNY/CPI may also prepare a written rebuttal to your statement of disagreement. If you do submit a statement of disagreement, ESSNY/CPI will include that statement with any subsequent disclosure of the health/clinical information to which the statement relates.
- ❖ You have the right to request a list of the disclosures ESSNY/CPI has made of your health/clinical information. Your request must be in writing. Your request should state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list that you request within a 12-month period will be free. For additional lists, ESSNY/CPI may charge you for the costs of providing the lists. ESSNY/CPI will notify you of the costs involved and you may wish to withdraw your request at that time before any costs are incurred. Notwithstanding the foregoing, you may request an accounting of disclosures of any “electronic health record” provided that your request states a time period which may be no longer than three years prior to the date on which the accounting is requested. We will not, however, keep or provide you with a list of certain disclosures, for example, disclosures made for treatment, payment, and health care operations, or disclosures made to you or made to others with your permission.
- ❖ You have the right to request further restrictions on how ESSNY/CPI uses or discloses your health information related to treatment, payment and health care operations as well as disclosures made to involved family/friends. Your request must be in writing. ESSNY/CPI, however, is not required to agree to your request. If ESSNY/CPI agrees to the requested restriction in writing, you may terminate that restriction in writing. ESSNY/CPI may also terminate the restriction, but only as it applies to health/clinical information about you that ESSNY/CPI creates or receives after its communication to you in writing of its decision to terminate.
- ❖ You have the right to request that we restrict disclosure to any health plan you participate in if the disclosure is for payment or health care operations and pertains to a health care item/service for which we were fully paid by someone other than the health plan.
- ❖ You have the right to request that ESSNY/CPI communicates with you in a way that will help you keep your information confidential such as by alternative means or at alternative locations. ESSNY/CPI will not ask you the reason for your request. Your request must be in writing. ESSNY/CPI will accommodate all reasonable requests.



To request access to your health/clinical information or to request any of the rights listed here, you may contact the ESSNY/CPI staff person providing service to you or you may contact the Privacy Officer of ESSNY/CPI at 450 West Nyack Road, Suite 9, West Nyack, New York 10994 or at (845) 627-0627.

## **How ESSNY/CPI Uses and Discloses Health Care Information**

### **Uses and Disclosures For Treatment, Payment and Healthcare Operations**

ESSNY/CPI may use and disclose health/clinical information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- ❖ **Treatment:** ESSNY/CPI will use your health/clinical information to provide you with treatment and services. We may disclose health/clinical information to doctors, nurses, psychologists, social workers, qualified mental health professionals, developmental aides, and other ESSNY/CPI personnel, contractors, volunteers or interns who are involved in providing you care. For example, involved staff may discuss your health/clinical information to develop and carry out your individualized service plan (ISP). Other ESSNY/CPI staff may share your health/clinical information to coordinate different services you need, such as medical tests, respite care and transportation. We may also need to disclose your health/clinical information to your service coordinator and other providers outside of ESSNY/CPI who are responsible for providing you with the services identified in your ISP or to obtain new services for you. ESSNY/CPI may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- ❖ **Payment:** ESSNY/CPI will use your health/clinical information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid or other government agencies. For example, we may need to provide the NYS Department of Health (Medicaid) with information about the services you received from ESSNY/CPI so they will pay us for the services. Also, we may disclose your health/clinical information to the US Social Security Administration, or the Department of Health to determine your eligibility for coverage or your ability to pay for services. These disclosures may be part of the regulations mandated for the services you receive under Medicaid guidelines.
- ❖ **Health Care Operations:** ESSNY/CPI will use and disclose health/clinical information in order to conduct our normal business operations. These uses and disclosures are necessary to operate our programs and to make sure all consumers receive appropriate, quality care. For example, we may use health/clinical information for quality improvement to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information for on-the-job training. We will share your health/clinical information for such administrative operations as obtaining legal services, conducting fiscal audits, resolving complaints and for fraud and abuse detection and compliance. We may also disclose health/clinical information to our business associates who need access to the information to perform administrative or professional services on our behalf. We may contact you with regard to our fundraising events to invite you to participate free of charge and to perhaps help us sell raffles/sponsorships. You may opt out of receiving these fundraising communications (or opt back in) by following the directions on these communications or by contacting the ESSNY/CPI worker who is your service provider or by calling the Privacy Officer of ESSNY/CPI at (845) 627-0627.

### **Other Uses and Disclosures that Do Not Require your Authorization**

In addition to treatment, payment and health care operations, ESSNY/CPI will use your health/clinical information without your permission for the following reasons:

- ❖ When we are required to do so by federal or state law;
- ❖ For public health reasons, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with products and to notify people who may have been exposed to a disease or are at risk of spreading the disease;
- ❖ To report domestic violence and adult abuse or neglect to government authorities if you agree or if we feel this is necessary to prevent serious harm;
- ❖ For health oversight activities, including audits, investigations, surveys, inspections and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are subject;

- ❖ For judicial and administrative proceedings, including hearings and disputes. If you or your estate are involved in a court or administrative proceeding we will disclose health/clinical information if the judge or presiding officer orders us to share the information;
- ❖ For law enforcement purposes, in response to a subpoena, or other legal process, (but only if efforts have been made to tell you about the request or obtain an order protecting the health/clinical information requested), to identify a suspect or witness or missing person, regarding a victim of a crime, a death, criminal conduct and in emergency circumstances to report a crime;
- ❖ Upon your death, to coroners or medical examiners for identification purposes or to determine cause of death, and to funeral directors to allow them to carry out their duties; and to family members or close personal friends who were involved in your care as long as we do not believe that you would have objected to such disclosure;
- ❖ To organ procurement organizations to accomplish cadaver, eye, tissue, or organ donations in compliance with state law;
- ❖ For research purposes when you have agreed to participate in the research or when an Institutional Review Board or Privacy Committee has approved the use of the health/clinical information for the research purposes;
- ❖ To prevent or lessen a serious and imminent threat to your health and safety or someone else's. In an emergency situation and/or in the event of harm to yourself or others we may disclose health/clinical information to avert or lessen a serious situation.
- ❖ To authorized federal officials for intelligence and other national security activities authorized by law or to provide protective services to the President and other officials;
- ❖ To correctional institutions or law enforcement officials if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution;
- ❖ To governmental agencies that administer public benefits if necessary to coordinate the covered functions of the programs;
- ❖ To the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries or illness without regard to fault.
- ❖ To business associates, which are vendors, agents, and contractors to ESSNY/CPI, who provide services to it, such as any after-hours answering service. Business associates have entered into contracts with ESSNY/CPI that provide for the same privacy practices that ESSNY/CPI provides. If the business associate enters into a subcontract with respect to those services, the contract between the business associate and the subcontractor will also provide those protections.

### **Uses and Disclosures that Require Your Agreement or Authorization**

ESSNY/CPI may disclose health/clinical information to the following persons if we tell you we are going to use or disclose it and you agree or do not object.

- ❖ To family members and personal representatives who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location. (This disclosure also applies after your death, unless doing so would be inconsistent with any prior express preference of yours that is known to ESSNY/CPI); or
- ❖ To disaster relief organizations that need to notify your family about your condition and location should a disaster occur.

### **Authorization Required For all Other Uses and Disclosures**

For all types of uses and disclosures not described in this Notice, ESSNY/CPI will use or disclose health/clinical information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are required for most uses and disclosures of psychotherapy notes (Positive Behavioral Interventions and Support Services and Community Integration Counseling Services (under the TBI Waiver) notes are not considered psychotherapy notes) and for marketing purposes. If this marketing involves financial remuneration to us from a third party, your authorization must state that such remuneration is involved. In addition written authorizations are also required with regard to the sale of protected health information and such authorizations must state that the disclosure will result in remuneration to us. Note: If you cannot give permission due to an emergency, ESSNY/CPI may release health/clinical information in your best interest. We must tell you as soon as possible after releasing the information.

You may revoke your authorization at any time, in writing. If you revoke your authorization in writing we will no longer use or disclose your health/clinical information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain health/clinical information that indicates the services we have provided to you.

### **Changes to This Notice**

ESSNY/CPI reserves the right to change this notice at any time. We reserve the right to make the revised notice effective for all health/clinical information we already have about you as well as any health/clinical information we receive in the future. Any revised notice will be provided to you in accordance with the HIPAA Privacy Rule. The effective date of this notice and any revised notice may be found on the bottom of each page. Any revised notice will be posted on our website at [www.essny.com](http://www.essny.com) and on [www.capabilitiespartnership.com](http://www.capabilitiespartnership.com) and posted in all our offices. You may always get a copy of our current notice by asking your ESSNY/CPI staff person who provides you service or by calling (845) 627-0627.

### **Use of E-Mail**

You may wish to communicate with the staff at ESSNY/CPI via email. This is possible however you must be aware that such communication is not secure and could be intercepted by a third party. Hence, ESSNY/CPI cannot and will not take any responsibility for the security and privacy of information you transmit in this manner. For your protection, you should avoid sending any identifying information, such as social security number, through e-mail. ESSNY/CPI staff will not send any protected health information via e-mail.

### **Complaints**

If you believe your privacy rights have been violated you may file a complaint with us or with the Department of Health and Human Services. To file a complaint with us, please contact Anna Vero, Privacy Officer and Executive Administrative Director at ESSNY/CPI's main offices at 450 West Nyack Road, Suite 9, West Nyack, New York 10994 or call (845) 627-0627. All complaints must be submitted in writing. You may also file a complaint with the Office for Civil Rights, Department of Health and Human Services, 26 Federal Plaza, Suite 3313, New York City, New York 10278. Complaints filed with the Department of Health and Human Services must be filed within one hundred eighty (180) days of the violation or from the time you should have known of the violation. No one will retaliate or take action against you for filing a complaint.

### **Mitigation**

ESSNY/CPI (and/or the applicable business associate, if applicable) will attempt to limit or "mitigate" any harm to you in the event of ESSNY/CPI's (or the applicable business associate's) inappropriate use of health/clinical information about you.

### **Interpretation**

A privacy officer appointed by ESSNY/CPI has the discretion to interpret this notice, which attempts to summarize the regulations under the Health Insurance Portability and Accountability Act, or HIPAA. Those regulations will supersede any discrepancy between the information in the notice and the regulations.

### **Further Information**

If you have any questions with regard to our Privacy Policy or if you would like further information, please contact the ESSNY/CPI worker who is your service provider or call the Privacy Officer of ESSNY/CPI at (845) 627-0627 or toll free 1-800-640-0371.