



Dear Caregiver Respite Program Applicant,

Thank you for your interest in Broomfield Senior Services' *no-cost* Caregiver Respite Program, offered in partnership with the Denver Regional Council of Governments (DRCOG). We are pleased to support you and your family through this valuable service.

To move forward, please complete and return the following three forms:

- **Family Caregiver Respite Assessment Form** (focused on the caregiver providing care)
- **Care Recipient Assessment Form** (focused on the individual receiving care)
- **Receipt of Notice of Privacy Practices**

You may submit the completed forms in any of the following ways:

- **Email:** Send to lcllements@broomfield.org
- **Mail:** Broomfield Community Center, 280 Spader Way, Broomfield, CO 80020
(Attn: Community Resources Coordinator)
- **Drop-Off:** Deliver to the Broomfield Community Center at the address above.

Program Eligibility Requirements:

- The **care recipient** must be a Broomfield County resident **and** at least **60 years of age**.
- The care recipient must require assistance at a "Some Help" or "Dependent" level for **two or more Activities of Daily Living (ADLs)**.
- The **caregiver applicant** must be a family member or loved one providing unpaid care and seeking respite through this program.

When completing the Care Recipient Assessment Form, please answer the questions based on the care recipient's abilities on their **worst day** to ensure we receive an accurate picture of their care needs.

You will also find additional documents included for your reference:

- *Program Guidelines*
- *Grievance Procedure*
- *Client Information and FAQs*
- *Notice of Privacy Practices*

Once I receive your completed forms, I will review them to confirm eligibility and determine the number of care hours you will be approved for. All caregiving services will be provided through our contracted partner, Griswold Home Care.

If you have any questions or need assistance while completing the forms, please don't hesitate to contact me. Thank you again for your time and participation in this program.

Warmly,

Lauren Clements

Community Resources Coordinator

City & County of Broomfield | Senior Services

303-464-5529 | lclements@broomfield.org

Family Caregiver Respite Assessment Form

Welcome! Please tell us a bit about you (the caregiver) so we can offer services that best meet your needs. All your personal information is confidential. Please see the attached FAQs for more information.

Registration and Eligibility Section- Must Be Completed Prior to Service

First Name: _____ Middle Name (if applicable): _____

Last Name: _____ Nickname (if applicable): _____

Date of Birth: _____ Age: _____

Caregiver/Care Recipient Relationship

Please check the box to confirm that you are an eligible Family Caregiver of an Older Adult:

- You are an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (unpaid) provider of in-home or community care to the care recipient

Please select the eligibility for your care recipient:

- Your care recipient is an older individual (60 years of age or older) with 2+ ADL limitations

OR

- Your care recipient is an individual with dementia or related neurological or cognitive disorder

What is your relationship to the care recipient?

- Husband Wife Domestic Partner Son/Son-in-Law
 Daughter/Daughter-in-Law Sister Brother Grandparent Parent
 Other Relative: _____ Non-Relative: _____

Contact Information Section

Home Phone: _____ Cell Phone: _____

Email: _____

Home Address Line 1: _____

Home Address Line 2 (Apt/Unit/Floor): _____

County: _____

City: _____ State: _____ Zip: _____

Mailing address is the same as home address

Mailing Address Line 1: _____

Mailing Address Line 2 (Apt/Unit/Floor): _____

City: _____ State: _____ Zip: _____

Demographics Section- Used for Anonymous Reporting to Our Funders

Gender (select all that apply):

- Male Female Non-binary/Third gender Transgender
 Another gender not listed: _____ Refuse to answer question

Ethnicity:

- Hispanic or Latino Not Hispanic or Latino Refuse to answer question

Racial Identity (select all that apply):

- American Indian or Alaska Native Asian or Asian American Black or African American
 Middle Eastern or North African Native Hawaiian or Pacific Islander
 White Another identity not listed: _____
 Refuse to answer question

Do you live alone or with others? Alone With others Refuse to answer question

Is your income above or at/below the amount listed for your household size in the table:

- Above At/below Refuse to answer question

Income Levels Table

Household Size	Monthly Income	Annual Income
1	\$1,304	\$15,650
2	\$1,763	\$21,150

Use the table to determine if your income is above or at/below the monthly or annual income listed for your household size. For each additional person, add \$5,500 to annual income.

Communication Section

What is your primary language?: _____

Service Access and Support Section

Can you access this service through another benefit or program? For example, through your care recipient's Medicaid, VA, or Medicare benefits, or food assistance programs.

Yes No Refuse to answer question I don't know

Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities.

Select "Yes" if any of the following statements are true for you:

- You live in a remote area, or
- You have a health condition or disability that makes it difficult for you to access community resources, or
- You have financial or technology challenges that make it difficult for you to access community resources, or
- You cannot drive or use public transportation, or
- You do not feel welcome in your community due to cultural or language barriers

Yes No Refuse to answer question

Emergency Contact Section

Name: _____ Phone: _____

Relationship: _____ Refuse to provide contact

Caregiver Needs Section

Are you getting help from anyone with your caregiver duties?

Yes - professional/paid (formal) help Yes - informal help
 Yes - both formal and informal help No Refuse to answer question

If yes, please explain: _____

Modified Caregiver Strain Index

Here is a list of things that caregivers may find to be difficult. If an item applies to you, please indicate whether it applies on A Regular Basis or Sometimes. If an item does not apply to you, please mark the No column. Your situation may be slightly different, but the item could still apply.

Modified Caregiver Strain Index	Yes, on a regular basis (2 pts.)	Yes, sometimes (1 pt.)	No (0 pt.)	Refuse to answer question (0 pt.)
My sleep is disturbed. For example: person I care for wanders at night; needs assistance; I can't sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiving is inconvenient. For example: helping takes a lot of time; it's a long drive over to help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiving is a physical strain. For example: lifting in or out of a chair/bed/toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiving is confining. For example: restricts my free time; I cannot go places I enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There have been family adjustments. For example: helping has disrupted my routine; there is no privacy; family arguments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There have been changes in personal plans. For example: I could not go on vacation; I cannot participate in activities that I enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There have been other demands on my time. For example: other family members need me; work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There have been emotional adjustments. For example: arguments with family about caregiving; anger; sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some behavior is upsetting. For example: person cared for has memory issues; outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Modified Caregiver Strain Index	Yes, on a regular basis (2 pts.)	Yes, sometimes (1 pt.)	No (0 pt.)	Refuse to answer question (0 pt.)
It is upsetting to find the person I care for has changed so much from their former self. For example: the care recipient is a different person than they used to be; unable to do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There have been work adjustments. For example: I have to take time off for caregiving duties; adjusting schedules; unable to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiving is a financial strain. For example: I use personal finances for caregiving; unsure about future financial situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel completely overwhelmed. For example: I worry about the person I care for; I have concerns for my future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Caregiver Strain Index Score: _____

Care Recipient Assessment Form

Please fill in this form about your care recipient.

Registration and Eligibility Section - Must Be Completed Prior to Service

First Name: _____ Middle Name (if applicable): _____

Last Name: _____ Nickname (if applicable): _____

Date of Birth: _____ Age: _____

Eligibility for the Care Recipient

Cognitive Impairment Eligibility Screening: The care recipient has cognitive impairment; and, the care recipient needs another person to provide physical guidance or spoken instructions to keep the care recipient or others safe.

Yes No

The care recipient has 2 or more activity of daily living limitations.

Yes No

Contact Information Section

Does the care recipient live with the caregiver? Yes No

If yes, skip to the Demographics Section

Home Phone: _____ Cell Phone: _____

Email: _____

Home Address Line 1: _____

Home Address Line 2 (Apt/Unit/Floor): _____

County: _____

City: _____ State: _____ Zip: _____

Mailing address is the same as home address

Mailing Address Line 1: _____

Mailing Address Line 2 (Apt/Unit/Floor): _____

City: _____ State: _____ Zip: _____

Demographics Section - Used for Anonymous Reporting to Our Funders

Gender (select all that apply):

- Male Female Non-binary/Third gender Transgender
 Another gender not listed: _____ Refuse to answer question

Ethnicity:

- Hispanic or Latino Not Hispanic or Latino Refuse to answer question

Racial Identity (select all that apply):

- American Indian or Alaska Native Asian or Asian American Black or African American
 Middle Eastern or North African Native Hawaiian or Pacific Islander
 White Another identity not listed: _____
 Refuse to answer question

Do you live alone or with others? Alone With others Refuse to answer question

Is your income above or at/below the amount listed for your household size in the table:

- Above At/below Refuse to answer question

Income Levels Table

Household Size	Monthly Income	Annual Income
1	\$1,304	\$15,650
2	\$1,763	\$21,150

Use the table to determine if your income is above or at/below the monthly or annual income listed for your household size. For each additional person, add \$5,500 to annual income.

Communication Section

What is your primary language?: _____

Service Access and Support Section

Health Insurance (select all that apply):

- Medicare Medicare Advantage Medicaid Medicaid Waiver(s) VA
 Private None Other insurance: _____
 Refuse to answer question

Are you homebound?

Select “Yes” if any of the following statements are true for you:

- You need the help of another person to leave your home, or
- You have a health condition or disability that makes it difficult to leave your home on a regular basis, or
- You are only able to leave your home infrequently and for short periods of time

Yes No Refuse to answer question

Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities.

Select “Yes” if any of the following statements are true for you:

- You live in a remote area, or
- You have a health condition or disability that makes it difficult for you to access community resources, or
- You have financial or technology challenges that make it difficult for you to access community resources, or
- You cannot drive or use public transportation, or
- You do not feel welcome in your community due to cultural or language barriers

Yes No Refuse to answer question

Emergency Contact Section

Name: _____ Phone: _____

Relationship: _____ Refuse to provide contact

Nutrition Screening Section

Nutrition Risk Score

Determine your nutritional health. If the statement is true for you, check the box in the “Yes” column and add the points in the “Yes Score” column to your total score.

Nutrition Risk Score Questions	Yes	No	Refuse to Answer Question	Yes Score
1. Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
2. Do you eat fewer than 2 meals per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
3. Do you eat few fruits, vegetables, or milk products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
4. Do you have 3 or more drinks of beer, liquor, or wine almost every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
5. Do you have tooth or mouth problems that make it hard for you to eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
6. Are there times you do not have enough money to buy the food you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
7. Do you eat alone most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
8. Do you take 3 or more different prescribed or over the counter drugs a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
9. Without wanting to, have you lost or gained 10 pounds in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
10. Are there times you're physically unable to shop, cook, and/or feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2

Total Nutrition Risk Score (Total “Yes” Score): _____

Total Nutrition Risk Score Meaning: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk - speak with a qualified health or social service professional.

Activities of Daily Living - Must Be Completed for Eligibility

For each activity, please mark the level of help the care recipient needs.

Activities of Daily Living	<u>Independent:</u> I don't need any help with this activity	<u>Some Help:</u> I need some help or reminders from another person, but I can do parts of this activity on my own	<u>Dependent:</u> I always need help from another person to do this activity
1. Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Dressing - Putting on and taking off clothing and shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Using the bathroom - Getting to and on/off the toilet, managing clothing, wiping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Transferring In/Out of Bed/Chair - Getting in and out of sitting or lying positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Walking/Getting Around the House	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Eating and drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on ADLs: _____

Instrumental Activities of Daily Living

For each activity, please mark the level of help the care recipient needs.

Instrumental Activities of Daily Living	<u>Independent:</u> I don't need any help with this activity	<u>Some Help:</u> I need some help or reminders from another person, but I can do parts of this activity on my own	<u>Dependent:</u> I always need help from another person to do this activity	Refuse to Answer Question
1. Meal Preparation - Planning, making, and cleaning up meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Shopping - selecting and paying for food, household supplies, clothing, and other items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Medication Management - getting prescriptions filled and taking medications as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Money Management - budgeting, using cards and bank accounts, paying bills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Using a Telephone - making and receiving calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Light Housework - tidying up, sweeping, vacuuming, mopping, cleaning kitchen and bathroom surfaces, taking out garbage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Heavy Housework - deep cleaning the home, moving light furniture to clean under/behind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Transportation - driving, walking, or using other forms of available transportation, like buses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on IADLs: _____

Does anyone help you with ADL or IADL activities?

- Yes No Refuse to answer question

If yes, who is assisting you? _____

Home Conditions Section

Does anyone smoke inside the client's home?

- Yes No Refuse to answer question

Are there any pets in the household?

- Yes No Refuse to answer question

If yes, please list pets: _____

Are any of your pets uncomfortable with visitors to the home?

- Yes No Not applicable



Are you interested in learning about nutrition and a healthy diet? If yes, you're invited to enroll in Text2LiveHealthy, a nutrition education program delivered to you via text message. Scan this QR code with your phone's camera to enroll or text the word FRUIT to 97699. Message & Data Rates May Apply. Text HELP for information. Text STOP to 97699 to opt out. No purchase necessary. For Privacy Policy and Terms and Conditions, visit: <https://coloradosph.cuanschutz.edu/text2livehealthy>

Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service providers and I give my consent to do so.

Signature: _____

Date: _____

If filled out by someone other than the caregiver client (for example a caregiver or assessor, please check here and sign below):

Filled out by: _____

Date: _____



City & County of Broomfield
Receipt of Notice of Privacy Practices

I acknowledge that I have received the City and County of Broomfield, Parks, Recreation and Senior Services Department Notice of Privacy Practices containing the following information:

1. The City and County of Broomfield, Parks, Recreation and Senior Services Department will use and disclose my medical information for the purpose of treatment, payment, department operations, to determine health-related services, to release information to individuals involved in my care, as required by law and to avert a serious threat to health or safety.
2. Special situations when medical information will be released including public health activities, as requested by law enforcement, in response to a subpoena and others as described in the notice.
3. My rights regarding medical information include the right to inspect, copy, amend the record, and to request an accounting of disclosures of my medical information. I also have the right to request a restriction on the use of my medical information, to request confidential communications, and to receive a paper copy of the Notice of Privacy Practices.
4. Other uses and disclosures of medical information not covered by the Notice of Privacy Practices or the laws will be made only with my written permission.
5. I have the right to file a complaint with the City and County of Broomfield, Parks, Recreation and Senior Services Department, or the Office of Civil Rights if I believe my privacy rights have been violated.
6. The City and County of Broomfield, Recreation and Senior Services Department has the right to change the Notice of Privacy Practices.

Family Caregiver

Printed Name: _____

Signature: _____

Date: _____

Care Recipient

Printed Name: _____

Signature: _____

Date: _____



Caregiver Respite Program Participation Guidelines

July 2025 - June 2026

The Caregiver Respite Program is grant funded through **Denver Regional Council of Governments (DRCOG)** and managed by the **City and County of Broomfield**. To help us serve all families fairly and make the best use of these grant funds, please follow these participation guidelines:

Using Your Hours

- Begin using your hours as soon as you're approved. You must use **at least 4 hours every 2 months** to stay active in the program.
- If you don't use your hours for over 2 months, your account will become **inactive**, and you'll need to be reapproved to participate again.
- You can use your hours all at once or spread them out, depending on your needs.

Need a Break?

- If you're planning something in the future like a vacation or surgery, please contact us to discuss a **temporary pause** in your enrollment. We'll try to save your hours if possible, though we can't guarantee future availability.

Scheduling Care

- Visits must be **at least 2 hours** long. You can schedule up to 24-hour care, pending schedule availability.
- You are responsible for scheduling care with **Griswold Home Care** at 303-848-8703. The more notice you give, the more likely you are to get your preferred caregiver and time.
- Be consistent if possible – a regular schedule helps ensure continuity of care.

Cancelling a Visit

- Please cancel with **as much notice as possible**. Frequent or last-minute cancellations may result in reduced hours or removal from the program.
- If you cancel with **less than 24 hours' notice**, the scheduled hours will be deducted from your total.

Holiday Care

- The program **does not cover holiday care** if it requires Griswold's holiday rate. You can still receive care on holidays by arranging and paying privately with Griswold.

Unused or Extra Hours

- If you don't plan to use all your hours, let us know so we can offer them to others.
- Need more hours? Contact us – if hours are available, we may be able to assign more based on your situation.

Transportation & Outings

- You can go out with your caregiver using one of these options:
 - **Your own vehicle**, with the caregiver driving.
 - **The caregiver's vehicle**, with **you paying mileage** directly to Griswold.
 - **EasyRide**, the City's free accessible transportation service – your caregiver can come with you. Call 303-464-5534 to learn more.
- Note: The program **does not cover any transportation costs**.

Important Notes

- **No tipping**: Caregivers cannot accept tips through this program.
- Hours are authorized **every 6 months**. Unused hours from July-December may not roll over into January-June.
- Let us know if you **no longer need the program** or have any concerns – communication helps us improve and support more caregivers.
- We also welcome your **positive feedback!**

Contact Information

Lauren Clements

Community Resources Coordinator
City and County of Broomfield Senior Services
Phone: 303-464-5529
Email: lclements@broomfield.org
Web: www.BroomfieldSeniors.com

Jim Middleton

Owner
Griswold Home Care
Phone: 303-848-8703
Email: westminster@griswoldcare.com
Web: www.griswoldcare.com/westminster-broomfield-boulder



Client Grievance Procedure

Clients of the City and County of Broomfield Senior Services have the right to voice concerns or submit complaints regarding the **EasyRide Transportation Program** or the **Caregiver Respite Program**. Complaints should first be directed to the appropriate program coordinator. If the issue is not resolved to the client's satisfaction, the concern will be forwarded to the **Senior Services Manager** for further review. If the matter remains unresolved, clients may contact the **Director of Parks, Recreation, and Senior Services** for additional support and resolution.

Caregiver Respite Program

Lauren Clements, Community Resources
Coordinator
303-464-5529 | lclements@broomfield.org

Nikki Crouse, Senior Services Manager
303-464-5528 | ncrouse@broomfield.org

EasyRide Transportation Program

Jennifer Hussey, Program Supervisor
303-464-5559 | jhussey@broomfield.org

Clay Shuck, Director of Parks, Recreation, and
Senior Services
303-460-6903 | cshuck@broomfield.org

You may also file a grievance with the Denver Regional Council of Governments (DRCOG) or the State Unit on Aging (SUA) if you are not satisfied with the resolution provided by Broomfield Senior Services.

**Denver Regional Council of Governments
(DRCOG)**
Area Agency on Aging
1001 17th Street, Suite 700, Denver, CO 80202
303-455-1000 | drcog@drcog.org

**Colorado Department of Human Services
State Unit on Aging**
1575 Sherman Street, 3rd Floor, Denver, CO
80203
303-866-2800

The complete Complaint, Grievance, and Appeal Procedures are available upon request by contacting DRCOG or the State Unit on Aging directly.



Client Information and FAQs

Please keep this information for your records.

Provider and Area Agency on Aging Information:

Your Service Provider: **Broomfield Senior Services**

Your local Area Agency on Aging: **Denver Regional Council of Governments (DRCOG)**

What is an Area Agency on Aging?

The Area Agency on Aging (AAA) is a regional organization that is designated by the state to use federal, state, and local funding to meet the needs of older adults in their community. The AAA provides services to older adults and caregivers directly and through partnerships with community provider agencies. AAAs also advocate for older adults.

Service Information

The service you are requesting is funded through the Older Americans Act (OAA) and/or Older Coloradans Act (OCA) funding. This federal and state funding helps older adults, 60+, remain in their homes and communities of choice. We are required to prioritize services for eligible individuals with greatest economic and social needs. Requests for services are processed as funds allow. We can provide you with referrals to other resources in your area, but we will not reach out to them without your permission.

What is the purpose of the client assessment?

We ask you to provide information so that we can:

- Offer services that best meet your needs
- Prove that our taxpayer-funded programs only serve eligible individuals
- Prove that we serve older adults and caregivers most in need of services
- Understand the needs of older adults in our community
- Show the need for funding our programs
- Meet reporting requirements from our funders

We do not use income information to determine your eligibility for services. Income and other demographic information (e.g. gender, race, ethnicity) are collected for anonymous demographic

reporting purposes. No personal information, such as your name or date of birth is disclosed in reporting.

What happens with the information from my client assessment?

We enter your information into a secure state database. As you receive services, we record the services you receive in the database. This helps us prove how we spent our funding. The database is secured to the standards outlined in the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH). Only authorized staff have access to the database. This means your data remains safe and confidential.

Will you sell my information?

No. We will never sell your information.

How do I provide feedback?

We love hearing how we can improve. Contact your service provider, **Broomfield Senior Services, 303-464-5526 (attn: Nikki Crouse, Senior Services Manager)**, or your local Area Agency on Aging at **303-455-1000** or **drcog@drcog.org**. Because we value your input, we may at times send you a survey to ask for your feedback.

How do I file a complaint, grievance, or appeal?

You have the right to file a complaint or grievance with your service provider. If you are not satisfied with the provider's decision, you can appeal the decision to your local Area Agency on Aging (AAA), and/or the State Unit on Aging (SUA). The complete Complaint/Grievance/Appeal Procedures are available upon request by contacting your local AAA and/or the SUA as follows:

Denver Regional Council of Governments, Area Agency on Aging

1001 17th Street, Suite 700

Denver, CO 80202

303-455-1000 or drcog@drcog.org

Colorado Department of Human Services, State Unit on Aging

1575 Sherman Street, 3rd Floor, Denver, CO 80203

303-866-2800

Colorado Anti-Discrimination Act

Individuals have the right to equal opportunity and access to services. Individuals cannot be excluded from participating because of disability, race, creed, color, sex, sexual orientation, gender identity, gender expression, marital status, national origin, or ancestry. Complaints related to discrimination may be filed at:

Colorado Civil Rights Division, 1560 Broadway, Suite 110, Denver, CO 80202

Phone: 1-800-262-4845 | 711 TTD - Relay | Email: DORA_CCRD@STATE.CO.US

Accessibility

If you need to request reasonable modifications or accommodations to access this document's content, please contact us at **303-464-5529**.

Can I make a donation?

We accept donations and gifts to contribute towards the cost of services and to support older adult programs. Every dollar we receive goes back into the programs and services. Donations are voluntary and are not required to receive services.

You can send donations to **Broomfield Senior Services, 280 Spader Way, Broomfield, CO 80020**.

Please include "Caregiver Respite" in the memo line for any donations via check.

How can I help?

We couldn't meet the needs of older adults in our communities without the amazing help from volunteers. To learn more about volunteering with older adults in Colorado, please visit <https://cdhs.colorado.gov/volunteer>. You can also reach out to your service provider or your local AAA to find out how you can help make a difference in your community.

What other resources are available?

Reach out to your AAA to get more information about the services available in your region.

DRCOG Aging and Disability Resource Center (ADRC): 303-480-6700, www.drcog.org

Broomfield Senior Services: 303-464-5529, www.BroomfieldSeniors.com

You can also call the statewide Aging and Disability Resources for Colorado (ADRC) for information about resources in your area: 1-844-COL-ADRC / 1-844-265-2372

You can get nutrition education through your phone. Text2LiveHealthy, is a free text messaging program that will send you 2-3 messages per week with easy low-cost ideas to eat healthy, stay

active and be independent. You'll also get information about local health-related events. To sign up, scan the QR code with your phone's camera or text FRUIT to 97699.



Message & Data Rates May Apply. Text HELP for information. Text STOP to 97699 to opt out. No purchase necessary. For Privacy Policy and Terms and Conditions, visit: <https://coloradosph.cuanschutz.edu/text2livehealthy>



NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE APRIL 14, 2003

Updated March 2023

Who will follow this notice?

This notice describes the privacy practices of Parks, Recreation, and Senior Services (Senior Services) and of:

- Any health care professional authorized to enter information into your medical record.
- All clinics and units of Senior Services.
- Any member of a volunteer group Senior Services allows to help you while you are being treated by Senior Services.
- All employees, staff, and other Senior Services personnel.
- All of our clinic sites and locations follow the terms of the notice. In addition, these clinic sites and locations may share medical information between them for treatment, payment, or Senior Services operational purposes as described in this notice.

Our promise regarding medical information:

Senior Services understands that medical information about you and your health is personal. Senior Services is committed to protecting medical information about you. We create a written record of the care and services you receive through Senior Services. We use this record to provide you with quality care and to meet certain legal requirements. This notice applies to all the records of your care generated by Senior Services, whether made by Senior Services personnel or your personal health care provider. Your personal health care provider may have different policies or notices regarding the provider's use and disclosure of your medical information created in your personal provider's office or clinic.

This notice tells you about the ways in which Senior Services may use and disclose medical information about you. Senior Services also describes your rights and certain obligations it has regarding the use and disclosure of medical information. Senior Services is required by law to:

- Ensure that medical information that identifies you is kept private;
- Provide notice to you of our legal duties and privacy practices related to your medical information; and
- Follow the terms of the notice that is currently in effect.

How Senior Services may use and disclose medical information about you:

The following items describe different ways that Senior Services may use and disclose medical information. For each of the uses or disclosures, this document will explain what they mean. Not every use or disclosure will be listed. However, all of the ways in which Senior Services is permitted to use and disclose information will be covered.

For Treatment: Senior Services may use medical information about you to provide you with medical treatment of services.

For Payment: Senior Services may use and disclose medical information about you so that the treatment and services you receive through Senior Services may be billed and payment collected from you, an insurance company, or a third party insurer.

For Health Care Operations: Senior Services may use and disclose medical information about you for Senior Services operations. These uses and disclosures are necessary to run the department and be certain that all of our patients receive quality care. For example, Senior Services may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. Senior Services may also combine medical information about many patients to decide what services are needed. Senior Services may also disclose information to doctors, nurses, technicians, and other personnel for review and learning purposes. Senior Services may also combine the medical information Senior Services has with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. Senior Services removes information that identifies you from this medical information so that others may use it to study health care and health care delivery without identifying specific patients.

Appointment reminders: Senior Services may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Individuals Involved in Your Care or Payment for Your Care: Senior Services may release medical information about you to a friend or family member who is involved in your medical care.

Research: Under certain circumstances, Senior Services may use and disclose medical information about you for research purposes. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, attempting to balance the research needs with patients' need for privacy of their medical information. Before Senior Services uses or discloses medical information for research the project must be approved through this process. We may disclose medical information about you to people preparing to conduct a research project. An example would be to provide assistance to search for patients with specific medical needs with the restriction that the information was not removed from Senior Services. Usually, Senior Services will ask for your permission if the organization performing the research study has access to your name, address, or other information that identifies you.

As Required by Law: Senior Services will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health and Safety: Senior Services may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.

Special Situations

Workers' Compensation: Senior Services may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: Senior Services may disclose medical information about you for public health or

human services activities. Those activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications, vaccines, or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if Senior Services believes a patient has been a victim of abuse, neglect, or domestic violence. Senior Services will only make this disclosure if you agree or when required by or authorized by law.

Health Oversight Activities: Senior Services may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, Senior Services may disclose medical information about you in response to a court or administrative order. Senior Services may also disclose medical information about you in response to a subpoena, discovery request, or other lawful processes by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: Senior Services may release medical information to a law enforcement official under the following circumstances:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, Senior Services is unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors: Senior Services may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information Senior Services maintains about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, submit your request in writing to the custodian of records, **Manager, Senior Services, 280 Spader Way, Broomfield, CO 80020**. If you request a copy of the information, there is a fee charged for the costs of copying, mailing, and other supplies related to your request. In certain limited circumstances, Senior Services may deny your request to inspect and copy. If you are denied access to this medical information you may request a review of the denial. The request to review the denial must be sent to the **Manager, Senior Services**. Another licensed health care professional will be appointed to Senior Services to review your request. Senior Services will comply with the outcome of this review.

Right to Amend: If you feel that the medical information Senior Services has about you is incorrect or incomplete in the records, you may ask Senior Services to amend the information. You have the right to request an amendment as long as the information is kept by or for Senior Services. To request an amendment, your request must be submitted in writing to the custodian of records, **Manager, Senior Services, 280 Spader Way, Broomfield, CO 80020**. You must provide a reason to support your request. Senior Services may deny your request if it is not in writing or does not include a reason for the request. In addition, Senior Services may deny your request if you ask us to amend information that;

- Was not created by us unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the medical information kept by or for Senior Services;
 - Is not part of the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

Right to an Accounting of Disclosures: You may have the right to request an “accounting of disclosures.” This is a list of the disclosures Senior Services has made of your medical information. To request this list or accounting of disclosures a written request must be submitted to the custodian of records, **Manager, Senior Services, 280 Spader Way, Broomfield, CO 80020**. Your request must state a time period, which may not be longer than six years and may not include dates before March 6, 2003. Your request must include a description of the format in which you want the list, either paper or electronically. The first request in a 12-month period is free. For additional lists, Senior Services will charge for the cost of providing the list. Senior Services will notify you of the fee and you may decide to change your request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information Senior Services uses or discloses about you for treatment, payment, or health care operations. You have the right to request a limit on the medical information Senior Services discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. **Senior Services is not required to agree to your request.** If we do agree we will comply with your request unless the information is needed to provide emergency treatment to you. Restrictions or limitations for information disclosure must be submitted in writing to the custodian of records, **Manager, Senior Services, 280 Spader Way, Broomfield, CO 80020**. The request must include a description of the limitations you are requesting, for example, a spouse.

Right to Request Confidential Communications: You have the right to request that Senior Services communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communication, a written request must be submitted to the custodian of records, **Manager, Senior Services Department, 280 Spader Way, Broomfield, CO 80020**. Senior Services will not ask you the reason for Senior Services your request. Senior Services will accommodate all reasonable requests. Your request must tell Senior Services how or where you wish to be contacted.

Right to a Paper Copy of this Notice: You have the right to a copy of this notice. You may ask HHS to give you a copy at any time. If you wish to retain a copy of this notice, ask the Administrative Technician at the reception desk for a copy of this notice.

Changes to This Notice

Senior Services reserves the right to change this notice. Senior Services reserves the right to make the revised or changed notice effective for medical information Senior Services already has about you as well as any information Senior Services receives in the future. Senior Services will post a copy of the current notice at all Senior Services clinic sites. This notice will contain on the first page, in the top right corner, the effective date. Each time you register at Senior Services for treatment or health care services, Senior Services will review your record to see if you have received a copy of the most recent notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Senior Services by submitting your written request to **Nikki Crouse, Senior Services Manager, 280 Spader Way, Broomfield, CO 80020 303-464-5526**. All complaints must satisfy the following criteria:

- They must name the City and County of **Broomfield Parks, Recreation, and Senior Services Department** as the subject of the complaint and describe the acts or omissions believed to be in violation.
- They must be filed within 180 days from the time when the complainant became aware of or should have recognized that the act of omission occurred unless Senior Services waives this time limit for good cause.
- **You will not be penalized for filing a complaint.**

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide Senior Services permission to use or disclose medical information about you, that permission can be revoked, in writing, at any time. If you revoke your permission, Senior Services will no longer use or disclose medical information about you for the reasons covered by your written authorization. Senior Services is unable to take back any disclosures it has already made with your permissions and Senior Services is required to retain records of the care that Senior Services has provided to you.

If you have questions about this notice please contact:

Nikki Crouse, Senior Services Manager, 280 Spader Way, Broomfield, CO 80020 303-464-5526