YOUR UNIVERSITY OF ROCHESTER health

Healthcare Provider Biometric Screening/Referral Form

for office use only
RN initials: _____
UR Empl ID: _____
Client ID: _____

SECTION I - EMPLOYEE / DEPENDENT INFORMATION - PLEASE ENTER YOUR INFORMATION

First Name | MI | Last Name

Date of Birth (MM/DD/YYYY) | Sex | Daytime telephone number

Email

SECTION II - OPTIONS - PLEASE SELECT OPTION A OR B (Values must be obtained in the current calendar year)

○ **Option A - I will complete section III and V**
1) I have taken the lab values from my lab sheet and entered them into Section III of this form. I will **fax my lab slip** with this form to **(585) 461-4488**. Provider signature is not required if Option A is selected.

○ **Option B - My provider will complete sections III, IV and V**
1) I have seen my Provider and my Provider will enter all values listed in Section III and sign as required. Either myself or my Provider will fax completed form to **(585) 461-4488**.

SECTION III - BODY MEASUREMENTS / BIOMETRIC RESULTS

Height ft in | **Weight** lbs | **Abdominal Girth** in | **Blood Pressure** Systolic / Diastolic | **Heart Rate**

Fasting ○ Yes ○ No

Cholesterol HDL: | LDL: | Non-HDL: | TRI:

Total Cholesterol:

Blood Glucose

Screening Date: (Values must be obtained in the current calendar year)

(MM/DD/YYYY)

SECTION IV - PROVIDER'S REFERRAL FOR PATIENT

CONDITION MANAGEMENT

- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Blood Pressure
- ☐ High Cholesterol
- ☐ Chronic Low Back Pain
- ☐ Stroke

LIFESTYLE MANAGEMENT

- ☐ Weight Loss and Diabetes Prevention
- ☐ Physical Activity
- ☐ Cholesterol Management
- ☐ Blood Pressure Management
- ☐ Stress Reduction
- ☐ Tobacco Cessation

SECTION V - PROVIDER INFORMATION - PLEASE ENTER PROVIDER INFORMATION WHO COLLECTED BIOMETRIC VALUES

Provider's Name: (please print) _____ Phone Number: _____

Provider Signature: _____ ☐ Provider is a member of Accountable Health Partners

Please complete the following pages of this form

Center for Employee Wellness
255 Crittenden Blvd. Rochester, NY 14642
Helpdesk: 585-275-6810

SECTION VI - EMPLOYEE / DEPENDENT SIGNATURE - PLEASE SIGN AND RETURN

Important Notice Regarding the YOUR Health Wellness Program

The medical components of the YOUR Health program (which include the Personal Health Assessment, Biometric Screenings, Lifestyle Management Program, Condition Management Program, and Behavioral Health Partners) are a grouping of voluntary wellness programs available to all employees enrolled in the University of Rochester's Health Care Plans. Other components of YOUR Health, such as Strong EAP and Well-U, are available to all University employees regardless of Health Care Plan enrollment.

The YOUR Health program also offers financial rewards for employees, spouses and domestic partners enrolled in a University Health Care Plan who participate in certain voluntary health screening activities and health management programs, as described below.

The YOUR Health program is administered in compliance with federal laws – including the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA), the Health Insurance Portability and Accountability Act (HIPAA), and the Affordable Care Act (ACA), among others – which permit employers to sponsor wellness programs that seek to improve employee health or prevent disease. This notice is intended to comply with requirements of those laws, and to explain your legal rights and how your health information will be protected.

Program Components and Financial Rewards

The YOUR Health screening programs include a Personal Health Assessment (or "PHA"), which asks a series of questions about your household and demographic information, health-related activities and behaviors, personal satisfaction and stress, physical activity levels, nutritional habits, sleep habits, substance use, health goals, and whether you have or had certain medical conditions (e.g., cancer, diabetes, high cholesterol, heart disease, high blood pressure, pulmonary disease, depression or anxiety, low back pain, allergies or stroke). The YOUR Health program also offers on-site biometric screenings, which will include your height, weight, body mass index (BMI), waist circumference, heart rate and blood pressure, as well as cholesterol and glucose levels (which requires a finger prick to obtain a small sample of blood).

The information from your PHA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through other components of the YOUR Health program, such as Lifestyle Management, Condition Management or Behavioral Health Partners. You also are encouraged to share your results or concerns with your own doctor. The results of your biometric screenings will be entered into your Electronic Health Record, where they can be accessed by your personal physician for treatment purposes (if your physician participates in the University's network).

Enrolled employees, spouses, and domestic partners who complete the PHA and all of the available biometric screenings will receive a taxable cash incentive of $125. Although participation is completely voluntary and you are not required to complete the PHA or participate in the biometric screenings, only those employees, spouses and domestic partners who do so will receive the $125 reward. Enrolled children are not eligible to participate in the PHA or biometric screenings, nor are they eligible for the cash incentive.

Additional cash incentives of up to $200 may be available for enrolled employees, spouses and domestic partners who participate in certain health management activities. Employees, spouses and domestic partners may each earn $100 for completion of a Lifestyle Management program, and an additional $100 for completion of a Condition Management Program. Lifestyle Management program options include individual programs for cholesterol management, blood pressure management, or tobacco cessation, and group programs for weight loss, stress reduction, physical activity and healthy lifestyles. The Condition Management program helps employees manage certain chronic health conditions, including asthma, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disorder, coronary artery disease, diabetes, high blood pressure, high cholesterol, low back pain, or stroke. There are no direct cash incentives for seeing a Behavioral Health Partners provider (for treatment of stress, anxiety or depression), but employee cost sharing is generally waived for BHP providers as part of the health plan design (except that employees enrolled in the HSA-Eligible plan must first satisfy the plan deductible).

If you are unable to participate in any of the activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. For example, if you are unable to attend one of the on-site biometric screening sessions, you may have the screenings performed and certified by your own health care provider. You may request a reasonable accommodation or an alternative standard by contacting the University Benefits Office at 585-275-2084. Recommendations of your personal physician will also be accommodated.

Protections from Disclosure of Medical Information

The information you share in the YOUR Health program is kept confidential and is protected by several laws, including HIPAA and the Americans with Disabilities Act, as well as the University's internal policies. Although the YOUR Health program and the University may use aggregate information it collects to design a program based on identified health risks in the workplace, the YOUR Health program will never disclose any of your personal information either publicly or to the parts of the University considered to be your employer (except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law). Medical information that personally identifies you that is provided in connection with the YOUR Health program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

The information you share in the YOUR Health program will be used only to promote your health, and may be forwarded to your personal physician or to other University health plans for purposes of treatment, payment, and health care operations. Specifically, the University of Rochester Health Care Plans (including Lifestyle Management, Condition Management, Behavioral Health Partners and Accountable Health Partners) and the Employee Assistance Program are part of an Organized Health Care Arrangement, which means that protected health information can be shared among those plan components for purposes of treatment, payment, and health care operations, without the need for your consent or authorization to use or disclose your health information to carry out these functions.

Only University employees and vendors responsible for administering or providing treatment services under the Health Care Plans and EAP, such as employees who work in the Benefits Office, the School of Nursing, the Healthy Living Center, Behavioral Health Partners or Accountable Health Partners, have access to YOUR Health program protected health information. This includes individuals with medical training such as Physicians, Internists, Lipidologists, Psychiatrists, Clinical Psychologists, Nurse Practitioners, Registered Nurses, Social Workers, Registered Dieticians, Exercise Specialists/Physiologists, Tobacco Cessation Counselors, and certified Wellness Coaches.

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All medical information obtained through the YOUR Health program will be maintained separate from your personnel records. Information that is stored electronically will be secured when at rest and encrypted when in transit, and no information you provide as part of the YOUR Health program will be used in making any employment decision. All individuals handling protected health information are trained in HIPAA privacy and security rules and subject to disciplinary action (up to an including termination of employment) if they inappropriately use or disclose your protected health information. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you within the timeframes required by law and our HIPAA policies.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the YOUR Health program and your medical treatment, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the YOUR Health program will abide by the same confidentiality requirements.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the University Benefits Office at 585-275-2084.

Notice of Nondiscrimination

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

The University of Rochester:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Interpreter Services at (585) 275-4778

If you believe that the University of Rochester has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Equal Opportunity Director & Title IX Coordinator
271 Wallis Hall, Box 270013
Rochester, NY 14627
Morgan Levy,
Director of Equal Opportunity Compliance and Title IX Coordinator
Morgan.Levy@rochester.edu
Phone: 585-275-7814

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

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

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-585-275-4778（email: Interpreter_services@urmc.rochester.edu）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-585-275-4778(email: Interpreter_services@urmc.rochester.edu).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך הילף סערוויסעס פריי פון אפצאל. רופט

1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

লk ʏ করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা u পলb আছে। ফোন করুন 1-585-275-4778 (email:

Interpreter_services@urmc.rochester.edu). I

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

ملحوظة: اذا كنت تتحدث اللغة العربية فان خدمات المساعدة اللغوية متوافرة لك بالمجان. اتصل برقم 1-585-275-4778 (رقم

(email: Interpreter_services@urmc.rochester.edu).:هاتف الصم والبكم

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

خبردار: اگر آپ اردو بولتے ہیں تو آپ کے زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال
1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu) کریں

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-585-275-4778 (email: Interpreter_services@urmc.rochester.edu).

Employee / Dependent Signature: _____ _____

(MM/DD/YYYY)

SECTION VII - CONFIRMATION - PLEASE CONFIRM (Check) YOU HAVE COMPLETED ALL SECTIONS AND ACTIONS

- ☐ Section I - Employee / dependent information entered
- ☐ Section II - Option A - lab slip faxed with completed and signed form

OR

Option B - This form collected from provider after sections III and IV are completed

- ☐ Section III - ALL biometrics data entered by employee or provider
- ☐ Section IV - Provider information entered including provider signature if Option B
- ☐ Section V - Form signed by employee / dependent
- ☐ Completed form along with a copy of the lab slip, if applicable, faxed to (585) 461-4488.
- ☐ Copy of this form retained by employee / dependent

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