YMCA Name: _____

Program Site: _____

BLOOD PRESSURE SELF–MONITORING

ENROLLMENT FORM

Today's Date:

First name:	**Last name:**
Phone #:	**Email:**
Preferred contact method: ☐ phone ☐ email ☐ text	
Gender: ◯ Male ◯ Female ◯ Prefer not to answer	**Date of birth:**
Have you ever been diagnosed with high blood pressure/hypertension?	◯ Yes ◯ No
Are you currently taking prescription medication to control or manage your high blood pressure?	◯ Yes ◯ No
Were you diagnosed in the *last 12 months* with high blood pressure/hypertension?	◯ Yes ◯ No
Do you have a home blood pressure cuff?	◯ Yes ◯ No

How did you hear about this program?

- ☐ Y staff member or volunteer
- ☐ A friend or family member or word of mouth
- ☐ A doctor or other health care professional
- ☐ A direct mailing/e-mail communication
- ☐ A poster, flyer or event at the Y
- ☐ The Y's web site
- ☐ Media (TV, web, radio, print, etc.)
- ☐ Other (please specify):

Are you a member of the Y? ◯ Yes ◯ No

Are you Hispanic, Latino(a), or Spanish origin? ◯ Yes ◯ No ◯ Prefer not to answer

What is your race:

- ◯ White or Caucasian
- ◯ Black or African American
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Other (please specify):
- ◯ Prefer not to answer

What is your highest level of education:

- ◯ Less than high school
- ◯ High school diploma or equivalency (GED)
- ◯ Associate degree (junior college)
- ◯ Bachelor's degree
- ◯ Master's degree
- ◯ Doctorate
- ◯ Professional (MD, JD, DDS, etc.)
- ◯ Other (please specify):

For Y Staff: Baseline Data

Initial BP Measurement:

Systolic BP _____ Diastolic BP _____ Arm ☐ Right ☐ Left

Measurement taken by:

HIPAA form received:	☐ Yes	Informed Consent form received:	☐ Yes	Auth for Release of Information to Health Care Provider form received:	☐ Yes ☐ No	Program fee that participant paid:	$

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FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH CARE PROVIDER

I authorize the Valparaiso Family YMCA (the "YMCA") to disclose my personal identifiable health information related to my participation in the YMCA's Blood Pressure Self-Monitoring Program to my Primary Care Physician and/or other individuals referenced below. I understand that this authorization is voluntary and that I may refuse to sign this Authorization, and that I may revoke it at any time by submitting my revocation in writing to the YMCA.

The information that will be used or disclosed will consist of health-related information used to manage hypertension relevant to or arising out of my participation in the YMCA's Blood Pressure Self-Monitoring Program. It will be disclosed to the persons listed below at my request. I understand that I am not required to sign this form to participate in the YMCA's Blood Pressure Self-Monitoring Program and that the information disclosed pursuant to this authorization may be redisclosed by the persons listed below.

Primary Care Physician Practice: _____

Physician: _____

Address: _____

_____

Phone Number: _____

Fax: _____

Other Individuals[1]: _____

_____

This Authorization will expire upon termination of my participation in the YMCA's Blood Pressure Self-Monitoring Program

_____
Participant Name (Print)

_____ _____
Participant Signature Date

[1] If listing others (e.g. those that are part of a participant's care team), contact information should be the same as the primary care physician or noted if different.

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AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION BLOOD PRESSURE SELF-MONITORING

Please complete all sections, date, and sign.

Participant Name:	**Date of Birth:**
Address:	

I voluntarily authorize (*i.e.*, permit) the use and disclosure of my health information, which includes but is not limited to name, address, and the fact that I have a medical condition that qualifies me for a program set forth below.

This information is to be used or disclosed by:	**And is to be provided to:**
YMCA Name: Valparaiso Family YMCA ("YMCA")[1]	YMCA of the USA (Y-USA)
Address: 1201 Cumberland Crossing Drive	101 N. Wacker Drive
City/State/Zip: Valparaiso, IN 46383	Chicago, IL 60606

[1] The programs provided by the YMCAs are layperson led and are not directed by licensed health care providers. Although it is our position that the YMCAs are not subject to the Health Insurance Portability and Accountability Act, as they are not health care providers, this form, in an abundance of caution, is designed to comply with that law and its requirements.

Information to be used and disclosed:

Health information collected in connection with Blood Pressure Self-Monitoring

The purposes of the uses and disclosures include (check all that apply):

☐ To bill third-party payors, including commercial insurance plans and government programs, for services.

☒ Program administration, operation, and evaluation.

☐ To fulfill applicable grant reporting requirements. This may require the re-disclosure of health information to a third-party, including government entities (*e.g.*, the Centers for Disease Control and Prevention ("CDC") or the Centers for Medicare and Medicaid Services ("CMS")).

☐ For use by our vendors that provide services to us in connection with the operation of our programs.

☒ To transfer to REDCap Online Data Collection System for purposes of tracking and verifying health outcomes related to Blood Pressure Self-Monitoring.

☒ To share with participant's primary care physician.

☐ For use by Y-USA's vendors that provide services to us and/or the YMCA. For example, in billing third-party payors, such as health plans, for the services we provide to you, Y-USA may sub-contract with a third-party medical billing company to process claims on our behalf.

☒ For uses and disclosures authorized or required by law.

By signing this authorization:

- I authorize the use and disclosure of my health information as described above for the purposes indicated.
- I understand that I can revoke (*i.e.*, take back) this authorization at any time. The revocation must be made in writing to the YMCA's privacy officer or other YMCA staff member responsible for privacy, Valparaiso YMCA , and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that YMCA will not condition treatment, payment, enrollment or eligibility for benefits on my providing this authorization.
- I understand that YMCA may receive payment or compensation (generally in the form of grants) from Y-USA, and, in some cases, such grants may condition funds on the disclosure of health information to Y-USA.
- I understand that persons or entities that receive health information under this authorization may not be required by privacy laws (such as the federal law called HIPAA) to protect the information and may share it with others without my permission, if allowed by laws applicable to them. Except as explicitly stated in this authorization, Y-USA may not further disclose my health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- If this authorization has not been revoked, it will terminate five (5) years after your completion of your last program unless a shorter period is specified under state law.

Signature of Participant:	**Date:**
Signature of Personal Representative:	**Date:**
If signed by a personal representative, state relationship to participant (e.g., parent, guardian, etc.):	

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FOR SOCIAL RESPONSIBILITY

BLOOD PRESSURE SELF-MONITORING
Informed Consent

First Name: _____

Last Name: _____

Age: _____ Date of Birth: _____

Informed Consent

I hereby consent to voluntarily participate in the YMCA's Blood Pressure Self-Monitoring program. I understand that the purpose of the program is to develop the habit of routinely self-monitoring my blood pressure. The program includes support from a Healthy Heart Ambassador who will train me on proper technique for taking my own blood pressure readings, two consultations with a Healthy Heart Ambassador each month where my blood pressure will be taken, a monthly nutrition education seminar highlighting how food is related to blood pressure management, and monitoring and tracking my blood pressure at least two times per month.

I understand that I am responsible for monitoring my own condition and blood pressure throughout this program, and I am responsible for following-up with my primary care physician on questions about any specific medical needs that may be indicated by these blood pressure readings.

I understand that the YMCA does not practice medicine and is not a substitute for the care I receive from my physician or other qualified healthcare providers. My blood pressure readings will not be used by YMCA to make a diagnosis of any disease or illness.

I understand that the Healthy Heart Ambassador is not a qualified healthcare professional, does not practice medicine and the support and/or training provided by the Healthy Heart Ambassador is not a substitute for the care I receive from my physician or other qualified healthcare providers.

YMCA OF THE USA
101 N Wacker Drive, Chicago IL 60606
P 800 872 9622 F 312 977 9063 ymca.net

I understand that the Healthy Heart Ambassador may contact 911 emergency services if:

- I receive a blood pressure reading that is 180 or higher for systolic pressure (top number); or
- I receive a blood pressure reading that is 110 or higher for diastolic pressure (bottom number);

and, in addition to either/both these blood pressure readings:

- I am feeling/having: uncomfortable or weak; pain or pressure in my chest; a headache; changes in my vision; trouble speaking; not 100% normal.

I will be responsible for following-up my primary care provider for evaluation and treatment as necessary.

In the event that medical clearance must be obtained prior to my participation in the program, I agree to consult my physician and obtain written permission from my physician prior to the commencement of any program.

Also, in consideration for being allowed to participate in this program, I agree to assume the risk of such exercise, and further agree to hold harmless the YMCA, its employees and agents, from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result in my injury or death, accidental or otherwise, during or arising in any way from the program.

In signing this consent form, I affirm that I have read this form in its entirety and I understand the nature of the program. I also affirm that my questions regarding the program have been answered to my satisfaction.

_____

Signature of participant Date

_____

Contact in case of emergency Phone number