# APPENDIX I

# SAMPLE RECRUITMENT LETTER AND HIPAA AUTHORIZATION FORM

AUTO FILL NAME AND ADDRESS

Dear NAME:

*(Name of Long-Term Care Insurance~~The XYZ~~ Company)* is taking part in an important national study about ways to reduce falls in the home. The study is being sponsored by the U.S. Department of Health and Human Services~~ Services and being conducted by a research company called LifePlans, Inc~~. The goal of the study is to learn more about ~~what types of things would be most effective in reducing~~ways to reduce or prevent people from falling in their homes and injuring themselves. This letter explains the research study you are being asked to join. Please read it carefully and contact us at the number provided if you have any questions.~~ and preventing elders from falling in their homes. XYZ Insurance Company invites you~~

**Purpose of Research Study**

The purpose of the study is to learn more about ways to stop or reduce falls in the home among people over age 65. You will be asked about health, lifestyle, home environment and other things that could influence whether or not someone falls. The definition of falling for this study includes any slip, trip or fall where you land on the ground.

**What Participation Means**

If you agree to participate in this study, this is what will happen:

- Information about your use of long-term care and medical services will be collected from your long-term care insurance company and Medicare. This will happen for everyone who agrees to participate in this study.

- ~~Your participation may involve~~ one or more ~~of the following components:~~Some of you will get one telephone call from a professional, like a nurse, who will ask questions about your medical history and health. Not everyone who agrees to participate in this study will get this phone call.

- Some of you will get telephone calls from a professional every three months. During these calls, you will be asked about exercise, whether you have experienced any falls, and whether there have been any

changes in your medical status. These calls will take place every three months for two years. You will also be given an Exercise Progress Chart and a Fall Journal with instructions to help you keep track of these things. This may help you remember them during the phone calls. Not everyone who agrees to participate in this study will get this phone call.

- If chosen, some of you~~One short telephone call (15-20 minutes) to discuss your medical history and physical functioning~~ will receive a free visit in your home from a trained clinician who will ask you questions about your health, lifestyle and medical conditions. Not everyone who agrees to participate in this study will get this free visit.

- If chosen, some of you will get a free health promotion and fall prevention "toolkit" containing items designed to help you stay healthy and safe in your home. Not everyone who agrees to participate in this study will get this free toolkit.

- If you are chosen to receive a free visit in your home, the results of that visit and specific steps to help promote independence, strength, balance and health will be mailed to you and your doctor.

- Two years after the start of the study, some of you will receive another free visit in your home to see how your health, medical conditions, home environment and lifestyle have changed. Not everyone who agrees to participate in the study while get this free visit.

**Your Right to Privacy**

**This study is completely voluntary. You should read this entire letter and get answers to any questions before you sign and agree to be in the study. The information collected in the study ~~you provide~~ will be kept confidential and will only be shared with the people you indicate, the research team or as provided by law. The information collected for this study will not affect the status of your long-term care insurance policy or any claims you may file in the future under your long-term care insurance policy.**

**Benefits and Risks of the Study**

Some people who are in this study may learn new information about your health and home, as well as feel more independent. You may also learn about ways to make your home a safer place and help you prevent slipping, tripping or falling. By sharing your information and experience, you may also help others learn ways to prevent falls in the home and maintain their independence.

The survey may include some questions that make you uncomfortable. If there are questions that you do not want to answer, you do not have to answer them and you may stop the interview at any time. You may learn new information about your health that you did not know before the study. An exercise program may be recommended to you. Please consult your doctor before beginning any new exercise or activity.

**Disclaimer**

Your long-term care insurance company, the researchers and the study sponsors make no commitment to provide any medical or other services, or payment for medical or other services that result as part of your participation in this study. Any claims filed with your long-term care insurance company and/or Medicare will be your responsibility and must be processed through standard procedures. Being in this study in no way implies eligibility or payment for any medical or long-term care service that is rendered.

**Persons to Contact with Questions or Concerns**

If you have any questions about this study, you may call the researchers directly at 1-800-525-7279, xXXX. One of the researchers for this project will be able to answer any questions you have.

As a *(Name of Insurance Company)* ~~client of XYZ~~ policyholder, your participation ~~and opinions are~~ is very important to us and you can make an important contribution to the solution of a real problem -- falls. The results of the study will assist in addressing national concerns regarding fall prevention, long-term care and health care in general.

**If you agree to participate in this study please check the box and sign your name below. In addition to signing your name, please complete the ~~three~~ enclosed HIPAA (Health Insurance Portability and Accountability Act) Authorization form ~~and proxy identification form~~ and return both this letter and the HIPAA form in the enclosed postage paid envelope on or before MONTH, DAY, YEAR.**

If you decide not to be in the study, please check the correct box below and return this letter in the enclosed postage paid envelope.

☐ I would like to be in this important Fall Prevention study.

_____
Print Insured's Full Name

_____
Signature of Insured or Legally Authorized Representative

_____
Date

If insured is incapacitated or unable to sign for some other reason, a qualified guardian or power of attorney must sign and so designate themselves.

**In the event that I am unable to participate in the study or become unavailable to answer questions over the study period, please contact the following person:** (you must identify a contact person)

Name (first name, last name): _____

Relationship to insured: _____

Mailing Address: _____

_____

(Please provide address, city, state and zip code)

Telephone number(s): daytime: _____

evening: _____

☐ I do not wish to participate in this important Fall Prevention study.

This authorization is valid for a period of five years, unless revoked in writing. I understand that I have a right to request a copy of this authorization and that one will be sent to me if requested. A photocopy of this authorization shall be as valid as the original.

**Health Insurance Portability and Accountability Act (HIPAA) Compliant Authorization**

Insured Name: _____ Date of Birth: _____

***This authorization is intended to comply with HIPPA.*** HIPPA stands for the Health Insurance Portability and Accountability Act of 1996, as amended. This act requires that written permission must be obtained from a person in order to share, request or provide personal health information.

I hereby authorize the following uses and disclosures of health information about me.

1. The health information that I am authorizing to be used or disclosed consists of all of the following information:

   My medical records and medical history and other information that relates to:

   - The diagnosis of any physical or mental condition,
   - The treatment or prognosis of any physical or mental condition, whether such treatment is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as AIDS, or sexually transmitted diseases.
   - Health and Medical history. This includes medication history, falls history, daily activity level and service use for assistance with personal care.
   - The filing and paying of both long-term care and acute care claims for services provided to me, whether such filing or paying is in electronic or paper form.

2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic or medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including *Name of Insurance Company*); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB) or any other organization, institution, or person having health information about me.

3. Health information about me may be disclosed to *Name of Insurance Company* and its affiliates, service providers, reinsurers, agents, and representatives, to potential resources in my community and to any consumer reporting agency such as the MIB.

4. Health information about me may be used or disclosed for the purposes of research. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory, and law enforcement entities.

5. *Name of Insurance Company* and its affiliates, including LifePlans, Inc., is authorized to disclose health information about me to the physician(s) I name below (please list your primary care physician and/or any other doctor you see regularly).

   Print Name:_____ Phone

   No.:_____

   Print Name:_____ Phone

No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

**HIPAA Compliant Authorization (continued)**

6. *Name of Insurance Company* is authorized to disclose health information about me to LifePlans, Inc. and Abt Associates for the purposes of Fall Prevention research. *Name of Insurance Company* and its affiliates are also authorized to disclose health information about me to the individuals designated below. (You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want *Name of Insurance Company* or it's designees to discuss your health information.)

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

Print Name:_____ Phone No.:_____

7. I understand that:

- My health information may be re-disclosed and no longer protected by HIPPA if the person receiving my health information is not required to comply with HIPPA. HIPPA only regulates certain types of entities, such as insurers and health care providers.
- A copy of this Authorization is as valid as the original.
- I will receive a copy of this Authorization.
- This Authorization expires when coverage under my long-term care insurance policy terminates.

_____
Participant's Signature (or Power of Attorney)

_____
Printed Name

_____

Date