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Disability Advisor

Dear Member,

Thank you for initiating our Disability Advisor Services, an independent, voluntary, free and confidential health benefit to help you obtain the appropriate resources, support and guidance while you are on Short Term Disability. HumanaCare is completely independent from your insurance provider and employer and does not share information with them unless directed by you.

The Disability Advisor service provides navigational support, assistance with filling out claims forms, engaging supportive resources and general assistance to help you better understand and work towards improving your situation.

You are your best advocate, and we need your help to make this process work.

To get started, please complete the following steps:

1. Fill out the enclosed two-step Acknowledgment and Release of Personal Health Information forms.
2. Return the signed and completed forms to HumanaCare using one of these three options:
    - FAX: 905-477-1956/ 1-877-477-1956
    - EMAIL: disabilityadvisor@humanacare.com
    - Overnight Courier: use the enclosed return label provided for your convenience.
3. Once HumanaCare receives your Acknowledgement and Release of Personal Health Information forms, we will start assisting you, beginning first with a more detailed intake assessment (by phone).

We are looking forward to working with you. Please contact us with any questions.

Sincerely yours,

Johanne Gariepy, RN
HumanaCare
Care Specialist
1-800-661-8193 x261
jgariepy@humanacare.com

FREQUENTLY ASKED QUESTIONS

What is HumanaCare's Disability Advisor Service?
Employees facing a disability situation have support that is uniquely designed for them. The service provides navigational support, assistance with filling out claims forms, engaging supportive resources and general assistance to help better understand and work towards a resolution of disability.

Who is HumanaCare? Do they work for the disability support provider?
HumanaCare is a Canadian company with almost three decades of experience. They are completely independent from your insurance provider and do not share information with them unless you direct them to.

Why is my company offering this service?
Your benefits provider, the Alberta Municipal Services Corporation (auma.ca) is providing this new service as part of the organization's commitment to ensure they address the needs of employees. By providing assistance to employees going through a disability challenge, they hope to improve the quality of service and support you receive.

Do I have to use this program? Do I need to pay for it?
No. Participation is completely voluntary and there is no cost to you.

Should I be concerned about the privacy of my personal and health information?
HumanaCare follows legislated privacy processes and protocols. Your information is always kept secure and never shared without your permission.

Who is eligible to use the service?
Individuals who have made, or are in the process of making a claim as part of their short-term disability process are eligible to receive services.

How does the process work?
The Disability Advisor will contact you at the appropriate time; explain the services, their role and other important information. It is your decision whether you feel you need their support, but if so, they will be available to help you better manage through the process. It is important to remember that they are on your side, and there to support you. This may include getting you connected with other programs and supports available to you, always based on your permission. The Disability Advisor will conduct an interview over the phone and in most cases will provide you with a consent form so that the Disability Advisor may gather information on your behalf.

How often will I speak to the Disability Advisor?
Each situation is unique. In most cases, the Disability Advisor will be in contact with you at least weekly over a number of weeks, but sometimes it can be more frequent. Again, they are there to support you in whatever way is appropriate, to get you the help and assistance you need.

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ACKNOWLEDGMENT

Please read carefully and sign at the bottom.

I wish to use the Disability Advisor services (the "Services") of HumanaCare Organizational Resource Services Inc., and its affiliates ("HumanaCare"). In order to do so, I acknowledge and agree to the following:

Relationship with HumanaCare: I understand that HumanaCare only provides medical and disability information and not medical care, diagnosis or treatment. I further understand that the use of the Services is not a condition of my insurance coverage, and that my decision to use the services and the information provided by HumanaCare does not affect my coverage or care. I understand that HumanaCare may disclose the fact of my use of the Services with the entity that has paid for my use of the Services, which may be my, employer or other entity. I understand that HumanaCare also arranges for consultations with specialists and other health professionals, and the selection of a particular medical provider or health professional does not constitute an endorsement by HumanaCare of that practitioner's credentials to practice their respective profession. I understand and agree that HumanaCare shall disclose my medical information to third party medical professionals in connection with the provision of the Services. Moreover, I understand and agree that any relationship resulting between me and any physician or medical professional who I may have been or may be referred to by HumanaCare is independent of my relationship with HumanaCare.

Disclosure to Treating Physician, Family Members or Others. I authorize HumanaCare to disclose any information it may possess or obtain relating to my medical condition to the following people, in addition to myself, for purposes of coordinating services to be provided to me by HumanaCare.

Name	Relationship	Contact Information

I HAVE READ AND UNDERSTAND THE TERMS OF THIS ACKNOWLEDGEMENT AND I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE SERVICES TO BE PROVIDED BY HUMANACARE. BY MY SIGNATURE BELOW, I HEREBY, KNOWINGLY AND VOLUNTARILY ACKNOWLEDGE AND AGREE TO THE FOREGOING REGARDING THE SERVICES AND THE MANNER IN WHICH THEY MAY BE PROVIDED BY HUMANACARE. IN ADDITION, PLEASE FIND BELOW MY EMAIL ADDRESS THAT I REGULARLY USE TO RECEIVE AND SEND EMAIL MESSAGES. HUMANACARE HEREBY HAS MY AUTHORITY (I) TO DELIVER ANY CORRESPONDENCE ADDRESSED TO ME TO THIS EMAIL ADDRESS IN LIEU OF SENDING IT IN PAPER FORM TO MY ADDRESS OF RECORD; AND (II) TO RECOGNIZE ANY CORRESPONDENCE FROM THIS EMAIL AS DIRECTIONS AND AUTHORIZATIONS BEING DELIVERED BY ME OR UPON MY SPECIFIC AUTHORITY AND HUMANACARE MAY ACCEPT ANY SUCH EMAIL CORRESPONDENCE AS IF IT WERE INSTEAD A WRITING DULY EXECUTED BY ME IN PERSON TO THE FULLEST EXTENT AUTHORIZED BY LAW.

Signature of Employee _____ Date: dd/mm/yyyy

Name of Employee (Please Print) _____

Email Address of Employee (Please Print) _____

Signature of Parent/Guardian/Substitute Decision Maker _____ Date: dd/mm/yyyy

Description of Authority _____

Name of Parent/Guardian/Substitute Decision Maker (Please Print) _____

RELEASE OF PERSONAL HEALTH INFORMATION

Patient's Name: _____

Date of Birth: _____
(dd/mm/yyyy)

Provincial Health Card #: _____

Phone Number: _____

To Whom It May Concern:

I have read and understand the information above and authorize the disclosure of my Personal Health Information to HumanaCare and authorize HumanaCare to collect from any of my health care providers, institutions, insurers, or employers ("Provider") listed on the last page of this release all Personal Health Information that HumanaCare deems necessary for the purpose of providing the Services to me, including, but not limited to, my complete medical records, as may be limited by my specific instructions below. The purpose of disclosures made pursuant to this Release is to enable HumanaCare to collect, review and coordinate information regarding my medical and disability care.

In the performance of the Service on my behalf, HumanaCare may provide my Personal Health Information to Service Professionals who participate in the review and analysis of my medical information. These third parties shall be bound by terms of confidentiality pursuant to agreements with HumanaCare, even though they are not parties to this release and may be subject to different obligations under federal, provincial and/or territorial laws governing the use and disclosure of my Personal Health Information. I understand that once the Provider(s) disclose(s) my Personal Health Information to HumanaCare, the Provider(s) can no longer guarantee the confidentiality of the information delivered since it is no longer under such Provider's control.

A photocopy of this release is to be considered as valid as the original.

I understand that I may refuse to sign, or may revoke (at any time), this Release for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my Provider(s); except, however, if my treatment at any of the Provider(s) is for the sole purpose of creating Personal Health Information for disclosure to HumanaCare, in which case such Provider(s) may refuse to treat me if I do not sign this Release.

TERM: This Release will remain in effect:

From the date of this authorization until the _____ day of _____, 200____.

Until HumanaCare has completed the Services on my behalf.

Other: _____.

Please send the information HumanaCare requests to the following address or to such other address as HumanaCare may indicate:

HumanaCare
Disability Advisor Services Department
7030 Woodbine Avenue, Suite 102
Markham, Ontario L3R 6G2
Toll-Free: **1-800-661-8193** Fax: **1-877-477-1956**
Email: disabilityadvisor@humanacare.com

Please initial and date below to indicate you have read the above paragraphs.

Initialed:_____ Date:_____

Should you, the health institution, require additional information, please contact HumanaCare at **1-800-661-8193 x261:**

Signature of Employee	Date: dd/mm/yyyy
Name of Employee (Please Print)	
Email Address of Employee (Please Print)	
Signature of Parent/Guardian/Substitute Decision Maker	Date: dd/mm/yyyy
Description of Authority	
Name of Parent/Guardian/Substitute Decision Maker (Please Print)	

PERSONAL HEALTH INFORMATION:

I hereby authorize, and request, the Provider(s) as listed on the last page of this Release to disclose the following confidential personal health information listed below to HumanaCare and its selected Service Professionals:

☐ **General Medical Record,**

Check General Medical Records if you want all of the following items provided or, instead, only check the individual materials you want provided.

- □ **Test Results**
- □ **Medication history**
- □ **X-Ray reports**
- □ **Office/consultation notes**
- □ **Immunization History**
- □ **Other** _____

Signature of Employee	Date: mm/dd/yyyy

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RELEASE OF PERSONAL HEALTH INFORMATION

Please list the health care providers, institutions, insurers, or employers that are treating you or that have any of your Personal Health Information:

Dr: _____ Specialty: _____

Facility/Hospital: _____

Phone: _____

Dr: _____ Specialty: _____

Facility/Hospital: _____

Phone: _____

Dr: _____ Specialty: _____

Facility/Hospital: _____

Phone: _____

Dr: _____ Specialty: _____

Facility/Hospital: _____

Phone: _____

Dr: _____ Specialty: _____

Facility/Hospital: _____

Phone: _____

Dr: _____ Specialty: _____

Facility/Hospital: _____

Phone: _____

Dr: _____ Specialty: _____

Facility/Hospital: _____

Phone: _____

Please initial and date below to indicate you have read the above paragraphs.

Initialed: _____ Date: _____