Taking Control of Your Health

City of Chicago Enrollment Form

(Must be enrolled in PPO Group #P16628, P16642 or P16643)

Please complete the following information. Once this enrollment form and the consent form have been received, you will be assigned a pharmacist coach who will contact you to set up your first session. This may take from 2-3 weeks. If you have questions, you can contact Margaret Rehayem, TCYH Program Manager at 1-888-944-9090 or via email at mrehayem@mbgh.org

Full Name: _____
(please print all information)

Street Address: _____

City, State, Zip: _____

Primary Contact Number: _____ (work, home, cell) Can we leave a message? ____ yes _____ no

Secondary Contact Number: _____ (work, home, cell) Can we leave a message? ____ yes _____ no

Primary E-mail Address: _____

Physician's Name: _____ **Physician's Phone Number:** _____

Physician's Address: _____

Date of Birth (MM/DD/YYYY): _____ **Gender:** [ ] Female [ ] Male

In order to match you with an appropriate pharmacist, please provide the following information:

Primary Language: _____

Ethnicity: [ ] African American [ ] Asian [ ] Caucasian [ ] Hispanic
[ ] Native American [ ] Pacific Islander [ ] Other

Highest Grade Completed: [ ] 8th Grade or Less [ ] Some High School [ ] High School Graduate
[ ] Some College [ ] College Graduate [ ] Post-Graduate

Are you currently participating in another Disease Management Program or other Diabetes Education Program?
[ ] NO [ ] YES - If yes, provide your Contact's name and phone number:

_____

What is your relationship to City of Chicago employee (check one): [ ] Self [ ] Spouse [ ] Dependent

If you check "Spouse" or "Dependent", list employee's name here: _____

Where would you prefer that your meetings with the Pharmacist Coach occur?

[ ] near workplace - list zip code of workplace _____ [ ] near my home - list zip code of home _____

[ ] Other: (Location: _____ Zip Code: _____)

Do you work shifts? [ ] No [ ] Yes - If yes, provide which shift and shift hours: _____

Blue Cross Identification #: _____ **Blue Cross Group #:**_____

(See Reverse Side)

CONSENT FORM

I am voluntarily participating in the *Taking Control of Your Health* program, a health management program sponsored by my employer, City of Chicago. My participation will require that I regularly meet with a personal pharmacist coach. I understand that failure to appear for two sessions in a rolling 12-month period will result in termination from the program*. I understand that my co-pays will be reduced or waived for diabetic medication and supplies provided I have first seen my pharmacist coach*. I understand my pharmacist coach will obtain certain medical/health information about my condition from an initial assessment form, from my physician, and/or other members of my health care team.

By signing this form, I am giving my consent to have information about my condition released to the pharmacist coach, *the Taking Control of Your Health* IPhA Pharmacist Network Coordinator, and its consultants and/or other health care providers participating in my care through my health plan. This information is to be used specifically and confidentially for my care (treatment, payment and operations).

Further, I give my consent that appropriately blinded data as to my identity and condition/ treatment may be aggregated with similarly blinded data from other participants enrolled in the same program for outcomes reporting, analysis and educational purposes.

I understand that I am required to sign this Authorization as a condition of my participation in the Program. I understand that participation in the program is voluntary and not a condition of employment. I also understand that I may revoke this consent at any time upon giving written notice to Margaret Rehayem at the Midwest Business Group on Health, 35 E Wacker Drive, Suite 1500, Chicago, IL 60601 or via fax at 312-372-9091 (Should you like to discuss with Margaret, you can reach her at 1-888-944-9090). I understand and agree that actions taken by any party related to the conduct of the *Taking Control of Your Health* program during the period that relied upon my consent would stand. I also understand that if this consent is not revoked it will continue for the duration that I am enrolled in the program and expire automatically should I discontinue my participation in the program.

Date: _____Participant Signature: _____

If additional consent is required (for dependents under age 18), have the authorized person sign below.

_____ _____

Signature **Printed Name**

_____

Relationship to Participant

PLEASE RETURN SIGNED FORM TO: Margaret Rehayem via FAX at 312-372-9091, E-MAIL mrehayem@mbgh.org or MAIL to Midwest Business Group on Health, 35 E Wacker Drive, Suite 1500, Chicago, IL 60601

TO BE COMPLETED BY THE TCYH PROGRAM COORDINATOR:

Participant BCBS ID#: _____ Participant Consent Date: _____

Participant Enrollment/Effective Date: _____ Initial Coach Appointment Date/Time: _____

Date of Participant Withdrawal from Program: _____

Reason for Withdrawal: _____