Administrative Address
985 Livingston Avenue
North Brunswick, NJ 08902
732.737.8279 – Phone and Fax
www.campjaycee.org

Campsite Address
223 Ziegler Road
Effort, PA 18330
570.629.3291 – 570.620.9861 Fax
info@campjaycee.org

Camp Jaycee and Genoa Pharmacy

The intention of the partnership with Genoa Pharmacy and Camp Jaycee is to enhance our safety measures for camper and staff alike on camp. In addition to providing accountability and security of camper medication administration, it will also allow our families a more efficient check in on arrival to Camp Jaycee. Please see the benefits of working with Genoa below.

Priority Check In

We offer priority check in for campers who would like to have prescriptions fulfilled with our partner pharmacy Genoa Healthcare. This option will significantly reduce your wait time at check in. Genoa will fill, package, and deliver to the camp infirmary prior the campers arrival. NOTE: If the camper takes any routine over the counter medications, birth control, supplements, lotions, drops or ointments a signed prescription or doctors note is required to be sent in with the camper's physical 6 weeks before arrival. **Genoa cannot fill these prescriptions.**

Please read the instruction thoroughly to begin the process and send all paperwork outlined to medical@campjaycee.org when it is ALL complete, at least 6 weeks prior to camper arrival at camp.

Genoa Paperwork

1) Genoa Enrollment Form (Page 2)
2) Responsible Party for Payment Form (Page 3)
3) Non-Child restraint contacts acknowledgement form (Page 4)
4) Acknowledgment of receipt of Genoa Healthcare Notice of Privacy Practices (Page 4)

Camper Paperwork (Page 5)

1) Family Contact
2) Current Pharmacy - name, location, and phone number
3) Current medication (completed during registration if accurate medications) list including:
    a. Campers Name
    b. Medication
    c. Time of administration
    d. Dosage
4) List of Over-the-Counter medication (OTC)
    a. Name of medication
    b. Time
    c. Dose
5) Current, new, never been used prescriptions for Genoa Pharmacy
6) Photocopy or scan of primary and secondary Pharmacy Insurance card (front & back)

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Camp Jaycee and Genoa Pharmacy Information

All campers who enroll in the Genoa Pharmacy program must complete this form. Participating in our partnership will provide a safer, smoother medication administration while staying with us, it will also significantly reduce your wait time at check in.

Camper Information	
Camper Last Name	Camper First Name
Family Contact Last Name	Family Contact First Name
Contact Phone Number (Primary)	Contact Phone Number (Secondary)

Camper Enrollment			
Session 1	Session 2	Session 3	Session 4
□ **Week** 1: June 26 – July 2 □ **Week** 2: July 3 – July 9	□ **Week** 3: July 10 – July 16 □ **Week** 4: July 17 – July 23	□ **Week** 5: July 24 - July 30 □ **Week** 6: July 31 – Aug 6	□ **Week** 7: Aug 7 - Aug 13 □ **Week** 8: Aug 14 – Aug 20
Does your camper attend another camp program? (ex. Camp Merry Heart) YES or NO			

Doctor and Pharmacy Information		
Camper's Doctor:		
Camper's Pharmacy	Pharmacy Location	Pharmacy Phone Number

Camper Medication
Please provide medication name and dose at appropriate time.
Please attach all prescriptions.
A list of medications/orders from your doctor are appropriate.
Please include all Over the Counter medications.

Medication Name	Morning	Lunch	Afternoon	Dinner	Evening

Please attached a copy of the front and back of the campers (primary and secondary) prescription insurance card.

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Consumer Enrollment Form

Section 1. Consumer Information

Consumer Name *Last* *First* *M.I.* Preferred Name:

Social Sec. # Date of Birth Sex: M / F Preferred Prounouns:

Mailing Address

Street *City* *State* *Zip*

Shipping Address

Street *City* *State* *Zip*

Email Address Phone

Section 2. Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Genoa Healthcare, LLC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our *Notice of Privacy Practice* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at http://www.genoahealthcare.com or contacting Genoa at 1-888-GENOARX (1-888-436-6279).

I acknowledge receipt of the Notice of Privacy Practices of Genoa Healthcare, LLC.

Name (printed): Signature: Date:

For Genoa Healthcare® Employee Use Only: Inability to Obtain Acknowledgement

Please document your efforts to obtain acknowledgment and the reason it was not obtained.

□ Notice of Privacy Practices given – Consumer unable to sign

□ Notice of Privacy Practices given – Consumer declined to sign

□ Notice of Privacy Practices and Acknowledgment mailed to consumer:

- ○ Date 1st attempt:
- ○ Date 2nd attempt:

Other reason consumer did not sign:

Employee Name Date

Employee Signature Site Location

Section 3. Brief Medical History

Diagnosis/Medical Conditions, please describe:

Medication Allergies: Y / N If yes, please describe:

Current Medications:

Current Pharmacy:

Section 4. Prescription Packaging

Packaging Preference: Vial - Child Resistant: ☐ 30-Day Card: ✔ Dispill: ✔

Other:

By providing my telephone number to Genoa Healthcare on this Consumer Enrollment Form, I agree to receive automated calls, prerecorded messages, and/or text messages related to my health care from Genoa Healthcare and its affiliates. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. By providing my e-mail address on this form, I agree to receive e-mail messages from Genoa Healthcare and its affiliates. To stop receiving e-mails at any time, I may click “unsubscribe” at the bottom of the e-mail. Genoa Healthcare may send my PHI to me, by text message or email, in an unencrypted manner. I acknowledge and accept that communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

*Certain restrictions apply on certain medications, please consult with the Pharmacist to see if you qualify.

**Genoa Healthcare will not share any information obtained and will not use it for any other purpose but for the Refill Reminder Program.

I understand and acknowledge that I am personally responsible for the charges at this site and that Genoa Healthcare will bill my insurance as a courtesy. In the event of non-payment, I understand that I will be responsible for any outstanding balance.

Consumer/Responsible Party Signature Date

Acknowledgment of receipt of Genoa Healthcare notice of privacy practices

By signing this document, I state that I have received a copy of the notice of privacy practices.

Name (print):

_____

Member ID # (optional):

_____

Member street address:

_____

Member City, ST, ZIP:

_____

Signature:

_____

Date:_____

Have you remembered to:

- Keep the notice of privacy practices brochure for your records?
- Sign and date this acknowledgment of receipt?

Mail in your acknowledgement of receipt:
You can return this acknowledgment of receipt to the following address for our records:

Genoa Healthcare
PO Box 9040
Carlsbad, CA 92018-9040

genoa healthcare

Responsible Party for Payment Form (RPF) – Payee

Completed Forms should be mailed to the Corporate Address for Genoa Healthcare at:
Genoa Healthcare • 18300 Cascade Ave S., Suite 251 • Tukwila, WA 98188

Date: _____

Client Name: _____ Acct #: _____ Facility #: _____

Responsible Party (Print Name):_____

Will pay for the following medications: _____

_____

From: _____ To: _____

Responsible Party Address:

_____

Street *City* *State* *Zip*

Phone Number: Home: _____ Work: _____

Payment Option: (Check One)

☐ Cash/Check/Money Order at Pharmacy Location: _____
(Pharmacy Name)

☐ Mail – Checks/Money Order should be made out to Genoa Healthcare and mailed to:
Genoa Healthcare • PO Box 77030 • Minneapolis, MN 55480-7730

☐ Credit Card – Please complete the Credit Card on File Authorization Form *(GENOA- CCARD AUTH 7.13)*

I have submitted the information above truthfully and I understand I am responsible for the costs of medications or supplies; which may include charges that are not covered by insurance. I also understand that Genoa Healthcare has the right to discontinue medication if I become delinquent in paying all balances owing.

The Responsible Party signature below confirms that the Responsible Party is taking responsibility for reimbursement to Genoa Healthcare for the charges incurred by the client listed above.

Responsible Party Signature: _____ Date: _____

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healthcare

Dear Genoa Healthcare Client _____:

State and Federal regulations require that we have a signed statement on file from you declining the use of child resistant containers for your prescription medications (this includes bubble packaging).

Please sign and date this statement and return it to Genoa Healthcare at your earliest convenience.

We appreciate your cooperation in this matter. If you have any questions or concerns, please do not hesitate to contact us.

Sincerely,

_____
Genoa Healthcare Pharmacist

"I do <u>not</u> want my medications dispensed in child resistant containers."

_____ _____
Signature Date

GENOA HEALTHCARE LLC
25 East Salem Street
Hackensack, NJ 07601
(201)546-5839