SPRING 2023

the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

GET YOUR BLOOD PRESSURE IN CHECK!

WITH THE YMCA'S BLOOD PRESSURE SELF-MONITORING PROGRAM

Program Basics:

This evidence-based program will focus on bi-weekly blood pressure measurement screenings, virtual nutritional seminars, as well as monthly group check-ins where we will discuss the progress we've made.

Participation is FREE and encouraged! We will distribute prizes to those who actively participate. Anyone looking for guidance managing their blood pressure is welcome to join.

1 in 3 American adults have high blood pressure

Take action now to improve your heart health!

Goals of the program include:

- Reduction in blood pressure
- Better blood pressure management
- Increased awareness of triggers that elevate blood pressure
- Greater knowledge of nutrition basics
- Healthier eating habits

INTERESTED?

Call us at (732) 257-4114 or complete an Enrollment Form available at the front desk and fitness center.

Raritan Valley YMCA
144 Tices Ln, East Brunswick, NJ 08816
www.raritanvalleyymca.org

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:	$

FOR YOUTH DEVELOPMENT®
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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: _____ ("YMCA")[1]	YMCA of the USA (Y-USA)
Address: _____	101 N. Wacker Drive
City/State/Zip: _____	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, _____ [INSERT NAME], 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.):	

the YMCA

Name: ______________________
Program Site: ______________________

BLOOD PRESSURE SELF-MONITORING LOG

Date / Time	Systolic BP	Diastolic BP	Arm	Hours of Physical Activity *(Weekly Total)*	Review Educational Materials *(Mark if Completed)*
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)
			☐ Right ☐ Left		☐ Review Guide ☐ Nutrition Ed. Video(s)