

2020 KEHP Biometric Screening Form



Instructions:

- 1. Complete all participant information, including email, and sign the form.
2. Visit your health care provider for a biometric screening and take this form.
3. This form is intended to be used at your wellness exam with your provider, pharmacy locations, and Premise Health onsite clinics.
4. To qualify for the LivingWell Promise ask your provider to complete the Biometric Screening Information section using results obtained between 1/1/2020 and 7/1/2020 and sign the form.
5. Submit form once, using one method listed below. Forms must be RECEIVED by 7/15/2020 to qualify for the LivingWell Promise.
Forms received after 7/15 will qualify for incentive points.
a. Securely upload online at https://totalwellnesshealth.com/gravity-landing/KEHP/ (preferred method).
b. Fax securely to 402-939-0604.
c. Mail to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. Forms must be received by 7/15/2020 to qualify for the LivingWell Promise. Please allow time for mailing.
6. Within 48 hours of form submission, a confirmation email will be sent to the email listed below. If a confirmation email is not received within 48 hours, please resubmit your form.
7. Please allow 10 business days for the information to be available on the portal.

PARTICIPANT INFORMATION

First Name: [grid] Last Name: [grid]
Date of Birth: (mm/dd/yyyy) [grid] Unique ID (last 4 of SSN): [grid]
Email: (Required to provide confirmation of form receipt.) [grid]
Gender: [radio] Male [radio] Female
Have you fasted for at least 8 hours? (No food. Only water permitted.) [radio] Yes [radio] No
Are you pregnant? (Females Only) [radio] Yes [radio] No

BIOMETRIC SCREENING INFORMATION

Date of Screening: (mm/dd/yyyy) [grid] Height: [grid] Weight: [grid] Waist: [grid] BMI: [grid]
Glucose: [grid] Total Cholesterol: [grid] HDL: [grid] LDL: [grid] Triglycerides: [grid] Blood Pressure: [grid] / [grid]
Systolic Diastolic

Clinician Printed Name: _____ Clinician Phone Number: _____
Clinician Signature: _____

CONSENT

Disclosure of Information. I understand that the information submitted on this form (my "Personal Information") will be transferred to StayWell by TotalWellness. My Personal Information is used by StayWell to provide wellness program services to me, which includes using the Personal Information to inform me of relevant health related and health education programs offered by StayWell or by another service contractor. In the event that StayWell's services are transitioned to another service provider, StayWell may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives, StayWell may provide my name/unique ID to KEHP to notify them of the fact that I am eligible for the incentive. In addition to any Personal Information disclosed as set forth above, aggregate, de-identified survey results may be made available to KEHP for program administration purposes. StayWell may also use my Personal Information as part of group statistical research and analysis, in a manner that does not identify me. I also understand that my Personal Information may be incorporated into my Health Assessment results by StayWell. Except for these types of usage and the uses specified in my StayWell Online terms of use, my Personal Information will not be disclosed by StayWell. StayWell understands that Personal Information may be considered protected health information that is subject to the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). StayWell will comply with the HIPAA to the extent applicable.

GINA Notice and Authorization. This Screening is part of the Kentucky Employees' Health Plan (KEHP) wellness program, which is a voluntary wellness program administered according to federal rules, including the Genetic Information Nondiscrimination Act ("GINA"). The results of this Screening may be considered GINA Protected Information. GINA requires that you receive this GINA Notice and Authorization prior to undergoing the Screening. This GINA Protected Information is used to help you understand your potential health risks and to offer you other wellness program services. The KEHP's wellness program safeguards GINA protected information and will not disclose any GINA Protected Information, except as permitted by GINA and other applicable law. Your GINA Protected Information will be disclosed to you and to vendors of the KEHP wellness program, for purposes of providing you with wellness services. Your GINA Protected Information will not be sold, exchanged or transferred, except to the extent required by law to carry out activities related to the KEHP's wellness program. You will not be asked to waive the confidentiality of this information as a condition of participating in the KEHP or as a condition of receiving any incentive. Your GINA Protected Information will only be disclosed to the KEHP in aggregate terms that do not disclose your specific identity.

Certification: I certify that the information supplied on this form is accurate and has been provided by me by my health care provider.

Participant Printed Name: _____ Date: _____
Participant Signature: _____

Submit form using one of the following methods:
Securely upload online at https://totalwellnesshealth.com/gravity-landing/KEHP/
Fax to: 402-939-0604 | Mail to: TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127