NCATP
North Carolina Assistive Technology Program

NCATP New Referral Packet

Packet must include:

- ☐ **- School Information Form** - 1 Page (if applicable)
- ☐ **- Referral Form** - 3 Pages
- ☐ **- Accessibility Form** - 1 Page (if applicable)
- ☐ **- Supporting Documentation**
- ☐ **- Payment Authorization, Purchase Order, or Promissory Letter**
- ☐ **- *NCATP Client Consent Documents** - 5 Pages

Email, Fax, or Mail Completed Packets To:
North Carolina Assistive Technology Program
Attn: Intake Coordinator
2804 Mail Service Center Raleigh, NC 27699-2804
ATIntake@dhhs.nc.gov
Phone: 919-368-5417 Fax: 984-687-9597

Our Intake Coordinator will contact the referral source to confirm receipt of the referral packet and will notify the source when the referral has been assigned to an Assistive Technologist or SLP.

ALL 3 NCATP Client Consent Documents MUST be signed and returned before the referral can be processed. Please choose your preferred method below:

☐ **Physically Signed & emailed to NCATP Intake Coordinator -** The referral person will provide hard copies of all 3 NCATP Client Consent Documents to the client or guardian for signature, and the referral person will then email the signed documents to the NCATP Intake Coordinator.

☐ **Signed electronically via DocuSign by the client or the parent/guardian (DocuSign automatically sends copies to the NCATP Intake Coordinator) -** NCATP will send all 3 NCATP Client Consent Documents via DocuSign for electronic signature to the client or parent/guardian at the following valid email address:

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School Information Form

If NOT submitting a school referral, SKIP to the next page

Student Name:	Classroom Type: Self Contained
School Name:	School Type: Public
School Address:	
City, State, Zip Code:	
School Contact Person Name:	Title: Other
Email:	Phone:
Is this student file pending a mediation agreement or in active litigation?	Unknown
Has this student previously received a screener or assessment for AT?	Unknown
Has this student previously received a screener or assessment for AAC?	Unknown

All NCATP staff, including AT and AAC Consultants, are State of North Carolina employees and are, therefore,covered under the North Carolina Torts Claims Act. A Certificate of Coverage is available upon request.

☐ I do NOT need a Certificate of Coverage ☐ I DO need a Certificate of Coverage

The Organization's name and address to be added on the Certificate of Coverage is:

My School System does NOT require a contract to fund professional services provided by NCATP.

☐ TRUE, and I understand my School System must provide a promissory letter on letterhead OR a Purchase Order with instructions on how, where, and whom to submit the invoice for payment.

☐ FALSE, my School System DOES require a contract. I understand that contracts require a review period by NCDHHS Legal Department and I will send my organization's contract to: ATIntake@dhhs.nc.gov

☐ I agree and understand NCATP will only bill for services AFTER the service has been provided and the written report is complete. NCATP will NOT bill monthly, but will provide one final invoice by the end of school year.

☐ I understand that AT/AAC assessments require multiple appointments over several months' time for background interviews, classroom observations, device trials, and writing the report. Due to this, in order for my referral to be considered "COMPLETE" and assigned to a NCATP Consultant, all documents to include a finalized contract, if applicable **MUST BE RECEIVED BY MARCH 1ST. Any school referral sent to NCATP after this date will be returned and a new referral will need to be submitted at the beginning of the next school year.**

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Date:

NCATP Referral Form

Consumer Name:		
Address:		
City, State, Zip:		County:
Cell Phone		Home Phone #:
Email:		
Educational Level:		
DOB:	Age:	Gender:
Parent/Guardian name if applicable:		
Guardian Email Address:		

Health Conditions (Check all that apply)

☐ Aging	☐ Cerebral Palsy	☐ Intellectual Disability	☐ Spinal Cord Injury
☐ Amputation	☐ CVA/Stroke	☐ Learning Disability	☐ Traumatic Brain Injury
☐ At Risk	☐ Deaf	☐ Mental Illness	☐ Visual Impairment
☐ Autoimmune	☐ Deaf-Blind	☐ Neurological Disease	☐ Other
☐ Autism	☐ Developmental Delay	☐ Orthopedic Disorder	☐ Other
☐ Blind	☐ Hard of Hearing	☐ Repetitive Stress Injury	☐ Other
Primary Diagnosis:		**Does the individual need an interpreter?**	

Other Services (Mark all that apply)

Types of Services	Source (Agency/Therapist/Contact) / Frequency
☐ Occupational Therapy	
☐ Speech Therapy	
☐ Physical Therapy	
☐ Psychological Services	
☐ EIPD	
☐ ABA	
☐ Other	

Does the individual use any special tools, devices, supports, etc.? List previous AT Experience **(Please bring all currently used assistive devices to the appointment.

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Location of Service: Pick One	*If services will be completed anywhere other than at an AT Center, please complete the attached Accessibility form*
Virtual Meeting Platform if Applicable: Pick One	
Type of Service Requested: Pick One	
Type of Category Requested: Pick One or More	
Employment Status: Pick One	
Specific Needs if Any:	
Reason for Referral and other Pertinent Information:	
Person Making the Referral: (The final report will be submitted to the referring party/agency and this person will be contacted if we have any questions)	
Contact Person:	
Organization Type:	
Organization Name:	
Address:	
City, State, Zip:	
Phone:	**Fax:**
Email :	
If different from the referring person, please provide the name, phone, and email of the individual who works directly with the consumer:	

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Please submit the following along with this referral form if applicable:

- Current **pertinent** medical records
- Current IEP/504
- Job Description and/or Description of Training
- Speech & Language Assessment
- Occupational Therapy Assessment
- Physical Therapy Assessment
- Vocational Evaluation
- Psychological Evaluation
- Behavioral Intervention Plan
- AT Assessment/Screener

CODE OF CONDUCT

In order to maintain a safe and supportive environment for our staff and customers we ask that you comply with basic safety requirements. While we encourage active participation and communication, we do ask that this be done in a civil manner even when there are disagreements or uncomfortable discussions taking place. Should you have concerns about how staff is relating to you that you are unable to work out with staff, you are encouraged to talk with the local supervisor or the NCATP Director at 919-664-1244 or with the Client Assistance Program 1-800-215-7227. You are always welcome to bring an advocate or family member with you should you desire.

We have listed below a list of behaviors that are not acceptable for anyone in contact with our staff either in the office or in the community. These same expectations apply for our staff as well. It should be noted that violation of this code of conduct may result in immediate termination of services from the NCATP. In addition, law enforcement authorities may be contacted, and appropriate legal action taken should a violation occur.

NO WEAPONS: NO THREATS, VERBAL OR PHYSICAL: NO AGGRESSIVE BEHAVIOR, VERBAL OR PHYSICAL: NO HARASSMENT

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Accessibility Form

Will GPS route to your address? Yes
NCATP Staff should park:
Parking location is: ☐ paved ☐ gravel ☐ grass ☐ dirt ☐ paid parking ☐ other
Entrance is wheelchair accessible: ☐ yes ☐ no
Entrance has: ☐ Steps How many? ☐ Ramp How many rails? ☐ Ramp is wood ☐ Ramp is metal
Describe pathway from parking location to entrance of home:
Does your home have wifi? ☐ Yes ☐ No
Are the doorways at least 30” wide? ☐ Yes ☐ No
Physical location setting of assessment: ☐ Main/ Entrance Level ☐ Sub Level ☐ Second Level ☐ Third Level ☐ Other Do you have any pets? ☐ Yes ☐ No If yes, please list type and quantity of pet(s) below: ***Please ensure all pets are secured during the visit to ensure the safety and health of our consultants***

Name of Referring Party Date

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In accordance with state law (10A NCAC 27D .0201) as specified in G.S. 122C, Article 3 you are being provided notice of your rights and responsibilities.

Client Rights:

Non-discrimination – You have the right to services regardless of your race, color, national origin, age, disability, creed, religious affiliation, ancestry, gender identity or expression, or sexual orientation.

Confidentiality – You have the right to privacy, security and confidentiality of your identity, diagnosis, and service needs.

PHI - You have the right to understand how your Protected Health Information (PHI) is disclosed for the purposes of services, payment, and healthcare operations.

Choices – You have the right to be informed about and involved in the services provided (assessment, training, etc.)

Dignity and Respect – You have the right to be treated with dignity and respect and to receive safe and considerate services in the least restrictive environment.

Informed Consent – You have the right to know all available options for services and the right to participate.

Refusal of Services – You have the right to withdraw from or refuse services from NCATP without any retaliation from staff.

Self-Advocacy/Legal – You have the right to access legal services or advocacy services on your behalf.

In North Carolina, you have the right to contact Disability Rights of NC for assistance or if you feel your rights are being taken away.

http://www.disabilityrightsnc.org/
1-877-235-4210 **Toll Free in NC**
(919) 856-2195 **in the Raleigh area**
(800) 735-2962 **TTY English**
(888) 825-6570 **TTY Spanish**
(919) 856-2195 **for Technical Assistance**

Mailing Address:
Disability Rights of NC
801 Corporate Center Drive, Suite 118
Raleigh, NC 27607

Always feel free to ask questions!

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Client Responsibilities:

You have the responsibility…

1. To keep appointments and be on time
2. To tell your consultant **24 hours** in advance if you are not able to keep an appointment
3. To share any changes that might impact your services
4. To inform your consultant of any changes in name, address, or telephone number
5. To attend all appointments in an alcohol and drug free condition
6. To provide a safe and hygienic environment within the community and/or home
7. To respect the privacy of individuals and staff
8. To treat other individuals and staff respectfully
9. To discuss with your consultant your needs, expectations, and goals as they relate to your communication and/or assistive technology services
10. To let your consultant know if you no longer want services
11. If you are under the age of 18 or if you have an appointed legal guardian, the parent or guardian must participate in the assessment and training process

Always feel free to ask questions!

I have been informed of my rights and responsibilities as they relate to services provided by the North Carolina Assistive Technology Program (NCATP).

_____

Name of Individual (Please Print)

_____ _____

Signature of Individual/Legal Guardian Date

_____ _____

Signature of NCATP Staff Date:

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Client Name: _____

AUTHORIZATION TO RECEIVE NCATP SERVICES

AUTHORIZATION FOR SERVICES: I voluntarily request and consent to AT/AAC services provided by the North Carolina Assistive Technology Program (NCATP). I authorize the performance of appropriate AT/AAC services, that may be determined necessary or beneficial by the consultant involved in my care. I understand that the practice of assistive technology services is not exact science, and I acknowledge that no guarantees have been made as to the results of services provided.

INFORMED CONSENT: I have been informed of the scope and purpose of the service, my rights, and issues of confidentiality, what is expected of me while receiving services, and I understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time. My refusal will not cause a threat of termination or termination from services; however, I understand that there may not be other services available from my provider. If I refuse a service and there are other services available, I will be offered those alternatives that may be suitable for me. The appointment times given to me are assigned to me alone, and I will make every effort to attend my scheduled appointment. If I need to cancel an appointment, I will call my consultant as soon as possible. I also understand that a minor may seek and receive periodic services from a doctor/physician without parental consent in accordance with G. S. § 90-21.5.

FOLLOW UP: I agree to be contacted after services to inquire about satisfaction with services, if applicable. AUTHORIZATION FOR EMERGENCY TREATMENT: In case of an emergency, I authorize NCATP to obtain emergency treatment from a physician or local hospital emergency room and/or the use of an ambulance. I understand that the minimum necessary health information, written or verbal, may be released to emergency-treating providers to meet the needs of the emergency.

RIGHTS AND RESPONSIBLILITIES: I have received Client Rights information which explains my rights and responsibilities. I have also received additional information that explains the grievance process. I understand that I may ask questions for clarification if I have questions or concerns. I agree to keep all information about others confidential and will not disclose or discuss with any person or agency outside of this agency.

NOTICE OF PRIVACY PRACTICES: I have also received and had the opportunity to read the Notice of Privacy Practices that explains how confidential information about me is used and disclosed by NCATP. I understand that I should ask questions or discuss any concerns at the time of my first contact with my consultant or other designated staff. I understand that I may request restriction(s) on how confidential information is used and disclosed, especially in terms of HIV and Substance Abuse information, and that in specific situations my request for restriction(s) may not be honored because of the State and Federal laws or other special situations. These exceptions to confidentiality have been explained to me as found in 45 CFR-2 and General Statutes 122-c, 52-56.

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Client Name: _____

METHODS OF CONTACTING: During and after services I agree to be contacted in the following way(s):

(Check all that apply)

☐ Email _____

☐ Cell Phone _____

☐ Home Phone _____

☐ Leave voice mail

☐ Text Message

☐ MS Teams / Zoom

☐ All of the above

_____

Print Name of Individual Receiving Services

_____ _____

Signature of Individual Receiving Services Date

_____ _____

Print Name of Legally Responsible Person Relationship to Consumer

_____ _____

Signature of Legally Responsible Person Date

_____

Signature of Witness (required only if Signature is an X mark or symbol)

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NOTICE OF PRIVACY PRACTICES

North Carolina Assistive Technology Program (NCATP)

The North Carolina Assistive Technology Program (NCATP) must collect timely and accurate health information about you and make that information available to members of your interdisciplinary team in this agency, so that they can accurately evaluate your functional limitations and provide the assistance you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of NCATP to protect your health information from unauthorized use or disclosure while receiving requested services.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within

NCATP, as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Notice* describes your rights regarding the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policy and procedures NCATP uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Client Acknowledgment

I have received NC Assistive Technology Program's (NCATP) Notice of Privacy Practices, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

_____

Name of Individual (Please Print or Type)

_____ _____

Signature of Individual/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

North Carolina Assistive Technology Program NCATP

Effective Date: April 1, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Responsibilities of (NCATP)

North Carolina Assistive Technology (NCATP) is required by law to protect the privacy of your health information and to provide you with a *Notice* of our legal duties and privacy practices associated with your PHI. This health information includes services that are provided to you and payment for those services. We will provide you a paper copy of this Notice upon request.

This *Notice* describes the ways we may share your past, present and future health information, ensuring that we use and/or disclose this information only as we have described in this *Notice*. We do, however, reserve the right to change our privacy practices and the terms of this *Notice*, and to make the new *Notice* provisions effective for all health information that we maintain. Any changes to this *Notice* will be posted in our agency offices (applies only to providers with direct relationships) and on our agency website at https://www.ncdhhs.gov/divisions/eipd/north-carolina-assistive-technology-program. Copies of any revised *Notices* will be available upon your request.

If at any time you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures, and practices you may contact our agency's Privacy Official Patricia Aaron at (919 664-1244). We are required by law to notify you of any breach of your unsecured PHI.

Use and Disclosure of Health Information without Authorization

Services

NCATP may use or disclose your health information, as needed to coordinate your services. This includes sharing your health information with other providers, both within and outside this agency, regarding your services when we need to coordinate with other providers.

> **Example:** We may share your health information with doctors, nurses and other health care personnel who are involved in providing your health care. For example: we will disclose information about you to the Assistive Technologist/Occupational Therapist/Speech Language Pathologist to assist them in providing appropriate services to you. Disclosing your health information to another health care provider would be especially important if your doctor knew you had allergic reactions to substances that could be life-threatening, so sharing your health information with another health care provider is essential for your protection and quality care.

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Payment for Services

NCATP may use and give your health information to other staff you designate to bill and collect payment for services received by you. We will share adequate information with departments that prepare bills and manage client accounts to ensure payment for services rendered. We may also share your health information with facility staff who review client services to make certain you have received appropriate services. To the extent any of your PHI includes records covered under 42 C.F.R. Part 2, we will comply with the terms and conditions of those regulations regarding disclosure for payment purposes.

> **Example:** The treatment provided to you needs to be shared with our agency's billing department and with your health plan so your health plan can pay your bill.

Health Care Operations

NCATP may use or disclose your health information in performing a variety of business activities that we call "health care operations". These "health care operations" allow us to improve the quality of care we provide to you and our other clients and help us to reduce health care costs. Some examples of the way we may use or disclose your health information for "health care operations" are:

- Review the services you received here and evaluate the performance of your team to ensure you have received quality care.
- Improve health care and lowering costs for groups of clients who have similar health problems and help manage and coordinate their care.
- Review and evaluate the skills, qualifications and performance of our health care providers that are taking care of you.
- Provide training programs for students, trainees, health care providers or non-health care professional (such as billing clerks) that allow these professionals to use the skills they have learned.
- Cooperate with outside organizations that review and determine the quality of care that we, and other healthcare organizations.
- Provide information to professional organizations that evaluate, certify or license health care provider, staff or facilities in a particular field or specialty.
- Assist others who review our activities such as other health care providers, lawyers and others who assist us in complying with specific laws.
- Plan for our agency's future operations such as evaluating information about the number of clients that need a particular assistive technology or augmentative communication evaluation or service.
- Resolve grievances such as use of health information during an investigation conducted by administration when a staff member within our agency files a grievance, protesting a particular issue.

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Other Circumstances

NCATP may use and/or disclose your health information for those circumstances that have been determined to be so important that your authorization may not be required. Prior to disclosing your health information, we will evaluate each request to ensure that only necessary information will be disclosed. Those circumstances include disclosures that are:

•Required by law

•For public health activities. For example, we may disclose health information to public health authorities if you have a communicable disease and we have reason to believe, based upon information provided to us, that there is a public health risk such as evidence of your noncompliance with your treatment plan. **If you suffer from a communicable disease such as tuberculosis or HIV/AIDS, information about your disease will be treated as confidential.** Other than circumstances described to you in other sections of this Notice, we will not release any information about your communicable disease except as required to protect public health or the spread of a disease, or at the request of the State or Local Health Director

• Regarding abuse, neglect, or domestic violence

• For law enforcement purposes unless or otherwise prohibited by State or Federal law

• For court proceedings such as court orders to appear in court with your health information

• Related to death such as disclosures to a funeral director

• Related to donation of tissues or organs

• Related to medical research

• To avert a serious threat to the health or safety of a person or the public

• Related to specialized government activities such as national security

• To correctional/custodial institutions or other law enforcement officials when you are in their custody

• For Worker's Compensation in cases pending before the Industrial Commission

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Contacting You

NCATP may use your health information to contact you to:

- Remind you of upcoming appointments

  Example: This agency may send an appointment reminder on a folded postcard to your home to remind you of a scheduled appointment.
  Example: This agency may contact you through a telephone call about an appointment that you have for evaluation or training.
  Example: This agency may contact you via email to remind you of an appointment or provide information regarding assistive technology devices/services/events, if you have expressed interest in receiving such.

- Make you aware of alternative treatment, services, products, or health care providers that may be of interest to you

  Example: If you are receiving services and/or training for a particular device and your health care team learns of new or alternative devices, we may contact you to inform you of such possibilities.

Use and Disclosure of Health Information That Allows You an Opportunity to Object

There are certain circumstances where we may disclose your health information and you have an opportunity to object. Such circumstances include disclosures to:

- Families, friends, or others involved in your services

  Example: We may share with a family member, relative, friend or other person identified by you, your health information that is directly related to that person's involvement in your services or payment for your care, such as your spouse, if that person monitors your medication schedule.
  Example: We may share with a family member, personal representative, or other person responsible for your care, your health information necessary to notify such individuals of your location and general condition to keep them involved with your services

- Public or private agencies

  Example: We may share your health information with the Division of Employment and Independence for People with Disabilities for service development.

If you would like to object to disclosure of your health information in any of the above circumstances, please contact our agency Privacy Official listed in this Notice.for consideration of your objection.

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Use and Disclosure of Health Information That Requires Your Authorization

NCATP.will not use or disclose your health information without your authorization except as specified in the above examples where use or disclosure of your information is allowed or when required by State or Federal law. For all other uses or disclosures, we will ask you to sign a written authorization that allows us to share or request your health information. Before you sign an authorization, you will be fully informed of the exact information you are authorizing to be disclosed/requested and to/from whom the information will be disclosed/requested.

You may request that your authorization be cancelled by informing our agency Privacy Official that you do not want any additional health information about you exchanged with a particular person/agency. You will be asked to sign and date the Authorization Revocation section of your original authorization. Your authorization will then be considered invalid at that point in time; however, any actions that were taken on the authorization prior to the time you canceled your authorization are legal and binding.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information as created and maintained by this agency¡.

Right to receive a copy of this Notice.
You have a right to receive a copy of NCATP's *Notice of Privacy Practices*. At your first encounter with this agency, you will be provided with an electronic copy or given a paper copy upon request. In the event of emergency services, you will be provided with Privacy Notice as soon as possible after emergency services have been rendered In addition, copies of this Notice that have been posted in several public areas throughout this agency as well as on the NCATP Internet website. You have the right to request a paper copy of this Notice at any time from our agency Admissions Officer or our agency privacy official.

Right to request different ways to communicate with you
You have the right to request to be contacted at a different location or by a different method. For example, you may request all written information be sent to your work address rather than your home address. We will agree with your request if it is reasonable to do so; however, your request must be made in writing and forwarded to our agency Privacy Official.

Right to request to see and copy your health information
You have the right to request to see and receive a copy of your health information in clinical, billing, and other records that are used to make decisions about you. Your request must be in writing and forwarded to our agency Privacy Official. If your request is approved, you may be charged a fee to cover the cost of the copy, excluding labor costs. Instead of providing you with a full copy of the health information, we may give you a summary or explanation of your health information, if you agree in advance to that format and to the cost of such information. Your request may be denied under certain circumstances. If we do deny your request, we will explain

our reason for doing so in writing and describe any rights you may have to request a review of our denial.

Right to request amendment of your health information

You have the right to request changes in your health information in clinical, billing, and other records used to make decisions about you. If you believe that we have information that is either inaccurate or incomplete, you may submit a request in writing to our agency Privacy Official and explain your reasons for the amendment. We must respond to your request within 60 days of receiving your request.

We may deny your request if:

•the information was not created by this agency (unless you prove the creator of the information is no longer available to change the information);
•the information is not part of the records used to make decisions about you;
•we believe the information is incorrect and incomplete; or•you do not have the right to see and copy the record.

If we deny your request to change your health information, we will tell you in writing the reasons for denial and describe your rights to give us a written statement disagreeing with the denial.

If we accept your request to change your health information, we will make reasonable efforts to inform others of the changes, including persons you name who have received your health information and who need the changes.

Right to request a listing of disclosures we have made

You have the right to request and receive a written list of certain disclosures of your health information, made after April 14, 2009. You may ask for disclosures we made up to six years before your request. This listing will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure. This agency is required to include on the list disclosures for the following:

•For your services
•For billing and collection of payment for your services
•For our health care operations
•Requested by you, that you authorized, or which are made to individuals involved in your care or
•Allowed by law

Your first request for a listing of disclosures will be provided to you free of charge. However, if you request a listing of disclosures more than once in a 12-month period, you may be charged a reasonable fee. We will inform you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

Right to request restrictions on uses and disclosures of your health information

You have the right to request that we limit our use and disclosure of your health information for services, payment, and health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your services or the payment of your services such as a family member or a friend. For example, you could ask us not to use or disclose the information about a previous condition you had.

We are not **required** to agree to such request. However, if we do agree, we must follow the agreed upon restriction (unless the information is necessary for emergency treatment or unless it is a disclosure to the U.S. Secretary of the Department of Health and Human Services).

You or your personal representative may cancel the restrictions at any time. In addition, this agency may cancel a restriction at any time, as long as we notify you of the cancellation.

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Complaints

If you believe your privacy rights have been violated by us, or if you want to complain to us about our privacy practices, you may contact our agency Privacy Official. All complaints should be submitted in writing. Contact information is as follows:

NCATP **Privacy Official Patricia**
Aaron 2801 Mail Service Center
Raleigh, NC 27699-2801
Phone: (919) 664-1244
Fax: (984) 687-9597
Patricia.Aaron@dhhs.nc.gov

The North Carolina Department of Health and Human Services operates a Customer Service Center Hotline, which has been designated to receive and document complaints and concerns regarding NCDHHS privacy practices, policies, and procedures related to the protection of individually identifiable health information. Contact information is as follows: **1-800-662-7030 (Toll Free)**

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. Contact information is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W.
Suite 16T70,
Atlanta, GA 30303-8909

C**ustomer Service Center: (800) 368-1019**

Fax: (202) 619-3818

TDD: (800) 537-7697

Email: ocrmail@hhs.gov

If you file a complaint, we will not take any action against you or change our treatment of you, in any way.