



## AFFILIATE APPLICATION

NON-EMPLOYEES: Partners, Out-posted Staff, Volunteers

**INSTRUCTIONS:** Completed applications should be delivered to your MAHEC Affiliate Supervisor.

### AFFILIATE ROLE

\_\_\_\_\_  
AFFILIATE POSITION TITLE

\_\_\_\_\_  
CURRENT EMPLOYER / SCHOOL / ORGANIZATION (IF ANY)

\_\_\_\_\_  
DATE OF APPLICATION

### CONTACT INFORMATION

\_\_\_\_\_  
LEGAL NAME (FIRST)

\_\_\_\_\_  
(MIDDLE)

\_\_\_\_\_  
(LAST)

\_\_\_\_\_  
PREFERRED NAME

\_\_\_\_\_  
LAST 4 DIGITS - SOCIAL SECURITY NUMBER

\_\_\_\_\_  
ADDRESS LINE 1

\_\_\_\_\_  
ADDRESS LINE 2

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
E-MAIL ADDRESS

### AFFILIATE QUESTIONNAIRE

- |  |     |     |    |
|--|-----|-----|----|
| 1. IF YOU ARE UNDER THE AGE OF 18, CAN YOU FURNISH PARENTAL CONSENT?   | YES | N/A | NO |
| 2. HAVE YOU EVER BEEN EMPLOYED BY OR AFFILIATED WITH MAHEC?  | YES |     | NO |
| A. PRIOR DATES _____   |     |     |    |
| 3. DO YOU HAVE ANY RELATIVES (BY BLOOD OR MARRIAGE) OR SIGNIFICANT PERSONAL RELATIONSHIPS WITH ANY CURRENT MAHEC EMPLOYEE? | YES |     | NO |
| A. NAME _____ RELATIONSHIP _____   |     |     |    |
| B. NAME _____ RELATIONSHIP _____   |     |     |    |

EDUCATION	SCHOOL	CITY / STATE	YEARS COMPLETED	DID YOU GRADUATE?	DEGREE / CERTIFICATE
HIGH SCHOOL / GED:					
ASSOCIATES:					
COLLEGE:					
GRADUATE:					
OTHER:					

LICENSES/CERTIFICATIONS	LICENSE NUMBER	STATE	ISSUE DATE	EXPIRATION DATE
TYPE:				
TYPE:				
TYPE:				

EMERGENCY CONTACTS	RELATIONSHIP	PHONE NUMBER
1.		
2.		
3.		

APPLICANT STATEMENT

- I certify that answers given herein are true and complete to the best of my knowledge.
- I authorize investigation of all statements contained in this application for affiliation as may be necessary in arriving at a decision to establish an affiliate relationship.
- I hereby understand and acknowledge that, unless otherwise defined by applicable law, any affiliate relationship with this organization is of an “at will” nature, which means that the affiliate may end the relationship at any time and the organization may sever the relationship at any time with or without cause.
- It is further understood that this “at will” affiliate relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by the President / CEO of this organization.
- I understand that false or misleading information given in my application or interview(s) may result in separation of affiliate relationship.
- I understand that I am required to abide by all rules and regulations of the organization.

APPLICANT SIGNATURE

DATE

PARENTAL CONSENT (IF UNDER THE AGE OF 18)

DATE



## AFFILIATE CONFIDENTIALITY STATEMENT

NON-EMPLOYEES: Students, Partners, Out-posted Staff, Volunteers

### AFFILIATE INFORMATION

LEGAL NAME (FIRST) (MIDDLE) (LAST)

CURRENT EMPLOYER / SCHOOL / ORGANIZATION (IF ANY)

HOSTING MAHEC DIVISION / DEPARTMENT  
(To Be Completed By MAHEC)

### CONFIDENTIALITY ACKNOWLEDGEMENT

By signing this form,

I understand that all patient information is the same as Protected Health Information (PHI) and includes, but is not limited to:

- Any information that is protected under state or federal law, including all medical, dental, and personal information concerning MAHEC patients;
- Information regarding the provision of services or submissions of claims;
- Any document containing a patient's name or identification number;
- Any information that identifies an individual and relates to past, present or future physical, dental, or mental health condition or care;
- Information about billing or payment of health care services for an individual;
- Information about eligibility or enrollment of an individual for services.

I agree to hold PHI in the strictest confidence and to not disclose or use PHI except as necessary to perform my approved assignment at MAHEC.

- I will only access PHI for which I have a legitimate business and/or clinical need to know;
- I shall only discuss PHI with or disclose to persons outside the specific medical or dental office where I am assigned only if the disclosure is consistent with MAHEC's Notice of Privacy Practices and HIPAA Privacy and Security Policies and Procedures;
- I shall only discuss PHI with or disclose to persons inside the medical or dental office where I am assigned for the purpose of treatment, billing and MAHEC operations consistent with MAHEC's Notice of Privacy Practices and HIPAA Privacy and Security Policies and Procedures. Discussions shall not be held in areas where unauthorized persons can overhear the conversation.

I agree that I will not access my own and/or family members PHI, which includes, but is not limited to: accessing the records through the EHR, dental record, and billing information.

I agree to hold employee information (i.e. salary, insurance, home phone, cell, home address/email, date of birth, social security number, etc.), customer information and any Affiliate information in which I am privy in the strictest confidence and to only use or disclose such information in accordance with MAHEC's Policies and Procedures and as authorized as part of my Affiliate assignment at MAHEC.

I may have access to Medicare/Medicaid customer and claims information which is subject to the provisions of the Freedom of Information Act. I agree to use this information only in connection with the determination of eligibility and payments of Medicare/Medicaid and not to misuse or disclose this information to unauthorized persons. If I do not comply, I may be subject to the criminal penalties in section 1106(a) of the Social Security Act which state that I shall be deemed guilty of a felony and, upon conviction thereof, shall be punished by a fine not exceeding \$10,000 for each occurrence of a violation, or by imprisonment not exceeding five (5) years, or both. I understand that noncompliance is also a violation of the Privacy Act of 1974, as amended and carries a criminal penalty of a misdemeanor and fine of not more than \$5,000.

I understand and acknowledge that failure to comply with the obligations contained in this Confidentiality Statement will result in action, including but not limited to notification to my school / employer / organization (if applicable) and immediate termination of my Affiliate assignment with MAHEC. I further agree that the obligations contained in this Confidentiality Agreement will continue after I complete my assignment. I have read this statement and agree to its requirements.

AFFILIATE SIGNATURE

DATE

PARENTAL CONSENT (IF UNDER THE AGE OF 18)

DATE



## AFFILIATE CORPORATE COMPLIANCE ACCOUNTABILITY FORM

NON-EMPLOYEES: Students, Partners, Out-posted Staff, Volunteers

### AFFILIATE INFORMATION

LEGAL NAME (FIRST)

(MIDDLE)

(LAST)

CURRENT EMPLOYER / SCHOOL / ORGANIZATION (IF ANY)

HOSTING MAHEC DIVISION / DEPARTMENT

(To Be Completed By MAHEC)

### CORPORATE COMPLIANCE ACKNOWLEDGEMENT

By signing and initialing this form,

\_\_\_\_\_ I acknowledge that I have been provided information on MAHEC's policies, procedures, rules and regulations including those governing the confidentiality, privacy and security of protected health information under HIPAA and agree to abide by them.

Access the **Compliance Program Policy** [here](#).

\_\_\_\_\_ I acknowledge that I may be exposed to information concerning MAHEC and/or MAHEC staff, employees, agents or patients and shall not disclose or use for my benefit or the benefit of others, or to allow others to do so, any Confidential Information unless authorized in writing by MAHEC and any other person having rights in same.

"Confidential Information" means all information that is not generally known to the public and which MAHEC or other persons (to the extent MAHEC owes a duty of confidence to any such other person) has rights, which information is marked confidential, restricted or proprietary by MAHEC or the party having rights in the same, or which, under all the circumstances, ought reasonably to be treated as confidential and/or proprietary, including without limitation, patient data, patient lists, patient information, staff credentialing and peer review information, business records, marketing materials and financial information.

\_\_\_\_\_ I understand that my privileges can be terminated, for failing to comply with MAHEC's policies, procedures, rules and regulations.

### DEFICIT REDUCT ACT AND FALSE CLAIMS POLICY ACKNOWLEDGEMENT

By signing and initialing this form,

\_\_\_\_\_ I acknowledge that I have reviewed MAHEC's policy on the Deficit Reduction & False Claims Act and agree to abide by the policies and procedures outlined.

Access the **Deficit Reduction Act: False Claims Policy** [here](#).

\_\_\_\_\_  
AFFILIATE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENTAL CONSENT (IF UNDER THE AGE OF 18)

\_\_\_\_\_  
DATE



## AFFILIATE NETWORK USAGE AGREEMENT

NON-EMPLOYEES: Students, Partners, Out-posted Staff, Volunteers

### AFFILIATE INFORMATION

LEGAL NAME (FIRST)

(MIDDLE)

(LAST)

CURRENT EMPLOYER / SCHOOL / ORGANIZATION (IF ANY)

HOSTING MAHEC DIVISION / DEPARTMENT  
(To Be Completed By MAHEC)

### NETWORK USAGE AGREEMENT

To ensure that MAHEC's computer and network resources are used for purposes intended, to ensure that computer and network use conform with accepted professional and ethical standards, and to ensure that computer and network use comply with Federal HIPAA regulations and North Carolina state criminal statutes, the signee below agrees to abide by the following policy:

Access to data within the MAHEC network is provided for administrative, clinical, educational, and research purposes that support the goals and mission of the organization. All information accessed, transmitted or stored, unless explicitly stated otherwise, is to be strictly confidential. Abuse of network accounts is subject to disciplinary action. "Abuse" includes but is not necessarily limited to the following activities:

- (1) unauthorized access or disclosure of confidential data, including patient Protected Health Information (PHI) without proper authorization, or other violations of MAHEC HIPAA Security policies and procedures.
- (2) use detrimental to the goals and mission of MAHEC or allowing such use by other individuals such as use of the network for private enterprise or commercial purposes.
- (3) in that responsibility for network abuse is the responsibility of the holder of the password in use, leaving login sessions unattended (including workstations) or sharing passwords is regarded as unapproved use of MAHEC equipment.
- (4) unauthorized modification or attempts to modify computer equipment
- (5) unauthorized modification or attempts to read, alter, change, execute, or delete files belonging to other users
- (6) violation of copyright or licensing agreements in data and computer applications
- (7) any other action which interferes with proper functioning of the network or infringes on another user's rights
- (8) installing software on the network or on your local machine without approval from IT
- (9) use of the Internet and/or e-mail that violates MAHEC's **Internet Acceptable Use Policy**

Any action taken (i.e., examining a user's data, e-mail or internet files) will be done cooperatively between IT, Human Resources, Corporate Compliance, and the immediate supervisor. In cases of computer misuse, appropriate disciplinary action may be taken against the user. Such options may include a loss of computer privileges, which could result in termination of employment. All personnel actions will follow standard personnel procedures as outlined in the MAHEC Employee Handbook.

Irrespective of internal disciplinary proceedings, MAHEC reserves the right to proceed criminally or civilly against the accused employee for alleged violation of current applicable local, state, or federal laws.

### AFFILIATE ACKNOWLEDGEMENT

I understand that MAHEC may incorporate monitoring software and may record, for management's use, the Internet address of any Internet site I visit. I understand MAHEC may keep a record of any network activity in which I transmit or receive any kind of file, including e-mail. I acknowledge that any message I send or receive will be recorded and stored in an archive file. These archives may be accessed by law enforcement agencies when required legal processes are executed. I know that any violation of this policy could lead to dismissal or applicable criminal prosecution.

I have read and understand the above and agree to comply with all computer network and Internet policies and maintain confidentiality of information to which I may be granted access.

AFFILIATE SIGNATURE

DATE

PARENTAL CONSENT (IF UNDER THE AGE OF 18)

DATE



## Student, Intern, and Affiliate Compliance, HIPAA, Risk Management, and OSHA Safety Training Attestation

**Form must be completed after viewing the PowerPoint located at the bottom of the affiliate webpage. Please visit [mahec.net/affiliates](http://mahec.net/affiliates) to view.**

I, \_\_\_\_\_, attest that I have completed the required  
(Student, intern, and or affiliate name)

Compliance, HIPAA, Risk Management, and OSHA Safety training module assigned on

\_\_\_\_\_.  
(Training date)

I understand the material contained in the training module and agree to comply with the guidelines outlined therein.

I understand that failure to follow these guidelines can result in immediate termination of any and all MAHEC privileges associated with the student learning experience.

**Signature:** \_\_\_\_\_  
(Student, intern, and or affiliate signature)

**Date:** \_\_\_\_\_

MAHEC department my learning experience will be with (check all that apply):

Behavioral Health/ Psychiatry

Dental

Family Medicine

Internal Medicine

OBGYN

Pharmacy

Public Health

Simulation Center

Talent Management

**Any questions regarding this training and attestation can be referred to the MAHEC Compliance Office at 828-254-4724.**