Alternative Financing Program (AFP)

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What: The Alternative Financing Program is a financial loan backed by Easterseals Crossroads for a person who needs assistive technology. All assistive technology is available for loans. Examples include, but are not limited to: mobility aids, Braille equipment, hearing aids, augmentative communication devices, computers, environmental control units, home or automobile modifications and accessible vehicles. Loans are currently limited to a minimum of $500 and a maximum of $35,000.

Who: This program is for individuals that are residents of Indiana and have a documented disability who need assistive technology and who otherwise could not obtain a financial loan.

Where: Easterseals Crossroads of Indianapolis, Indiana has partnered with STAR Financial Bank to offer a low-interest loan.

Why: The INDATA Project has state and federal requirements to provide a loan assistance program. We believe that everyone should have access to assistive technology if it is needed and therefore INDATA and Easterseals Crossroads have made this partnership to facilitate low-interest loans.

How: Interested individuals may obtain an AFP application from the INDATA Project at Easterseals Crossroads by calling 888-466-1314 or by calling Nikol Prieto, Community Outreach Coordinator, at (317) 466-2013 Extension 2484. Currently, applications can be obtained by mail or electronically.

Qualifications:

Individuals will first receive an application from the INDATA Project, which asks for:

- Documentation of disability (letter from a nurse, physician, case worker or certifying official).
- Intended use of the assistive technology that the loan would provide, including vendor information and anticipated cost.
- Questions regarding the individuals' acknowledgment of the loan relationship with STAR Financial, that the individual is required to repay the loan and that the loan is not a grant, gift or other type of funding source.

Loan selection process: INDATA will determine if an individual is qualified for the program by reviewing the loan application. If qualified, the individual must fill out a loan application from STAR Financial Bank.

Assistive Technology — Alternative Financing Program Application

The INDATA Project
Easterseals Crossroads
4740 Kingsway Drive, Indianapolis, IN 46205
317-466-2013 / 888-466-1314
tech@eastersealscrossroads.org

Borrower Information
Name:
Address:
City, State, Zip:
Phone:
Alt. Phone:
Email:
Age:

General Disability:

- ◯ Vision
- ◯ Hearing
- ◯ Speech
- ◯ Learning, Cognitive, Developmental
- ◯ Mobility
- ◯ Other

Intended use of AT:

- ◯ Daily Living
- ◯ Environmental Adaptation
- ◯ Vehicle Modification/Transportation
- ◯ Computers and Related
- ◯ Recreation, Sports, Leisure
- ◯ Other

Required Documentation

☐ **Documentation of Disability is attached**
(Letter from physician, nurse, case worker or other certifying official)

In order to participate in the alternative financing program individuals must:
1. Reside in Indiana
2. Have a documented disability
3. Complete INDATA and lending institution's loan applications

What type of equipment is to be purchased?	
What is anticipated cost of equipment?	
Anticipated vendor of equipment:	
Have extended warrantees, upgrades or other sources of on-going cost been considered?	
Why do you need this technology? How will it increase your independence?	
Have other possible funding sources been explored?	
Do you understand that this is a bank loan program, not a grant, gift, or other type of fund source? (Please write yes or no)	
Do you understand that you will be required to repay this loan? (Please write yes or no)	
Do you understand that you are entering into a bank loan relationship with STAR Financial? (Please write yes or no)	

taking on disability together

Acknowledgement of Receipt of Notice of Privacy Practices

I have been offered, read or received a copy of Easterseals Crossroads Notice of Privacy Practices. I understand and am aware of the health information being released about me and further understand my rights regarding my health information. I further understand that, if I have additional questions or concerns, I may contact: **Privacy Officer Phone: Wade Wingler at 317.466.1000**

(Print) Name of Consumer:

Consumer's Signature:

Date:

Staff Member:

Representative's Signature:

Date:

Refusal to Sign

Consumer has refused to sign this acknowledgement; reason given was:

Staff Member: Date:

STAR
Bank | Insurance | Private Advisory

❑ If you intend to apply for joint credit, please initial here: Applicant_____ Co-Applicant_____

Date_____ Term_____

Loan Request $_____ Rate_____

EQUAL HOUSING LENDER

❍ **INDIVIDUAL** ❍ **JOINT** **PURPOSE**_____

Applicants, please complete the information below

NAME	BIRTH DATE	SOC. SEC. NO.	PHONE NO.

CURRENT ADDRESS	CITY	STATE	ZIP	YEARS THERE
PREVIOUS ADDRESS (If less than 2 years)	CITY	STATE	ZIP	YEARS THERE

CURRENT EMPLOYER OR SOURCE OF INCOME	ADDRESS	WORK PHONE
POSITION	GROSS WAGES $_____ ❍ HOUR ❍ WEEK ❍ MONTH ❍ ANNUAL	YEARS THERE
PREVIOUS EMPLOYER (If less than 2 years)	ADDRESS	YEARS THERE
E-MAIL ADDRESS	NEAREST RELATIVE	
RELATIVE'S ADDRESS	RELATIVE'S PHONE NO.	

Co-applicants, please complete the information below (If co-applicant has a separate residence, please have this person complete a separate credit application.)

NAME	BIRTH DATE	SOC. SEC. NO.	PHONE NO.

CURRENT EMPLOYER OR SOURCE OF INCOME	ADDRESS	WORK PHONE
POSITION	GROSS WAGES $_____ ❍ HOUR ❍ WEEK ❍ MONTH ❍ ANNUAL	YEARS THERE
PREVIOUS EMPLOYER (If less than 2 years)	ADDRESS	YEARS THERE
E-MAIL ADDRESS	NEAREST RELATIVE	
RELATIVE'S ADDRESS	RELATIVE'S PHONE NO.	

Other sources of income (Alimony, child support, or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation.)

	$
	$

Credit references - PLEASE LIST ALL OBLIGATIONS. USE AN ADDITIONAL SHEET OF PAPER IF NECESSARY. PLACE AN "X" IN LAST BOX IF TO BE PAID BY PROCEEDS.

CREDITOR	ACCOUNT #	MO. PYMNT.	BALANCE	"X" PAID BY PROCEEDS

Other assets - PLEASE LIST OTHER ASSETS (I.E., 401K, RENTALS, VEHICLES, STOCK, ETC.) **Value**

Bank references - PLEASE LIST THE INSTITUTION(S) WHERE YOU HAVE YOUR PERSONAL CHECKING AND SAVINGS ACCOUNTS

	NAME OF INSTITUTION	BALANCE
❍ **CHECKING ACCOUNT**		$
❍ **SAVINGS ACCOUNT**		$

HOME ❍ RENT ❍ OWN ❍ OTHER	MORTGAGE HOLDER/LANDLORD	MONTHLY PAYMENT	MORTG INTEREST RATE	BALANCE OWED	MARKET VALUE	PURCHASE PRICE	DATE & AMOUNT OF LAST APPRAISAL
		$					$_____

Please sign below

- Are you a co-maker, endorser, or guarantor on any loan or contract? ❍ Y ❍ N For whom? _____
- Is any income listed in this section likely to be reduced before the credit request is paid off? ❍ Y ❍ N

I /We hereby certify that the information given in this application is true, correct, and complete. I/We authorized STAR Financial Bank ("STAR") to conduct such credit inquiries as may be deemed necessary to investigate and confirm my/our income, liabilities, credit history, and financial condition; and I/We hereby consent to the disclosure and release of the information sought by such inquiries.

Your Opt-Out Right: If you want STAR not to share any non-public personal information about you, related to this application with non-affiliated third parties, you may opt-out of information sharing, that is, you may direct us not to share information (other than as permitted by law). See the STAR Privacy Notice for more information.

☐ To opt-out now, place an "X" in the box to the left to opt-out of information sharing related to this specific application with non-affiliated third parties (other than sharing permitted by law). This opt-out covers applicant and any co-applicant.

STAR may not condition an extension of credit to you on either:

- **Your purchase of an insurance product or annuity from the bank or any of its affiliates.**
- **Your agreement not to obtain, or a prohibition on your obtaining, an insurance product or annuity from an unaffiliated entity. You are free to purchase an insurance product or annuity from another source.**

I acknowledge that I am not required to purchase any insurance product from STAR in connection with my application for credit. I have received this disclosure orally and in writing.

By signing below, I certify that I have read and agree to the terms of this application, and I have received and read the STAR Privacy Notice.

APPLICANT'S SIGNATURE	DATE
CO-APPLICANT'S SIGNATURE (if applicable)	DATE

Please continue on reverse side

For Bank Use Only

Region _____

Branch _____

Lender # _____ Lender Signature _____

Secondary # _____ Secondary Signature _____

Approved ☐ Conditioned ☐

Amount $_____Rate_____Term _____

1st Pmt Date _____

Fixed_____ Variable_____ Single Pay_____ Balloon ____

Autopay Y ◯ N ◯

Pmt Coupons Y ◯ N ◯

Denied ❍

Reasons

*After verbal notification to applicant, forward application for retention

Collateral Description

Auto VIN _____

Mileage _____

Ins Co and Agent _____

Value $_____

Source of Valuation

Appraisal ◯

Nada ◯

Black-book ◯

Other ◯

Disbursements

Payable to:

_____ $_____

_____ $_____

_____ $_____

_____ $_____

Income Verification:

Paystub Y ◯ N ◯

Taxes Y ◯ N ◯

Other Y ◯ N ◯

Comments/Verifications

For Bank Use Only

❑ In Person Application: Oral disclosure given, and written notification delivered.

❑ Telephone Application: Oral disclosure given and written (with return envelope) mailed within three (3) business days of receipt of application.

❑ Mail Application: Written notification (with return envelope) mailed to address on application within three (3) business days of receipt of application.

Bank Employee Signature:_____ Date: _____

4740 Kingsway Dr. | Indianapolis, IN 46205
317.466.1000 | 317.466.2000 fax

3215 E. Thompson Rd. | Indianapolis, IN 46227
317.782.8888 | 317.466.2000 fax
eastersealscrossroads.org

Purpose: To change the way the world defines and views disability by making profound, positive differences in people's lives every day

NOTICE OF PRIVACY PRACTICES
(45 CFR 164.520(a))

Effective Date: April 2, 2018

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.

If you have any questions about this Notice, please contact:

Privacy Officer | Phone 317.466.1000

WHO WILL FOLLOW THIS NOTICE

This Notice describes our practices and that of:

- Any health care professional authorized to enter information into your record.
- All departments and units of Easterseals Crossroads.
- Any member or volunteer group we allow to help you at Easterseals Crossroads.
- All employees, staff and other personnel of Easterseals Crossroads.
- All these entities, sites and locations follow terms of this Notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or Easterseals Crossroads operations purposes described in this Notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Easterseals Crossroads. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by Easterseals Crossroads. Other Health Care Rehabilitation Facilities may have different policies or Notices regarding use and disclosure of your medical information.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private
- give you this Notice of our legal duties and privacy practices with respect to medical information about you
- follow the terms of the Notice that is currently in effect

HOW ARE WE REQUIRED BY LAW TO DISCLOSE MEDICAL INFORMATION ABOUT YOU

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We will use and disclose medical information about you when we have a "Duty to Report" under state or federal law; because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Risks. We will disclose medical information about you for public health reporting required by federal or state law. These activities generally include the following:

- to prevent or control disease, injury or disability
- to report births and deaths
- to report a child abuse or neglect
- to report reactions to medications or problems with products
- to notify people of recalls of products they may be using
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- to notify the appropriate government authority if we believe a Consumer has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We will disclose medical information as required by law to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we will disclose medical information about you when properly ordered to do so by a court.

Law Enforcement. We will release medical information if asked to do so by a law enforcement official and if permitted by law:

- In response to a court order
- If required by state or federal law
- To identify or locate a suspect, fugitive, material witness or missing person
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at a Easterseals Crossroads facility
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime

Protective Services for the President and Others. We will disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, psychologists, nurses, social workers, therapists, technicians, medical students or other Easterseals Crossroads personnel who are involved in taking care of you. Different departments of Easterseals Crossroads also may share medical information about you in order to coordinate the different things you need. We may also disclose medical information about you to people outside Easterseals Crossroads, such as other health care providers involved in providing medical treatment for you and to people who may be involved in your medical care, such as family members, clergy or others we use to provide services that are part of your care.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at Easterseals Crossroads, or other health care providers from whom you receive treatment, may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at Easterseals Crossroads so your health plan will pay us or reimburse you for your treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for Easterseals Crossroads operations or to another health care provider or health plan, if you have a relationship with that health care provider or health plan. These uses and disclosures are necessary to run Easterseals Crossroads and make sure all of all consumers receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many consumers to decide what additional services Easterseals Crossroads should offer, what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, social workers, therapists, nurses, psychologists, technicians, medical students and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Health Care Rehabilitation Facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific consumers are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at Easterseals Crossroads.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities. We are a not-for-profit organization which depends upon support from the United Way, Foundations and our own fundraising efforts from individuals and corporations. If we provide information about our services, we will not release information regarding a specific individual without prior written approval from you unless it is to our Business Associates. If it is to our Business Associates, only demographic information and dates of service may be released. If you do not wish us to contact you regarding our fundraising efforts, you must notify the Privacy Officer, in writing.

Individuals Involved in Your Health Care or Payment for Your Care. If there is a friend or family member involved in your medical care, we may release certain limited information to them. We may also release information to someone who helps pay for your care. We may also disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. We occasionally engage in research. We may use or share your information for research, as permitted by law.

Marketing and Public Relations. In order for us to create public awareness and to generate referrals, we engage in a variety of marketing and public relations activities. If we provide information about our services, we will not release information regarding a specific individual without prior written approval from you. We may release protected health information to our Business Associates if they are assisting us with such communications. If you do not wish for us to contact you regarding these efforts, you must notify the Privacy Officer, in writing.

SPECIAL SITUATIONS

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about consumers of Easterseals Crossroads to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care or (2) to protect your health and safety or health and safety of others or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, under some circumstances you may request that the denial be reviewed. Another licensed health care professional chosen by Easterseals Crossroads will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Easterseals Crossroads.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support your request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the medical information kept by or for our facility
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete

Right to an Accounting of Disclosures. You have the right to request an "Accounting of Disclosures." This is a list of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than 6 years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period is free. For additional lists, we may charge you for the costs of providing the list. We will notify 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. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a specific treatment session you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our website, eastersealscrossroads.org.

To obtain a paper copy of this Notice, request one in writing from the Privacy Officer or from an admissions specialist.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in each of our facilities. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, upon admission to Easterseals Crossroads for treatment or any other service, we will offer you a copy of our current Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Easterseals Crossroads or with the Secretary of the Department of Health and Human Services. To file a complaint with Easterseals Crossroads, contact the Privacy Officer at (317) 466-1000. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Easterseals Crossroads Acknowledgment of Receipt of Notice of Privacy Practices:

I have been offered, read, or received a copy of the Crossroads' Notice of Privacy Practices. I understand and am aware of the health information being released about me and further understand my rights regarding my health information. I further understand that if I have additional questions or concerns, I may contact: Wade Wingler, Privacy Officer, at Phone 317-466-1000.

Consumer Signature: _____
Printed Name: _____
Date: _____