

4.5 Annual Acknowledgment Statement for Title X Staff

Policy

All Title X staff must attest, upon hire and once annually, to follow Title X Family Planning practices and regulations.

Procedure

All staff must sign an Annual Title X Acknowledgement Statement (page two of this policy) annually. Sub-grantees must keep signed copies in program records.

Annual Acknowledgement Statement for Title X Staff

All Staff

Read and review the Title X requirements outlined below. Initial/check each item and sign the bottom to acknowledge understanding of these requirements.

Voluntary Participation^{1,2}

- I agree to provide family planning services solely on a voluntary basis.
- I understand individuals must not be subjected to coercion to receive services to use or not to use any method of family planning.
- I understand acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other services or programs offered.

Prohibition of Abortion in Title X Family Planning^{3,8,9,12,14}

- I understand abortion cannot be a method of family planning. I may be subject to prosecution if I coerce or try to coerce any person to undergo abortion or sterilization procedure.
- I understand that a Title X clinic cannot take affirmative action to assist a patient to secure an elective abortion.
- I understand Title X clinics cannot provide, promote, refer for, support, encourage, or advocate for abortion as a method of family planning.
- I understand that Title X clinic staff cannot lobby for the passage of legislation to increase the availability of abortion care during time staff time paid by Title X or with clinic resources paid for by Title X.

Non-Discrimination in Family Planning⁶

- I am aware family planning services must be provided without regard to religion, race, color, national origin, disability, sex, age, and number of pregnancies or marital status.

Client Confidentiality/HIPPA⁷

- Personal information of both patients and employees that is collected, used, stored, and disclosed, that comes to my attention as a result of my employment with this medical practice, must be kept confidential and secure as per Health Insurance Portability Act (HIPAA) and the office's policies, both during and after my term of employment.
- It is my responsibility to be familiar with the practices' policies and procedures regarding privacy, confidentiality, and security of personal information and that I am expected to comply.
- I will access and use personal information of patients only on a need to know basis as it pertains to my role and responsibilities.
- I will only share personal information with individuals who need to know and who are also involved in providing health care services to the patient.
- I will strive to keep patient personal information accurate and up-to-date.
- I understand that I cannot access personal information or that of family, friends, or coworkers unless they are under my direct care or if I need to do so as part of my official duties and responsibilities with the practice.

- Should I have reason to believe that a privacy breach has occurred, I will notify the individual responsible of the privacy in the office.

Conflict of Interest¹¹

- I will not use my position for private gain for myself or others.
- I have read, reviewed, and signed my organization's Conflict of Interest Statement.

Emergency Management/Preparedness¹⁰

- I have completed my organization's emergency management training and understand my role in an emergency or natural disaster.

Adolescent Services^{5,7,13}

- I agree to encourage family participation in the decision of minors to seek family planning services.
- I will document specific actions taken to encourage family participation or the reason family participation was not documented.
- I agree to provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.
- I agree to follow state laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, incest, or human trafficking.

Employee, Board Member or Volunteer Signature

Print Name: _____

Signature: _____

Date: _____

Family Planning Director Signature

Print Name: _____

Signature: _____

Date: _____

References:

- ¹ Sections 1001 & 1007 PHS Act
- ² 42 CFR 59.5(a)(2)
- ³ Section 205, Public Health Law 94-63
- ⁴ 42 CFR 59.5(b)(10)
- ⁵ 42 CFR 59.5(b)(4)
- ⁶ 42 CFR 59.5(a)(4)
- ⁷ 42 CFR 59.11
- ⁸ 42 CFR 59.14(a)
- ⁹ 42 CFR 59.16(2)
- ¹⁰ 29 CFR 1910 Subpart E; OSHA
- ¹¹ HHS Grants Policy Statement 2007, II-7; Title X Program Requirements 13.3
- ¹² 42 CFR 59.16(a)(1)
- ¹³ 42 CFR 59.5(a)(14)
- ¹⁴ 42 CFR 59.5(a)(5)