

DENTAL Medical History Form

Date _____

Name _____ Home Phone () _____
Last First Middle

Address _____ Business Phone () _____
Number, Street

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth ____/____/____ Sex M F Height _____ Weight _____ Single _____ Married _____
mo. day yr.

Name of Spouse _____ Closest Relative _____ Phone () _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No |
| 3. My last physical examination was on _____ | | |
| 4. Are you now under the care of a physician? | Yes | No |
| If so, what is the condition being treated? | | |
| 5. The name and address of my physician(s) is _____ | | |
| 6. Have you had any serious illnesses, operation, or been hospitalized in the past 5 years? | Yes | No |
| If so, what was the illness or problem? | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? | Yes | No |
| If so, what medicine(s) are you taking? | | |
| 8. Do you have or have you had any of the following diseases or problems? | | |
| a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease | Yes | No |
| b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | Yes | No |
| 1. Do you have chest pain upon exertion? | Yes | No |
| 2. Are you ever short of breath after mild exercise or when lying down? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| 4. Do you have inborn heart defects? | Yes | No |
| 5. Do you have a cardiac pacemaker? | Yes | No |
| c. Allergy | Yes | No |
| d. Sinus trouble | Yes | No |
| e. Asthma or hay fever | Yes | No |
| f. Fainting spells or seizures | Yes | No |
| g. Persistent diarrhea or recent weight loss | Yes | No |
| h. Diabetes | Yes | No |
| i. Hepatitis, jaundice or liver disease | Yes | No |
| j. AIDS or HIV infection | Yes | No |
| k. Thyroid problems | Yes | No |
| l. Respiratory problems, emphysema, bronchitis, etc. | Yes | No |
| m. Arthritis or painful swollen joints | Yes | No |
| n. Stomach ulcer or hyperacidity | Yes | No |
| o. Kidney trouble | Yes | No |
| p. Tuberculosis | Yes | No |
| q. Persistent cough or cough that produces blood | Yes | No |
| r. Persistent swollen glands in neck | Yes | No |
| s. Low blood pressure | Yes | No |
| t. Sexually transmitted disease | Yes | No |
| u. Epilepsy or other neurological disease | Yes | No |
| v. Problems with mental health | Yes | No |
| w. Cancer | Yes | No |
| x. Problems of the immune system | Yes | No |

9. Have you had abnormal bleeding? Yes No
 a. Have you ever required a blood transfusion? Yes No
 10. Do you have any blood disorder such as anemia? Yes No
 11. Have you ever had any treatment for a tumor or growth? Yes No
 12. Are you allergic or have you had a reaction to:
 a. Local anesthetics Yes No
 b. Penicillin or other antibiotics Yes No
 c. Sulfa drugs Yes No
 d. Barbiturates, sedatives, or sleeping pills Yes No
 e. Aspirin Yes No
 f. Iodine Yes No
 g. Codeine or other narcotics Yes No
 h. Other Yes No
 13. Have you had any serious trouble associated with any previous dental treatment? Yes No
 If so, explain _____
 14. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No
 If so, explain _____
 15. Are you wearing contact lenses? Yes No
 16. Are you wearing removable dental appliances? Yes No

Women

17. Are you pregnant? Yes No
 18. Do you have any problems associated with your menstrual period? Yes No
 19. Are you nursing? Yes No
 20. Are you taking birth control pills? Yes No

Chief Dental Complaint _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

 Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

(Date) _____ Signature of Dentist _____

Medical history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALERT

Patient Number: _____ Patient Name: _____ Page # _____

1. PREMEDICATION: Yes No
Type Recommended:

2. ALLERGIES:

3. Complete list of current medications, including both prescription and over-the-counter:

	Start Date	End Date		Start Date	End Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

4. Updated:

Date	Initials	Date	Initials	Date	Initials
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CONSENT TO TREATMENT

please print

Patient Name						
Address		Number & Street		Town/City		State
						Zip Code
Date of Birth	Height	Weight	Sex	Marital Status	Occupation	
			<input type="checkbox"/> Male <input type="checkbox"/> Female			

1. I authorize the performance on _____ of the dental treatment plan as explained to me by _____ (state "myself" or name of patient)
2. The foreseeable material risks* and benefits of the accepted treatment plan have been explained, and I fully understand them.
3. Alternative treatment plans have been presented, and explained to me including their benefits and foreseeable risks.
4. I also understand that in the provision of dental treatment, oral conditions may be photographed, and I consent to this as long as my identity is not revealed. I understand that these photographs may be used for medical documentation, teaching, research or scientific publication. I also understand that other members of the dental and/or medical profession may be present as observers.
5. I understand that the practice of dentistry/medicine is not an exact science, and I acknowledge that I have received no guarantees or assurances about the outcome of treatment or any of its components, benefits or results.
6. I understand that changes in the accepted treatment plan may be necessary during the course of treatment, and I will be informed of these changes.
7. I fully understand that a specific dental procedure may be referred to another general dentist or specialist in another dental clinic.
8. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.
9. I have read this entire consent to treatment, and fully understand the conditions of this consent and have no additional questions.

*Foreseeable risks are those that other practitioners in the community tell their patients in similar situations.

SUPPLEMENT FOR PERSONS UNDER 18 INTENDING TO CONSENT FOR THEMSELVES Check Yes or No as appropriate.
To be completed by patient who has not reached his or her birthday and wishes to consent to treatment:

1. Age at last birthday..... _____
2. Are you now or have you ever been married?.... Yes No
3. Are you now or have you ever been a parent?... Yes No
4. Are you now in the armed forces?..... Yes No
5. For females: Are you pregnant?..... Yes No
6. Are you self-supporting?..... Yes No

*Question 6 need not be answered if the answer to questions 2, 3, 4 or 5 is yes.

Furthermore, the cost of treatment, as listed at right, has been explained to me and I agree to pay the fee, in whole or in part, as it becomes due and owing.

I understand that treatment modifications may be required as treatment progresses and that the fee may need to be modified to reflect those changes. I further understand that, whenever possible, I will be informed of any changes as the need to them becomes apparent.

CATEGORY OF SERVICE	FEE (EST)
1. Diagnostic	
2. Operative	
3. Periodontics	
4. Oral Surgery	
5. Endodontics	
6. Oral Pathology	
7. Fixed Prosthesis	
8. Removable Prosthesis	
9. Other	
Fee- Total Care Sum of lines 1-9	

CONSENT TO TOTAL CARE & FEE	
Signature of Patient or Legal Representative	Date

CATHOLIC CHARITIES HEALTH SYSTEMS
of the Diocese of Rockville Center Inc. (CCHS)
DIAGNOSTIC AND TREATMENT CENTER
Special Dental Services (SDS)

PATIENT AGREEMENT

I, _____, or my legal designate have consented to dental treatment by the Special Dental Services, and will hereby abide by the regulations set forth by Catholic Charities Health Systems governing the use of the facilities at 333 North Main in Freeport.

I understand that Catholic Charities Health Systems is a smoke-free environment, and that smoking is not allowed on the premises, with the exception of the smoking room accessible only to clients of the Adult Day Health Care Services.

I also understand that substance usage on the premises will not be tolerated. While neither the Adult Day Health Care Services or the Special Dental Services exclude persons solely on the basis of their substance use, Catholic Charities Health Systems does expect all clients to adhere to the following policies:

1. No substance usage on site.
2. No access to any services while under the influence of any non-prescribed substance.
3. No selling or sharing of any substance with another patient/client at the facility.

I understand that failure to adhere to these policies may result in either postponement of treatment, or possible termination from the Special Dental Services.

I further understand that physical violence or threat of violence will result in suspension of treatment on the day that it occurs, as well as for a period of time to be determined at the time of the incident. Possession or use of a weapon of any kind will result in immediate termination from the Special Dental Services. I further understand that any question of child abuse or neglect will be reported to the appropriate authorities as mandated by the State of New York.

State and federal laws shall govern all questions concerning the construction, validity, and interpretation of this Agreement and the performance of the obligations imposed by this Agreement.

In compliance with New York State laws, federal laws, and Catholic Charities Health Systems standards, no person shall be discriminated against on the basis of race, color, creed, sex, religion, national origins, sexual orientation, citizenship status, marital status, or disability. Catholic Charities Health Systems admits and treats all clients on this non-discriminatory basis.

I, the undersigned, have read the above, and I assume the responsibility to abide by all of the provisions above.

I have also received a copy of the Patient's Bill of Rights.

Patient Name (Print)

Patient Signature

Date

Witness Name (Print)

Witness Signature

Date

CATHOLIC CHARITIES HEALTH SYSTEMS

SPECIAL DENTAL SERVICES

Please print legibly and provide all information requested.

Registration Date: _____ Patient Number: _____

Name: _____
Last First M.I. Sex: _____

Social Security #: _____ Driver's License #: _____ State: _____

Date of Birth: _____ Adult or Child Birthplace: _____

LOCAL ADDRESS

Street _____

City State Zip _____

Home Phone Business Phone _____

PERMANENT ADDRESS

Street _____

City State Zip _____

Home Phone Business Phone _____

Other names by which you are or have been known: _____

Have you been previously treated by YES Emergency Care
Catholic Charities Special Dental Services? NO, if yes, for _____ Routine Care Date last treated _____

Person responsible for payment: Name _____ Social Security # _____

Relation to Patient: _____ Driver's License #: _____ State: _____

Address _____
Street City State Zip _____

Telephone: Home _____ Business _____

Employer _____ Occupation _____

Parent or Guardian (if patient is a minor) _____

Address _____
Street City State Zip _____

Telephone: Home _____ Business _____

Employer _____ Occupation _____

Emergency Contact: _____

Telephone Number: _____ Relation to Patient: _____

Payment Information: Self-Pay Current Medicaid # _____ Seq. # _____
 Third Party will reimburse patient ADAP # _____

Printed Name _____

Signature _____

Date _____

Patients' Bill of Rights

As a patient in a health care facility in New York State,
you have the right, consistent with law, to:

- (1) Understand and use these rights. If for any reason you do not understand or you need help, the health care facility **MUST** provide assistance, including an interpreter.
- (2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.
- (3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- (4) Receive emergency care if you need it.
- (5) Be informed of the name and position of the dentist who will be in charge of your care.
- (6) Know the names, positions and functions of any staff involved in your care and refuse their treatment, examination or observation.
- 7) A no smoking room.
- 8) Receive complete information about your diagnosis, treatment and prognosis.
- 9) Receive all the information that you need to give informed consent to any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- 10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Orders - A Guide for Patients and Families."
- 1) Refuse treatment and be told what effect this may have on your health.
- 2) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
- 1) Privacy while in the dental clinic and confidentiality of all information and records regarding your care.
-) Participate in all decisions about your treatment and discharge from the clinic. The dental clinic must provide you with a written discharge plan and written description of how you can appeal your discharge.
-) Review your dental record without charge. Obtain a copy of your dental record for which the dental clinic can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
- 1) Receive an itemized bill and explanation of all charges.

Complain without fear of reprisals about the care and services you are receiving and to have the dental clinic respond to you and if you request it, a written response. If you are not satisfied with the response, you can complain to the New York State Health Department. The dental clinic must provide you with the Health Department telephone number.

Authorize those family members and other adults who will be given priority to visit consistent with your

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

New York State Department of Health

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
 - Both (non-HIV medical and HIV-related information)
 - My non-HIV medical information **

Information in the box below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information: _____ _____
Name of person whose information will be released: _____
Name and address of person signing this form (if other than above): _____ _____
Relationship to person whose information will be released: _____ _____
Describe information to be released: _____
Reason for release of information: _____
Time Period During Which Release of Information is Authorized From: _____ To: _____
Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any: _____ _____
Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences): _____ _____

All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature _____ Date _____

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____

**CATHOLIC CHARITIES HEALTH SYSTEMS
 Diocese of Rockville Center Incorporated
 DENTAL SERVICES
 Grievance/Complaint Instructions**

In the event that you wish to file a complaint about the services provided by Dental Services of the CCHS and or one of the staff, a Grievance/Complaint Procedure has been developed to bring your complaint to the attention of the appropriate administration staff who will assist you in resolving whatever problem that may exist.

The following is a description of the various steps available to you if you wish to file the complaint directly or anonymously. Remember, the right to make such a complaint is part of the Client's Rights.

- 1. When you, a member of your family, partner or designee have a recommendation or complaint, you or they should discuss the complaint directly with the Office Manager or Dental Director. This individual will promptly record the nature of the complaint, the efforts made to resolve the problem and the findings. You and the staff member will be asked to sign the complaint.**
- 2. If the complaint is not resolved to your satisfaction, the staff member will send the complaint to the Chief Operating Officer or you may call the Chief Operating Officer at (516) 733-7011. The Chief Operating Officer will investigate the complaint, discuss it with you or your designee and submit a written decision to you within five (5) working days.**
- 3. If not satisfied with the program response, you may contact the Executive Director at (516) 733-7013 or Human Resources at (516) 733-7006 or, in writing at 90 Cherry Lane, Hicksville, NY 11801.**
- 4. If you are not satisfied with the agency response you may complain in writing to the offices of Long Island's United Way, Ryan White Care Act, Part A at 819 Grand Blvd., Deer Park, NY 11729 or by calling Myra E. Alston at (631) 940-3724, Debra Ross at (631) 940-3758,**
- 5. If you wish to file a complaint anonymously, please write a statement, place it in an envelope and put in the program "In Box".**

Date approved:	Date(s) Reviewed:	Page 1 of 1

Catholic Charities Careware Intake Data Form

Date: _____

CLIENT DATA

Personal Information

First name: _____ Middle initial: _____ Last name: _____

Date of Birth: _____

Sex: Male ___ Female ___ Transgender unknown _____

Transgender male to female ___ Transgender female to male ___

Refused to report _____ Unknown _____

Demographic Information:

HIV/AIDS Services

History of alcohol abuse: Yes ___ No ___

History of substance abuse: Yes ___ No ___

Mental illness: Yes ___ No ___

HIV/AIDS hospitalization: Yes ___ No ___

REFERENCES: Please circle the most appropriate answer

A. Diagnosis

AIDS
HIV Asymptomatic
HIV Symptomatic

B. Housing

Congregate residence
Rent/Own house/apartment
Shelter/Motel
Without shelter (homeless)

G. MARITAL STATUS

Common law
Divorced
Living as married
Married
Separated
Single – Never married
Widow(er)
Unknown

H. RACE

Alaskan native
Asian or Pacific Islander
Black/African American
Hispanic
Native American
White/Caucasian
Other
Unknown

I. HISPANIC

Cuban
Mexican
Puerto Rican
Not Hispanic
Other Hispanic
Unknown

J. PRIMARY INCOME SOURCE

AFDC
Alimony-Child support
Department of Veteran Affairs
Family/Spouse contribution
Home relief
Public assistance
Retirement/pension
SSI Pending
SSI/SSDI or SSA
Wages/salary/etc.
None
Other
Unknown

K. YEARLY GROSS INCOME RANGE

< \$9,570

\$9,570 - \$19,200

\$19,201 - \$28,771

\$ 28772 - \$38,400

\$ >38,400

Number of persons in household: _____

Emergency Contact

First name: _____

Last name: _____

Home telephone: _____

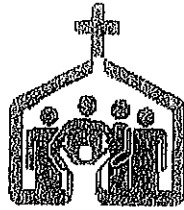
Work telephone: _____

Mobile telephone: _____

Email address: _____

Relationship: _____

Address: _____



Catholic Charities – Diocese of Rockville Centre

Dental Services

No show, broken appointment notification

I _____ understand that if I fail to appear for my appointment or give 24 hours' notice before cancellation, I am subject to a \$20 charge and/or possible dismissal from Catholic Charities Dental Services.

Patient name or guardian: _____

Witness: _____

Date: _____

ACKNOWLEDGMENT OF GRIEVANCE/COMPLAINT INSTRUCTIONS

I, _____ acknowledge that I have been provided with a copy of Catholic Charities Health Systems of the Diocese of Rockville Centre, Inc.'s grievance/complaint instructions.

Print: _____

Sign: _____

Date: _____

CATHOLIC CHARITIES HEALTH SYSTEMS
Diocese of Rockville Center Incorporated
DENTAL SERVICES
Grievance/Complaint Instructions

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Date approved:	Date(s) Reviewed:	Page 1 of 1

Catholic Charities

Diocese of Rockville Centre
90 Cherry Lane
Hicksville, New York 11801-6299



Thomas F. Casey Administrative Center
Phone: (516) 733-7000
Fax: (516) 733-7099
www.CatholicCharities.cc

Re: Compliance Program

Dear Service Recipient:

Catholic Charities is committed to providing the highest quality services to those we serve and conducting our business with integrity and in compliance with applicable federal and state laws and regulations. To this end, we have established a Compliance Program that we expect all employees and those with whom we contract to comply. In an effort to promote compliance, the Agency's Corporate Compliance Manual and Appendix A providing detailed information about the laws which play a role in preventing and detecting fraud, waste and abuse in federal health care programs and related whistleblower protections under such laws may be accessed on our website: www.catholiccharities.cc under the heading, "About Us" at the bottom of the page.

In addition, we ask and encourage you, the recipient of our services, to help us maintain the proper work environment by reporting instances of fraud, waste and abuse, HIPAA violations, identity theft as well as other instances of staff misconduct that might come to your attention. If you become aware of any such instances or if you have any questions about our Compliance Program, please feel free to contact me at (516) 733-7093 or at Bruno.Julia@catholiccharities.cc so that the instances may be investigated or referred to the proper department. Anonymous reports may be made by leaving a message at 516-733-7029.

Thank you for your cooperation and participation in the Catholic Charities' Compliance Program. It is only by correcting situations brought to our attention that we are able to serve you better!

Very truly yours,

Julia Bruno
Acting Compliance Officer