

# 2010-2011

## WILLIAMSON COUNTY COMMUNITY SUPERVISION AND CORRECTIONS DEPARTMENT (CSCD / CTTC) WELLNESS PROGRAM

The CSCD / CTTC Wellness Program is administered by the Williamson County Human Resources Department. The Wellness Program encourages each eligible employee to adopt healthy lifestyle behaviors. Participation in the program is strictly voluntary.

This document outlines the procedures and requirements to participate in the Wellness Program which consists of a monetary reimbursement incentives for those who complete and submit an Affidavit of Annual Wellness Care, Affidavit of Annual Dental Care, 10 Week Nutrition, Exercise, and/or Behavioral and Lifestyle Modification Program Reimbursement Form.

- 1) Eligibility for participation in the Wellness Program begins on November 1, 2010 for current active employees in a full time position with CSCD / CTTC. New hire eligibility begins on their first day of employment in a full time position with CSCD / CTTC.
- 2) You are eligible to participate until your employment is terminated, you change status to part time or seasonal, or you retire. You must be an active Employee **up through the end of the current Wellness Program year (October 31, 2011)** to be eligible for approved payment of Wellness Program Points.
- 3) Employees out on an active military duty leave of absence for thirty (31) days or more are not eligible to participate in the Wellness Program during their leave of absence. Eligibility to participate in the Wellness Program will be reinstated upon return to work.
- 4) Employees out on Administrative Leave without Pay for thirty (31) days or more are not eligible to participate in the Wellness Program during their leave of absence. Eligibility to participate in the Wellness Program will be reinstated upon return to work.
- 5) If a former employee is re-hired within the same Wellness Program year, any Wellness points accrued prior to their last employment termination date will not be reinstated upon their re-hire date.
- 6) Wellness Affidavits for Annual Wellness Care and Annual Dental Care 11/1/2010-8/31/2011 must be received in the Human Resources Department no later than the last day of the following month after completion of the examination(s).  
*(i.e. For annual dental care completed on 1/13/2011, the wellness affidavit is due no later than 2/28/2011)*  
Wellness Affidavits for Annual Wellness Care and Annual Dental Care 9/1/2011-10/31/2011 must be received in the Human Resources Department by 10/31/2011.  
*(i.e. For annual dental care completed on 10/28/2011, the wellness affidavit is due no later than 10/31/2011)*  
10 Week Nutrition, Exercise, Behavioral, and Lifestyle Modification Program Reimbursement Form may be submitted upon completion of all the requirements, but no later than 10/31/2011.

Wellness Affidavits and Reimbursement Forms may be submitted to the Human Resources Department one of five ways: Email [wellness@wilco.org](mailto:wellness@wilco.org) • Fax (512) 943-1535 • Interoffice Mail • Hand Deliver • U.S. Mail

### **Wellness Program Points / Reimbursement:**

- 1) Throughout the Wellness Program year, the Human Resources Department reviews each affidavit and reimbursement form for fulfillment of the program requirements. Participant files will also be audited by the Williamson County Auditor's Office Internal Control Department. Approved payment of wellness program points / reimbursements to eligible employee will be through the regular payroll process, is taxable, and subject to TCDRS retirement deductions.

**Maximum Wellness Program Reimbursement/Points Per Eligible Employee = \$125.00**

**Reimbursement for accrued points, up to the maximum of 125, will be paid out no later than 12/16/2011**

**Annual Wellness Care (100 points = \$100.00) examples listed below:**

- Blood Pressure
- Weight and/or Body Mass Index
- Review and Update of your Immunization Status
- Review of your Health Risk Assessment and Targeted Counseling as Indicated
- Screenings / Tests as Recommended by U.S. Preventive Services Task Force (USPSTF) Clinical Prevention Guidelines and your Physician. Website: [www.preventiveservices.ahrq.gov](http://www.preventiveservices.ahrq.gov)
- Initiation of discussions regarding Personal Health Care Preferences
- Coordination of Disease Management and Support Services

**Health Risk Assessment (HRA):**

The Health Risk Assessment (HRA) offered by Creative Wellness Solutions at <http://ohra.ucis.dal.ca> must be completed every Wellness Program Year. **In order to accrue wellness points for annual wellness care the HRA certification of completion must be submitted with the completed Affidavit of Annual Wellness Care.**

Your Health Risk Assessment is confidential. You may chose to grant your health care provider access to review at an annual wellness care visit. You learn more about your current health status and your health risk factors, and receive information about free resources available through Creative Wellness Solutions at <http://ohra.ucis.dal.ca> . This knowledge can help you as you set your own personal health goals. After completing the HRA, print the certificate of completion and submit with your completed Affidavit of Annual Wellness Care.

**Annual Dental Care (25 points = \$25.00) examples listed below:**

- Routine Exam and Cleaning
- X-Rays

**Maximum Total Reimbursement for 10 Week Program Per Eligible Employee = \$150.00**

**Reimbursement, up to the maximum of \$150.00, will be processed no later than 30 days following approval**

**10 Week Nutrition, Exercise, Behavioral and Lifestyle Modification Program:**

Eligible Employees may participate in a 10 Week Nutrition, Exercise, Behavioral and Lifestyle Modification Program with a certified instructor. Employees who complete the entire 10 Week program may request reimbursement of the course fee up to a maximum of \$150 per Employee / Spouse / Retiree per Wellness Program year.

To determine eligibility for reimbursement you must submit the following documentation and obtain prior approval from the Human Resources Department.

- Copy of the Program Outline with the following:
  - Certified Instructors Name and Facility Name
  - Specific Dates of the 10 Week Program
  - Course fee

Upon completion of the program you will need to submit a completed 10 Week Nutrition, Exercise, Behavioral, and Lifestyle Modification Program Reimbursement Form.

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**Wellness Program inquiries should be directed to:**

Williamson County HR Generalist, Risk Analyst

Phone: (512) 943-1533

Fax: (512) 943-1535

Email: [wellness@wilco.org](mailto:wellness@wilco.org)

Website: <http://sharepoint/default.aspx>

## 2010-2011 CSCD / CTTC WELLNESS PROGRAM

### AFFIDAVIT OF ANNUAL WELLNESS CARE

Employee Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

The Health Risk Assessment (HRA) offered by Creative Wellness Solutions at <http://ohra.ucis.dal.ca> must be completed every Wellness Program Year. The HRA certification of completion **must** be submitted with the Affidavit of Annual Wellness Care.

The intent of this affidavit is to incentivize establishing a medical home where comprehensive wellness care, such as the examples listed below, have been documented in the patient's medical record.

#### Annual Wellness Care (100 points)

- Blood Pressure
- Weight and/or Body Mass Index
- Review and Update of your Immunization Status
- Review of your Health Risk Assessment and Targeted Counseling as Indicated
- Screenings / Tests as Recommended by U.S. Preventive Services Task Force (USPSTF) Clinical Prevention Guidelines and your Physician. Website: [www.preventiveservices.ahrq.gov](http://www.preventiveservices.ahrq.gov)\*
- Initiation of discussions regarding Personal Health Care Preferences
- Coordination of Disease Management and Support Services

☐ Check here if your practice is recognized under the NCQA PCC-PCMH\*\* program and circle level: 1 2 3

\_\_\_\_\_  
PRINTED NAME OF HEALTH CARE PROVIDER

\_\_\_\_\_  
SIGNATURE OF HEALTH CARE PROVIDER

*I, the undersigned Employee have read the Wellness Program Reimbursement Procedures and Requirements, and hereby certify that I have fulfilled the above requirements for reimbursement. By signing below, I hereby certify under penalty of perjury, under the laws of the State of Texas, the foregoing is true and correct.*

\_\_\_\_\_  
EMPLOYEE #

\_\_\_\_\_  
EMAIL ADDRESS (optional)

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE

Date: \_\_\_\_\_, 20\_\_\_\_

**Please retain a copy of this document for your records before submitting to the Human Resources Department.**

**Wellness Affidavits may be submitted to the Human Resources Department one of five ways:**

**Email [wellness@wilco.org](mailto:wellness@wilco.org) • Fax (512) 943-1535 • Interoffice Mail • Hand Deliver • U.S. Mail**

**Wellness Affidavits must be received in the Human Resources Department no later than the last day of the following month after completion of the examination(s). Examination(s) completed 9/1/2011 – 10/31/2011 must be received in the Human Resources Department by October 31, 2011.**

\*Not all screenings / tests are recommended every year. Your provider will recommend how often you should be tested.

\*\*National Committee for Quality Assurance, <http://www.ncqa.org/tabid/631/Default.aspx>.

## **2010-2011 CSCD / CTTC WELLNESS PROGRAM**

### **AFFIDAVIT OF ANNUAL DENTAL CARE**

Employee Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

#### **Annual Dental Care (25 points) for an adult generally includes:**

- Routine Exam and Cleaning
- X-Rays

\_\_\_\_\_  
PRINTED NAME OF DENTAL CARE PROVIDER

\_\_\_\_\_  
SIGNATURE OF DENTAL CARE PROVIDER

*I, the undersigned Employee have read the Wellness Program Reimbursement Procedures and Requirements, and hereby certify that I have fulfilled the above requirements for reimbursement. By signing below, I hereby certify under penalty of perjury, under the laws of the State of Texas, the foregoing is true and correct.*

\_\_\_\_\_  
EMPLOYEE #

\_\_\_\_\_  
EMAIL ADDRESS (optional)

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE

Date: \_\_\_\_\_, 20\_\_\_\_

**Please retain a copy of this document for your records before submitting to the Human Resources Department.**

**Wellness Affidavits may be submitted to the Human Resources Department one of five ways:**

**Email [wellness@wilco.org](mailto:wellness@wilco.org) • Fax (512) 943-1535 • Interoffice Mail • Hand Deliver • U.S. Mail**

**Wellness Affidavits must be received in the Human Resources Department no later than the last day of the following month after completion of the examination(s). Examination(s) completed 9/1/2011 – 10/31/2011 must be received in the Human Resources Department by October 31, 2011.**

# 10 Week Nutrition, Exercise, Behavioral, and Lifestyle Modification Program Reimbursement Form

Employee Printed Name (First, Middle, Last):	
Address:	Phone Number:
Employee ID Number:	Email Address:
Name and Address of Facility:	Date of Completion:
Certified Instructor Printed Name:	
Certified Instructor Signature:	

1. Participate in an approved 10 Week Program Nutrition, Exercise, Behavioral, and Lifestyle Modification Program.
2. Upon completion of the program participants may receive reimbursement of the course fee up to a maximum of \$150 per Eligible Employee per Wellness Program year.
3. Send completed reimbursement form, copy of receipt including the facility name, payment date, course fee, and certificate of completion to the Human Resources Department by October 31, 2011.
4. Participants may be contacted by the Human Resources Department if additional documentation or information is needed for reimbursement approval.
5. A Human Resources representative will review; if approved, will sign and forward to the Payroll Department.
6. Reimbursements will be processed no later than 30 days following approval.

***I, the undersigned Employee have read the Wellness Program Reimbursement Procedures and Requirements, and hereby certify that I have fulfilled the above requirements for reimbursement. By signing below, I hereby certify under penalty of perjury, under the laws of the State of Texas, the foregoing is true and correct.***

EMPLOYEE #	EMAIL ADDRESS (optional)	SIGNATURE OF EMPLOYEE
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Date: \_\_\_\_\_, 20\_\_

**Reimbursement Forms may be submitted to the Human Resources Department one of five ways:**  
**Email wellness@wilco.org • Fax (512) 943-1535 • Interoffice Mail • Hand Deliver • U.S. Mail**

I have verified the information on this form and approve the following for reimbursement.	
<div style="border-bottom: 1px solid black; text-align: center;">/</div> <div style="border-bottom: 1px solid black; text-align: center;">Human Resources Representative Signature</div>	<div style="border-bottom: 1px solid black; text-align: center;">/</div> <div style="border-bottom: 1px solid black; text-align: center;">Date Signed</div>
<div style="border-bottom: 1px solid black; text-align: center;">/</div> <div style="border-bottom: 1px solid black; text-align: center;">Budget Line Item Number</div>	<div style="border-bottom: 1px solid black; text-align: center;">/</div> <div style="border-bottom: 1px solid black; text-align: center;">Amount Approved</div>



CreativeWellnessSolutions

*Working Well.*

**Atlantic Health and Wellness  
Institute, Research Affiliate**

## **Congratulations for choosing to participate in the online health assessment, designed for adults 18 years or older.**

**Terms of Use.** By participating in the health assessment, you agree that the results of the assessment will be used for educational purposes only and that it is not intended to and cannot replace the advice of a medical professional.

**Use of Personal Information.** The Creative Wellness Solutions and The Atlantic Health and Wellness Institute will retain the information you submit in the course of taking the online health assessment.

If you consent to be bound by this End User Notice, information about you may be published and distributed in aggregate data form (your data combined with those of other participants which does not personally identify you).

**Consent.** By clicking "I agree" below, I acknowledge that I have read, understand, and agree to the above and assert that I am at least 18 years of age. If I choose to click "I disagree" below, I understand that I will not have access to the online health assessment.

To begin, click on "I Agree".

START your healthy lifestyle now...