



Families On The Move of New York City, Inc. (FOTM)  
 Yesterday, Today, Tomorrow...Families On The Move.

*Families On The Move of New York City, Inc.  
 358 St. Marks Place, Suite 302  
 Staten Island, NY 10301  
 Phone: 347-682-4870 / Fax: 718-447-6539*

<b>Referring Agency:</b>		<b>Case Worker Name:</b>	
<b>Referring Agency Address:</b>		<b>City/State:</b>	<b>Zip Code:</b>
<b>Email:</b>		<b>Phone Number:</b>	<b>Fax Number:</b>
<b>Reason for Referral/Diagnosis:</b> <hr/> <hr/> <hr/>		<b>Client is aware of referral:</b> <input type="checkbox"/> YES  <input type="checkbox"/> NO	
<b>Parent Name:</b>		<b>Parent Signature:</b>	
<b>Address:</b>		<b>City/State:</b>	<b>Zip Code:</b>
<b>Email:</b>		<b>Cell Number:</b>	<b>Phone Number:</b>
<b>Parent DOB:</b>	<b>Parent Gender Identity:</b>		<b>Parent Sex at Birth:</b>
<b>Services Needed</b>			
<input type="checkbox"/> <b>Anger Management Training</b>			
<input type="checkbox"/> <b>Circle of Security Parenting Series Training (For parents of children up to 5 years old)</b>			
<input type="checkbox"/> <b>Parenting Skills Training</b>			
<input type="checkbox"/> <b>Parenting Skills Training (Spanish)</b>			

*To register or for more information, please contact:  
 Simone Richards, Training Manager  
 Phone 347-695-7868 / Email: institute@fotmnyc.org*



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### **ANGER MANAGEMENT REGISTRATION FORM**

**DATE:** \_\_\_\_\_ **LOCATION:** \_\_\_\_\_

<b>NAME:</b>		<b>DOB:</b>	
<b>ADDRESS:</b>		<b>CITY:</b>	<b>STATE:</b> <b>ZIP:</b>
<b>HOME #:</b>	<b>CELL #:</b>	<b>EMAIL:</b>	
<b>GENDER:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____ _____	<b>AGE GROUP:</b> <input type="checkbox"/> 6 - 12 <input type="checkbox"/> 13 - 18 <input type="checkbox"/> 19 - 30 <input type="checkbox"/> 30 +	<b>MARITAL STATUS:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<b>Are you a Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ _____	<b>Ethnicity</b> <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander	<b>Education Level Complete:</b> <input type="checkbox"/> Elementary <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Vocational School	
<b>Social Security #:</b> _____ - _____ - _____	<b>Income Source:</b> <input type="checkbox"/> Employment <input type="checkbox"/> SSI/SSD <input type="checkbox"/> Public Assistance <input type="checkbox"/> Other: _____ _____	<b>Health Conditions:</b> _____ _____ _____ _____	



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**Health Insurance:**

**Private: Carrier:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

**HMO Carrier:** \_\_\_\_\_ **ID #:** \_\_\_\_\_

**Medicaid: CIN #** \_\_\_\_\_

**None**

**Primary Doctor:** \_\_\_\_\_

**SYSTEM(S) INVOLVMENT:**

- ACS**
- JUVENILE JUSTICE**
- SPECIAL EDUCATION**
- BEHAVIORAL HEALTH**
- SUBSTANCE ABUSE**
- OTHER:** \_\_\_\_\_
- FAMILY COURT**
- CRIMINAL JUSTICE**
- MENTAL HEALTH**
- EMOTIONAL HEALTH**

**Case Worker's Name and Phone #**

\_\_\_\_\_

<b>HOUSEHOLD COMPOSITION:</b>	<b>NAME:</b>	<b>RELATIONSHIP:</b>	<b>D.O.B:</b>

**Have you ever taken an Anger Management class before? If so, when?**

\_\_\_\_\_  
\_\_\_\_\_

**Do you currently have substance abuse challenges?** \_\_\_\_\_



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<p><b>Why are you taking this class? (check all that apply)</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <b>Manage anger related issues</b></li><li><input type="checkbox"/> <b>Recognize feelings of anger</b></li><li><input type="checkbox"/> <b>Court ordered</b></li><li><input type="checkbox"/> <b>Learn about drugs/violence</b></li><li><input type="checkbox"/> <b>Juvenile Justice</b></li><li><input type="checkbox"/> <b>ACS involvement</b></li><li><input type="checkbox"/> <b>Other:</b> _____</li></ul>
<p><b>Do you currently have an order of protection against someone or does someone have one against you?</b></p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><b>How did you hear about the class?</b></p> <p><input type="checkbox"/> <b>Flyers/Announcements</b>   <input type="checkbox"/> <b>Friend/Relative</b>   <input type="checkbox"/> <b>Agency Referral</b>   <input type="checkbox"/> <b>Court Ordered</b></p>
<p style="text-align: center;"><b>What services are you interested in receiving while at Families On The Move:</b></p> <p><input type="checkbox"/> <b>Parenting Classes</b>   <input type="checkbox"/> <b>Support Groups</b>   <input type="checkbox"/> <b>Anger Management Classes</b>   <input type="checkbox"/> <b>Advocacy</b></p> <p style="padding-left: 40px;"><input type="checkbox"/> <b>Afterschool Activities</b>   <input type="checkbox"/> <b>Workshops</b>   <input type="checkbox"/> <b>Peer to Peer Support</b></p>

# AUTHORIZATION FOR RELEASE OF INFORMATION



Person's Name (Last, First, M.I.) \_\_\_\_\_

.....

Date of Birth .....

This authorization must be completed by the person or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

## PART 1: Authorization to Release Information

**Description of Information to be Used/Disclosed:**

**Purpose or Need for Information:**

1. This information is being requested:
  - by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or
  - Other (please describe) \_\_\_\_\_
2. The purpose of the disclosure is (please describe):

**From:** Name, Address, & Title of Person/  
Organization/Facility/Program Disclosing Information

Families On The Move Of New York City, Inc.

358 St. Marks Place, Suite 302  
Staten Island, NY 10301

**To:** Name, Address, & Title of Person/Organization/Facility/  
Program to Which this Disclosure is to be Made

***NOTE:** If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- A.** I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:
1. Only the information described in this form may be used and/or disclosed as a result of this authorization.
  2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
  3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
  4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (*insert name of facility/program*) \_\_\_\_\_  
I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
  5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
  6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16).

**B-1. One-Time Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above to the person/organization/facility/program identified above.

My authorization will expire:

- When acted upon;  90 Days from this Date;  Other \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

Facility/Agency Name	Person's Name (Last, First, M.I.)	Date:
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**B-2. Periodic Use/Disclosure:** I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

- When I am no longer receiving services from *(insert name of facility/program)* \_\_\_\_\_ ;
- One year from this date;
- Other \_\_\_\_\_

**C. Service Recipient's Signature:** I certify that I authorize the use of my health information as set forth in this document.

\_\_\_\_\_  
Signature of Service Recipient or Personal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Service Recipient's Name (Printed)

\_\_\_\_\_  
Personal Representative's Name (Printed)

\_\_\_\_\_  
Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

**D. Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: \_\_\_\_\_  
Staff person's name and title

Authorization Provided To: \_\_\_\_\_

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

**To be Completed by Families On The Move of New York City, Inc:**

\_\_\_\_\_  
Signature of Staff Person Using/Disclosing Information

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date Released

### PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Service Recipient or Personal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Service Recipient Name (Printed)

\_\_\_\_\_  
Personal Representative's Name (Printed)

\_\_\_\_\_  
Description of Personal Representative's Authority to Act for the Service Recipient *(required if Personal Representative signs Revocation of Authorization)*