FOTM
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

Please Type or Print Clearly

Referring Agency:	**Case Worker Name:**	
Referring Agency Address:	**City/State:**	**Zip Code:**
Email:	**Phone Number:**	**Fax Number:**
Reason for Referral/Diagnosis:		**Client is aware of referral:** □ **YES** □ **NO**
Parent Name:	**Parent Signature:**	
Address:	**City/State:**	**Zip Code:**
Email:	**Cell Number:**	**Phone Number:**
Parent DOB:	**Parent Gender Identity:**	**Parent Sex at Birth:**

Services Needed
□ **Anger Management Training**
□ **Circle of Security Parenting Series Training (*For parents of children up to 5 years old*)**
□ **Parenting Skills Training**
□ **Emotional Fitness Parenting Training (*Special Needs*)**

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

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PARENTING REGISTRATION FORM

DATE: _____ LOCATION: _____

NAME:			**DOB:**
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
HOME #:	**CELL #:**		**EMAIL:**

GENDER: □ **Male** □ **Female** □ **Other: _____** **_____**	**AGE GROUP:** □ **6 - 12** □ **13 - 18** □ **19 - 30** □ **30 +**	**MARITAL STATUS:** □ **Single** □ **Married** □ **Divorced** □ **Widowed**	**Are you a Veteran?** □ **Yes** □ **No**

Primary Language Spoken: □ **English** □ **Spanish** □ **Other: _____** **_____**	**Ethnicity** □ **Black or African American** □ **White** □ **Asian American** □ **Hispanic or Latino** □ **American Indian or Alaskan Native** □ **Native Hawaiian or other Pacific Islander**	**Education Level Complete:** □ **Elementary** □ **High School/GED** □ **Some College** □ **Associate's Degree** □ **Bachelor's Degree** □ **Master's Degree** □ **Vocational School**

Social Security #: **_____-_____-_____**	**Income Source:** □ **Employment** □ **SSI/SSD** □ **Public Assistance** □ **Other: _____** **_____**	**Health Conditions:** **_____** **_____** **_____** **_____**

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Health Insurance:

□ **Private: Carrier: _____ID #:_____**
□ **HMO Carrier: _____ID #:_____**
□ **Medicaid: CIN #_____**
□ **None**
Primary Doctor: _____

SYSTEM(S) INVOLVMENT:

□ **ACS** □ **FAMILY COURT**
□ **JUVENILE JUSTICE** □ **CRIMINAL JUSTICE**
□ **SPECIAL EDUCATION** □ **MENTAL HEALTH**
□ **BEHAVIORAL HEALTH** □ **EMOTIONAL HEALTH**
□ **SUBSTANCE ABUSE**
□ **OTHER: _____**

Case Worker's Name and Phone #

_____

HOUSEHOLD COMPOSITION:	NAME:	RELATIONSHIP:	D.O.B:

Have you ever taken a Parenting class before? If so, when?

_____

_____

Do you currently have substance abuse challenges? _____

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Why are you taking this class? (check all that apply)

- □ **To become a better parent**
- □ **Having problems with children**
- □ **Court ordered**
- □ **Learn about drugs/violence**
- □ **Juvenile Justice**
- □ **ACS involvement**
- □ **Other: _____**

Do you currently have an order of protection against someone or does someone have one against you?

_____

_____

How did you hear about the class?

□ **Flyers/Announcements** □ **Friend/Relative** □ **Agency Referral** □ **Court Ordered**

What services are you interested in receiving while at Families On The Move:

□ **Parenting Classes** □ **Support Groups** □ **Anger Management Classes** □ **Advocacy**

□ **Afterschool Activities** □ **Workshops** □ **Peer to Peer Support**

AUTHORIZATION FOR RELEASE OF INFORMATION

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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_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Facility/Agency Name	Person's Name (Last, First, M.I.)	Date:

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)*