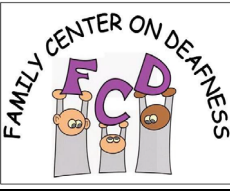


<i>Intake-Update-Close:</i>		FAMILY CENTER ON DEAFNESS	
Date Submitted:		12445 62nd St. Largo, Florida 33773	
* Intake Date :		Voice: 727-501-2323 Video: 727-253-6285	
		Email: info@fcdpinellas.org	

HOUSEHOLD			
* Name:	*Household* FIRST _____ * LAST _____	* Household Income:	_____
* Home Arrangement:	_____	* # of Adults:	_____
		* # of Children:	_____

Service Type: Adult	(SELF)
* Name: _____ <div style="display: flex; justify-content: space-between;"> * FIRST * LAST MIDDLE SUFFIX </div>	
Home Address: _____	
* DOB (mm dd yy): _____	
Address Line 2: _____	
Social Security: _____ N/A	
City: _____ State: <u>Florida</u> Zip Code: _____	
Deaf / Hearing: _____	
Home #: _____	Video Phone #: _____
* Sex:	M or F
Cell #: _____	Text / voice/ Both: <u>Voice or Text or Both</u>
Gender: _____	
Email: _____	* Current Living Situation: _____
* Race: _____	
* Education Status: _____	* Speak Language: _____
* Ethnicity: _____	
* Referred From: _____	* Relation to Head of Household: _____

Service Type: OTHER ADULT(S) IN FAMILY (If more than one, attach additional sheet)			
* Name:	* FIRST _____ * LAST _____	MIDDLE	SUFFIX
Home Address: _____		* DOB (mm dd yy): _____	
Address Line 2: _____		Social Security: _____ N/A	
City: _____ State: <u>Florida</u> Zip Code: _____		Deaf / Hearing: _____	
Home #: _____	Video Phone #: _____	* Sex:	M or F
Cell #: _____	Text / voice/ Both: <u>Voice or Text or Both</u>	Gender: _____	
Email: _____	* Current Living Situation: _____	* Race: _____	
* Education Status: _____	* Speak Language: _____	* Ethnicity: _____	
* Relation to Head of Household: _____			

Service type: CHILDREN IN FAMILY (If more than 3, attach additional sheet)			
* Name:	* FIRST _____ * LAST _____	MIDDLE	SUFFIX
Home #: _____		Video Phone #: _____	
* DOB (mm dd yy): _____			
Cell #: _____		Text / voice/ Both: <u>Voice or Text or Both</u>	
Social Security: _____		N/A	

Email: _____	* Current Living Situation: _____	Deaf / Hearing: _____
Student ID #: _____	* Speak Language: _____	* Sex: _____ M or F
* School Name: _____	* Grade/ Education: _____	Gender: _____
* Relation to Head of Household: _____	* Ethnicity: _____	* Race: _____

Service Type: CHILD 2

* Name: _____	* FIRST _____	* LAST _____	MIDDLE _____	SUFFIX _____
Home #: _____	Video Phone #: _____	* DOB (mm dd yy): _____		
Cell #: _____	Text / voice/ Both: _____ Voice or Text or Both	Social Security: _____	N/A	
Email: _____	* Current Living Situation: _____	Deaf / Hearing: _____		
Student ID #: _____	* Speak Language: _____	* Sex: _____ M or F		
* School Name: _____	* Grade/ Education: _____	Gender: _____		
* Relation to Head of Household: _____	* Ethnicity: _____	* Race: _____		

Service Type: CHILD 3

* Name: _____	* FIRST _____	* LAST _____	MIDDLE _____	SUFFIX _____
Home #: _____	Video Phone #: _____	* DOB (mm dd yy): _____		
Cell #: _____	Text / voice/ Both: _____ Voice or Text or Both	Social Security: _____	N/A	
Email: _____	* Current Living Situation: _____	Deaf / Hearing: _____		
Student ID #: _____	* Speak Language: _____	* Sex: _____ M or F		
* School Name: _____	* Grade/ Education: _____	Gender: _____		
* Relation to Head of Household: _____	* Ethnicity: _____	* Race: _____		

SECTION 5: REQUEST FOR SERVICES

My signature below certifies that I request FCD staff provide the services identified; have received a copy of the Participant Rights & Responsibilities/Confidentiality Policy and the Written Statement of Purpose(s) for Collection of Social Security Numbers; commit to complete my part of plans set up with FCD staff; agree to volunteer my family's time and talents to meet community needs and achieve personal goals; give permission for household members to be photographed/ videotaped for purposes of promoting the program and its funders; have reviewed the information provided on this application and claim it to be true and accurate to the best of my knowledge.

_____ Signature of Applicant	_____ Date
_____ Submitted by	_____ Initials

Submitted SAMIS INFORMATION FORM for entry on



**Authorization and Consent for Disclosure,
Receipt, and Use of Confidential Information
by the Juvenile Welfare Board of Pinellas County**

I, _____ (print participant name(s))
acknowledge that I am a participant of _____ (name of
program or service). I acknowledge that the Juvenile Welfare Board of Pinellas County ("JWB")
provides funds to make the program or service in which I am participating available. I also
acknowledge that in order to make sure that all services delivered to participants are of the
highest possible quality, JWB may need to review information about me and these services.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that as necessary to carry out the purposes listed herein, JWB may review all information about me, including my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB generally provides no direct services to me, except in certain circumstances may facilitate service delivery I further acknowledge that JWB does not provide medical diagnoses to me and JWB is not a covered entity as that term is defined under HIPAA (the Health Insurance Portability and Accountability Act).

I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, any information concerning the performance of any tests, results of those tests, and counseling and treatment records, as allowed by all state, federal and local laws, including, but not

limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42. I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program, or with respect to information used in research, or for compliance and quality review activities performed by JWB or its agents, upon completion of the last research project or compliance/ quality review, whatever occurs latest. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

 Witness Signature

 Date

 (print participant name)

 Effective Date

 Signature of Participant or Participant's
 Authorized Representative (check one):

☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents
 Required)

(print participant name)

Effective Date

Signature of Participant or Participant's
Authorized Representative (check one):

- ☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

Signature of Participant or Participant's
Authorized Representative (check one):

- ☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

Signature of Participant or Participant's
Authorized Representative (check one):

- ☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

Signature of Participant or Participant's
Authorized Representative (check one):

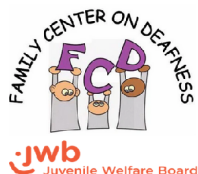
- ☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents
Required)

(print participant name)

Effective Date

Signature of Participant or Participant's
Authorized Representative (check one):

- ☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents
Required)



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www.fcdpinellas.org

Medical Emergency

In case of a medical emergency, I understand that reasonable effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the person in charge to select a physician, to hospitalize, secure proper treatment for, and to order injections, anesthetics, or surgery deemed necessary for the health of my child. I hereby give my consent to any emergency facility and/or physician to administer necessary treatment to my child, named above, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants.

CHILD'S NAME _____ DOB _____

FAMILY PHYSICIAN: _____ PHONE: _____

HEALTH INSURANCE NAME/#: _____

BLOOD TYPE: _____ DATE DPT/TETANUS: _____

MEDICAL CONDITIONS: _____

LIST ALL CURRENT MEDICATIONS _____

Will your child need to take any prescription medications during the program?

YES OR NO. If yes, please inform the case manager.

ALLERGIES: _____

Specific activities to be restricted for health reasons: _____

CONTACT INFORMATION:

EMERGENCY CONTACT: _____ PHONE: _____

PARENT/GUARDIAN: _____ DAY PHONE: _____

EVENING PHONE: _____ CELL PHONE/PAGER #: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

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Permission for Transportation

My child, _____, has my permission to participate in all activities of the **FAMILY CENTER ON DEAFNESS** (FCD). I permit him/her to be transported by/with authorized staff/volunteers by van, bus, car, or on foot and release staff and officers of the FCD of any responsibility other than reasonable care.

I have read and understand the above:

Parent/Guardian Signature _____

Printed name _____

Date _____

FAMILY CENTER ON DEAFNESS, INC.



jwb
Juvenile Welfare Board

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Permission to Use Photograph

I grant to Family Center on Deafness, its representatives and employees the right to take photographs of me and my property in connection with events that I participate in. I authorize Family Center on Deafness, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Family Center on Deafness may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Participant name _____

Date _____

Signature, parent or guardian _____
(if under age 18)

PINELLAS COUNTY SCHOOLS
AUTHORIZATION FOR STUDENT CONTACT/RELEASE OF INFORMATION

Date _____

The undersigned hereby authorize(s) the School Board of Pinellas County, Florida, or its below-identified employee(s) or agent(s) to allow access to student on campus and/or to send or receive the below-listed information to or from the following named agency(ies) or other entity(ies):

Pinellas County Schools, Florida

Attention: _____

Name of Agency and/or other Entity

Address

Address

City State Zip

City State Zip

Telephone Number

Telephone Number

Information Needed By:

_____/_____/_____

☐ Medical/Neurological

☐ Intellectual/Psychological/Psychiatric

☐ Educational Records

☐ Service Summary

☐ Biopsychosocial
History

☐ Exceptional Student Program Records

☐ Agency to see student on campus

☐ Other: _____

If for any reason you are unable to forward the records we have requested, please contact us. Thank you.

STUDENT: Name _____ Birthdate _____

Address _____

City _____

School _____ Grade _____

All information received by the School Board shall be used for legitimate educational purposes and confidentiality of all student records shall be maintained in accordance with applicable federal and state law. Further, the undersigned authorizes the School Board to release the above-stated educational records only for the following purposes: _____

☐ Provision of counseling/social services to student/family

☐ Sharing of information

☐ Other:

This release remains valid during student's educational career in district. I understand that I may revoke this release at any time by notifying in writing of my desire to limit or revoke this release. In addition, the Agency listed above may wish to have access to the student at school for case management, counseling, school visits, or other reasons. Please mark one of the following boxes regarding your desire.

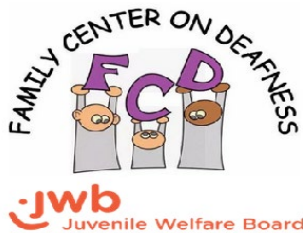
☐ I hereby grant permission for the Agency listed above to have access to my student at school.

☐ I do not want the Agency listed above to have access to my student at school.

Parent/Guardian Signature Date

Student Signature if applicable Date

The child MUST sign if he/she is 18 years of age or older.



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Participant Rights and Responsibilities

All client services at the Family Center on Deafness are conducted on a completely voluntary basis. FCD's policy is that any and all activities or programs shall be conducted without discrimination on the basis of race, sex, age, income, handicap, national origin, religious creed, political opinions, affiliations, or sexual orientation in accordance with Title VI of the Civil Rights Act of 1964, the Civil Rights Restoration Act of 1987 and the Florida Civil Rights Act of 1992.

All participants receiving services from FCD have the **right** to:

- Be assigned a primary contact person on FCD staff.
- Be treated equitably and with respect.
- Be informed of the services available.
- Participate in the planning of services to be provided.
- Have the right of confidentiality and privacy will be adhered to.
- Receive referrals for approval of other services as needed.
- Receive information in a method of communication that is individually accessible.
- Receive services in a professional, ethical, confidential, and timely manner.
- Submit grievances through a formal, standardized process.
- Have reasonable access to participant records, in accordance with current regulations and program requirements.
- Receive a copy of Participant Rights and Responsibilities.
- Receive written explanation upon termination of services by FCD.
- Withdraw from/terminate services at any time.

All participants receiving services from FCD have the **responsibility** to:

- Read and follow the Participant Rights and Responsibilities.



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- Provide full and accurate information as requested on the intake forms, and update that information as needed.
- Actively participate in service planning and implementation.
- Attend all activities and events as agreed with staff.
- Keep scheduled appointments or cancel with appropriate notice.
- Maintain the confidentiality of the program and of other participants at all times.
- Inform the staff of any changes that impact services to be provided, ex: new address, phone number, etc.
- Refrain from bringing drugs, alcohol, or weapons of any kind on the FCD property.
- Dress appropriately for visits to FCD and corresponding events/activities.
- Refrain from violent or abusive behavior including physical or verbal threats, the use of foul language, or acts of aggression towards other participants, staff, or property.
- Pay for any intentional damage personally caused to the property.
- Express suggestions or concerns about services provided.
- Contribute talents and time to furthering the goals of FCD.

Grievance Procedure

We recognize that in any environment in which people interact regularly, conflicts, complaints or concerns may arise. These issues may be between individuals, with staff, or regarding specific policies or rules. This grievance procedure is in place to ensure you have a process to formally log your complaint or concern, be heard, and have an opportunity for resolution.

You have the right to begin the Grievance Procedure if you believe that any policy has been unfairly applied to you, or that you and/or your children have been mistreated by anyone professionally associated with FCD.

All grievances should first be brought to the attention of your Case Manager or FCD Point of Contact. This is an informal process, just give them a call or send an email or talk to them in person. If the issue is not resolved, you can request a meeting with the Executive Director. To do that, you can email info@fcdpinellas.org or call the office at (727) 501-2323, and ask to make an appointment. If after following the above steps, you feel there is no resolution to your grievance, a meeting can be requested, in writing, with the President of the FCD Board of Directors. Email within 3 days after the meeting with the Executive Director to request a meeting. The Board of Directors will make the final decision on how the grievance will be resolved. The decision will be given both verbally and in writing. A copy of the decision will be placed in your file for our records.



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FCD maintains a formal mechanism through which participants can express and resolve grievances, including denial of service, which includes:

- The right to file a grievance without interference or retaliation.
- Timely written notification of the resolution and an explanation of any further appeal, rights or recourse.
- At least one level of review does not involve the person about whom the complaint has been made or the person who reached the decision under review.

Confidentiality and Privacy Protections

The Family Center on Deafness protects the confidentiality of information of all clients. FCD considers a family's right to privacy to be of utmost importance. Information that is divulged by clients to staff members, in private, is held in strict confidence.

When permitted or required by law, regulation, or court order, confidential information may be released without the authorization of the client. However, the client and legal guardian should still be informed that the information will be released. FCD informs the client, prior to his or her disclosure of confidential or private information, about circumstances when FCD may be legally or ethically permitted or required to release such information without the client's consent.

When FCD receives a request for confidential information about a client, or when the release of confidential information is necessary for the provision of services, prior to releasing such information, FCD:

- Determines if the reason to release information is valid.
- Obtains the client's informed, written authorization to release the information, if feasible.
- Obtains informed, written authorization from a parent or legal guardian, as appropriate.
 - When the client is a minor or an adult under the care of a guardian, FCD will follow any laws or regulations allowed or required to obtain the authorization of clients' parents or legal guardians.



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I, _____, have received, read, understand and agree to abide by the Family Center On Deafness' Participant Rights And Responsibilities.

Parent/Guadian

Date

Accepted By:

Date