Intake-Update-Close:		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:** _____ (* FIRST) _____ (* LAST) _____ (MIDDLE) _____ (SUFFIX)

Home Address: _____ *** DOB (mm dd yy):** _____

Address Line 2: _____ **Social Security:** N/A

City: _____ **State:** Florida **Zip Code:** _____ **Deaf / Hearing:** _____

Home #: _____ **Video Phone #:** _____ *** Sex:** M or F

Cell #: _____ **Text / voice/ Both:** Voice or Text or Both **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:** Florida **Zip Code:** _____ **Deaf / Hearing:** _____

Home #: _____ **Video Phone #:** _____ *** Sex:** M or F

Cell #: _____ **Text / voice/ Both:** Voice or Text or Both **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:** 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 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 Colletion 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 jwb Juvenile Welfare Board

**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 **FCD (Family Center on Deafness),**(*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 provides no direct services to me, including, but not limited to, coordination of services, recommendation of services, or medical diagnoses. I further acknowledge that 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, 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

Juvenile Welfare Board
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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, upon completion of the last research project 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.

_____
(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)

_____ _____
Witness Signature Date

I hereby authorize *for* the information referenced above to be shared with the following schools or entities checked below. I also authorize the Pinellas County School Board to share any education records and information regarding my child with JWB.

- ○ Pinellas County School
- ○ Cross Bayou Elementary
- ○ Morgan Fitzgerald Middle School
- ○ Pinellas Park High School
- ○ All Children's Hospital
- ○ Terri Pendleton LMHC
- ○ Juvenile Welfare Board
- ○ Other_____
- ○ Other_____

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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:_____

The mission of the FAMILY CENTER ON DEAFNESS is to link Pinellas County, Florida, households with deaf or hard of hearing members to relevant services by providing programs and referrals for parents, youth, and community partners that promote family and individual independence and self-sufficiency.

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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 _____

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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: _____

_____
Address

_____
City State Zip

_____
Telephone Number

Family Center on Deafness
Name of Agency and/or other Entity

12445 62nd St # 303
Address

Largo FLorida 33773
City State Zip

727-648-4969
Telephone Number

Information Needed By:

_____/_____/_____

- ☐ Medical/Neurological
- ☑ Educational Records
- ☑ Biopsychosocial History
- ☑ Intellectual/Psychological/Psychiatric
- ☐ Service Summary
- ☑ Exceptional Student Program Records
- ☑ Agency to see student on campus
- ☐ Other: Audiological and general information

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.

White – Agency Yellow – Parent Pink – School/Student Services Gold – Central Files

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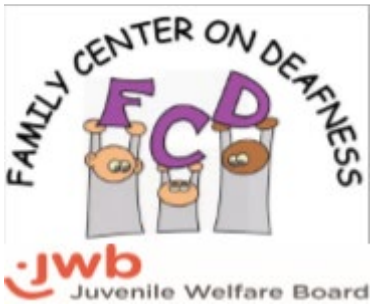

Participant Rights and Responsibilities

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 brining 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 call Vanessa Barahona at 727-501-2323 or email at vanessa@fcdpinellas.org, 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 Cherasaron@pcsb.org the meeting request within 3 days after the meeting with the Executive Director. 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.

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