Intake Form

Journey Wellness & Consulting Group, LLC.
364 E. Main Street Ste 184
Middletown, DE 19709
Phone: (302) 723-8859 Fax: (302) 351-7176
Info@JourneyWellnessDelaware.com

Name: ____

Client's Gender Assigned at Birth: ____________ Affirmed Pronouns:______________________

Birth Date: ____

Client Address:
____

____

Client's Phone: ________________________ Email: ______________________________

Client's Insurance Carrier: ____________________ Insurance #:_________________________

Parent/Insurance Subscriber (if not client. Please include address if not the same as client) :

____

What are you seeking help with/for:
____
____
____

Current medications, if any:
____
____

Current Diagnoses (if any):
____
____

Additional Comments (if any):

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Telehealth Disclosure

Telemedicine Informed Consent

I ________________________________ hereby consent to engage in telemedicine (e.g., internet, email or telephone based therapy) with Journey Wellness & Consulting Group, LLC (Journey Wellness) as a mode of my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic

storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that, despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with California law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

____ _________________Date
Signature of Patient or Legal Guardian, if applicable

____ _________________Date
Print Name of Patient or Legal Guardian, if applicable

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Patient Notice of Privacy for Protected Health Information

The Notice of Privacy Practices provided by **Journey Wellness & Consulting Group, LLC.** describes such uses and disclosures more completely.

I hereby give my consent for **Journey Wellness & Consulting Group, LLC.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Journey Wellness & Consulting Group, LLC.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Journey Wellness & Consulting Group, LLC. (using above contact information).**

With this consent, **Journey Wellness & Consulting Group, LLC.** may call my home or other alternative provided contact and leave a voice mail or personal reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance concerns, and information pertaining to clinical care.

With this consent, **Journey Wellness & Consulting Group, LLC.** may use my mailing address to assist the practice in carrying out TPO, such as appointment reminder cards and patient statements (marked "Personal and Confidential").

With this consent, **Journey Wellness & Consulting Group, LLC.** may e-mail to my provided contact, items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Journey Wellness & Consulting Group, LLC.** restricts use or disclosure of my PHI to carry out TPO.
The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Journey Wellness & Consulting Group, LLC.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Journey Wellness & Consulting Group, LLC. may decline to provide treatment to me.

____
Signature of Client/Parent or Legal Guardian

_________________________Date

____
Print Name of Signature of Client/Parent or Legal Guardian

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INFORMED CONSENT FOR TREATMENT

I hereby provide my consent to accept psychiatric, mental health, or alcohol and drug abuse treatment as described to me by the clinicians at Journey Wellness & Consulting Group, LLC. (JWCG).

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Journey Wellness & Consulting Group, LLC. (JWCG).
2. I acknowledge that I have been given information regarding my rights and responsibilities as a participant.
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services from Journey Wellness & Consulting Group, LLC.
5. I understand that I am responsible to pay a copay and that it is payable each time I come for treatment. If changes in fees or co-pays should happen, Journey Wellness & Consulting Group, LLC. will notify me immediately regarding my responsibility.
6. I understand that I may address any concerns or grievances with my therapist or any other representative of my behavioral health member services team.
7. I am freely choosing to enter treatment, and I understand that I may discontinue treatment at any time.
8. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives. I may stop services at any time, however I am still responsible for paying for services I have received.

_______________________________________ _______________

Signature of Client/Parent or Legal Guardian Date

MINOR (Emancipated Minors Only):

Due to the following reason ____, I have the legal capacity

under applicable ____________________ (State)law to apply for consent to such treatment and services mentioned in this form, without parental consent.

_______________________________________ _______________

Signature of Participant Date

PARENT OR GUARDIAN OF MINOR CHILD:

I, ___________________________________, do hereby state that I am the parent or legal guardian of the participant

_____________________________________; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_______________________________________ _______________

Signature of Participant/ Parent or Legal Guardian Date

_______________________________________ _______________

Witness Date

*As witness, I acknowledge that the above information has been signed by the client and services will be rendered as described in the policies and procedures forms.

Journey Wellness & Consulting Group, LLC.
5700 Kirkwood Hwy, Suite 204
Wilmington, DE 19808
Phone: (302) 691-8116 Fax: (302) 351-7176
Email: Info@JourneyWellnessDelaware.com

CONTACTING YOUR THERAPIST

Therapists may often not immediately available by telephone. Calls can not be answered when therapist is with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible; it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from your therapist or and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please do one of the following:

- Contact Crisis Intervention Services: Northern Delaware 302-577-2484 or 800-652-2929;
- Southern Delaware 302-577-2484 and 800-345-6785
- Go to your local hospital Emergency Room
- Call 911 and ask to speak to the mental health worker on call

Your therapist will make every attempt to inform you in advance of planned absences.

OTHER RIGHTS

If you are unhappy with your therapeutic process, talk with your therapist or contact the office so that your concerns can be addressed. Such comments will be taken seriously and handled with care and respect. You may also request a referral to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about therapist specific training and experiences.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this agreement (Policies & Procedure Form /Client Service Agreement) and the Notice of Privacy Practices and agree to their terms.

Patient's or Patient's Representative Signature: ________________________________ Date: ___/___/___

Print Patient's or Patient's Representative Name: ____

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AUTHORIZATION TO OBTAIN AND/OR DISCLOSE PROTECTED INFORMATION

Client's Name: ________________________________ Date of Birth: ______________________________

I authorize the use of disclosure of the above named individual's information as described below:

The following organization is authorized to **OBTAIN and/or DISCLOSE (*CIRCLE ONE OR BOTH)*** the selected information to the person listed below:

Journey Wellness & Consulting Group, LLC.

The type of information to be used or disclosed is limited to the following:

- ☐ Verbal Only
- ☐ Admission & Discharge Dates Only
- ☐ Educational Records
- ☐ Attendance
- ☐ Classroom Attendance
- ☐ Classroom Behavior
- ☐ Progress Notes
- ☐ Individual Education Plan
- ☐ Psychoeducational/Therapy Transcripts
- ☐ Psychological Evaluations
- ☐ School Visit(s)
- ☐ Other: ____________________________________

I understand that the information in my health record may include information related to sexually transmitted diseases, including HIV/AIDS. It may also contain information about treatment for alcohol and drug abuse.

The information may be obtained from or disclosed to the following individual or organization:

CHECK ONE:	REFERRAL SOURCE	THERAPIST	PSYCHIATRIST	CCCP	PCP
	SCHOOL/WELLNESS CENTER	PROBATION	EMPLOYER	FAMILY MEMBER	**OTHER**

____

(Individual or Organization) (Address/phone)

for the purpose of:__________________Coordination of Care______________________________

This Authorization to Release Protected Health Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), standards for privacy of individually identifiable health information standards, 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereof. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Department of Health Information Services at Rockford Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in 60 days.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Guardian/Parent Signature:_______________________________________ Date:______________

Therapist Signature:____ Date:______________

Life Events Checklist

Designed by Caelan Kuban, Sarah Slamer and William Steele

TLC's *Life Events Checklist* is a screening tool designed to identify potentially traumatizing events that have occurred in a child or adolescent's lifetime. This tool does not diagnosis PTSD, however, it does identify incidents and events a child or adolescent has experienced that may lead to PTSD.

DIRECTIONS:
Instruct the respondent (child, adolescent, parent or caregiver) to check every item on the list that the child or adolescent has experienced, either as a victim, witness, peer, or if they were related in some other way to whomever experienced the event. Ask them to write down any other incidents that are not on the list that they believe might have been traumatic for the child or adolescent, such as a prolonged hospital stay.

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TLC@starrtraining.org

Life Events Checklist

Name ______________________________ Date ________________

Instructions: Check all of the following life events that your child or adolescent has experienced. Write down any other incidents that are not on the list that might have been traumatic for your child or adolescent.

Home

- ❑ Death of a family member
- ❑ Domestic violence
- ❑ Abuse
- ❑ Neglect
- ❑ Separation/divorce
- ❑ Incarceration of a parent or sibling
- ❑ Neighborhood violence
- ❑ Robbery or theft
- ❑ Abuse of drugs or alcohol by parent/guardian/sibling
- ❑ Illness of family member
- ❑ Fight with parent/guardian/sibling
- ❑ Utilities turned off
- ❑ Other: ______________________

School

- ❑ Behavior problem
- ❑ Failing grade
- ❑ Fight/bullying
- ❑ Victim of bullying
- ❑ Use of drugs or alcohol
- ❑ Skipped school or a class
- ❑ Death of a teacher or classmate
- ❑ Illness of a teacher or classmate
- ❑ Conflict with a teacher
- ❑ Conflict with a classmate
- ❑ Other: ______________________

Personal

- ❑ Family treatment
- ❑ Psychotropic medication
- ❑ Illness
- ❑ Cutting/self abuse
- ❑ Use of drugs or alcohol
- ❑ Eating disordered behavior
- ❑ Suicidal ideation
- ❑ Intense sadness
- ❑ Intense hopelessness
- ❑ Intense anger leading to harming someone else
- ❑ Other: ______________________

Social

- ❑ Argument with friend
- ❑ Use of drugs or alcohol
- ❑ Car accident
- ❑ Witness to fight
- ❑ Witness to violence
- ❑ Trouble making friends
- ❑ Does not get along well with others
- ❑ Other: ______________________

CTS

Child Report (Age 7+)

Child ID: ______________________ Date Completed: _____________ Administered By: _______________

Gender: ☐ Male ☐ Female Age: _________

EVENTS: Sometimes, scary or very upsetting things happen to people. These things can sometimes affect what we think, how we feel, and what we do.

		Yes	**No**
1.	Have you ever seen people pushing, hitting, throwing things at each other, or stabbing, shooting, or trying to hurt each other?	☐	☐
2.	Has someone ever really hurt you? Hit, punched, or kicked you really hard with hands, belts, or other objects, or tried to shoot or stab you?	☐	☐
3.	Has someone ever touched you on the parts of your body that a bathing suit covers, in a way that made you uncomfortable? Or had you touch them in that way?	☐	☐
4.	Has anything else very upsetting or scary happened to you (loved one died, separated from loved one, been left alone for a long time, not had enough food to eat, serious accident or illness, fire, dog bite, bullying)? *What was it?* ____________________	☐	☐

REACTIONS: Sometimes scary or upsetting events affect how people think, feel, and act. The next questions ask how you have been feeling and thinking recently.

	How often did each of these happen in the last 30 days?	**Never/ Rarely**	**1-2 times per month**	**1-2 times per week**	**3+ times per week**
5.	Strong feelings in your body when you remember something that happened (sweating, heart beats fast, feel sick).	0 ☐	1 ☐	2 ☐	3 ☐
6.	Try to stay away from people, places, or things that remind you about something that happened.	0 ☐	1 ☐	2 ☐	3 ☐
7.	Trouble feeling happy.	0 ☐	1 ☐	2 ☐	3 ☐
8.	Trouble sleeping.	0 ☐	1 ☐	2 ☐	3 ☐
9.	Hard to concentrate or pay attention.	0 ☐	1 ☐	2 ☐	3 ☐
10.	Feel alone and not close to people around you.	0 ☐	1 ☐	2 ☐	3 ☐

Notes:

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CTS

Caregiver Report (Age 6+)

Child ID: ______________________ Date Completed: _____________ Administered By: _______________

Child's Gender: ☐ Male ☐ Female Child's Age: __________

EVENTS: Sometimes, scary or very upsetting things happen to people. These things can sometimes affect what we think, how we feel, and what we do.

		Yes	No
1.	Has your child ever seen people pushing, hitting, throwing things at each other, or stabbing, shooting, or trying to hurt each other?	☐	☐
2.	Has someone ever really hurt him/her? Hit, punched, or kicked him/her really hard with hands, belts, or other objects, or tried to shoot or stab him/her?	☐	☐
3.	Has someone ever touched him/her on the parts of his/her body that a bathing suit covers, in a way that made you or your child uncomfortable? Or has someone had your child touch them in that way?	☐	☐
4.	Has anything else very upsetting or scary happened to your child (loved one died, separated from loved one, been left alone for a long time, not had enough food to eat, serious accident or illness, fire, dog bite, bullying)? *What was it?* ____	☐	☐

REACTIONS: Sometimes scary or upsetting events affect how people think, feel, and act. The next questions ask how your child has been feeling and thinking recently.

How often did each of these happen in the last 30 days?	**Never/ Rarely**	**1-2 times per month**	**1-2 times per week**	**3+ times per week**
5. He/she has strong feelings in his/her body when he/she remembers something that happened (sweating, heart beats fast, feel sick).	0 ☐	1 ☐	2 ☐	3 ☐
6. He/she tries to stay away from people, places, or things that remind him/her about something that happened.	0 ☐	1 ☐	2 ☐	3 ☐
7. He/she has trouble feeling happy.	0 ☐	1 ☐	2 ☐	3 ☐
8. He/she has trouble sleeping.	0 ☐	1 ☐	2 ☐	3 ☐
9. It's hard for him/her to concentrate or pay attention.	0 ☐	1 ☐	2 ☐	3 ☐
10. He/she feels alone and not close to people around him/her.	0 ☐	1 ☐	2 ☐	3 ☐

Notes:

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CTS

Child Report – Spanish Version

Child ID: ______________________ Date Completed: _____________ Administered By: _______________

Gender: ☐ Male ☐ Female Age: __________

Eventos: A veces pasan cosas que asustan o alteran a las personas. Estas cosas a veces afectan la forma cómo pensamos, lo que sentimos y lo que hacemos.

	Si	No
1. ¿Alguna vez has visto personas empujándose, pegándose, o arrojándose cosas las unas a las otras, o apuñalándose, disparándose, o tratando de hacerse daño las unas a las otras?	☐	☐
2. ¿Alguna vez alguien te ha lastimado seriamente? ¿Te ha pegado, dado puñetazos o patadas muy duro, con manos, cinturones u otros objetos, o ha tratado de dispararte con un arma o apuñalarte?	☐	☐
3. ¿Alguna vez alguien te ha tocado en las partes de tu cuerpo que se tapan con un traje de baño, de una manera que te hizo sentir incómodo(a)? ¿O te hizo tocar las partes de su cuerpo que se tapan con un traje de baño, de una manera que te hizo sentir incómodo(a)?	☐	☐
4. ¿Te ha sucedido alguna otra cosa que te molestó o te asustó mucho? (p.ej. alguien que tú querías murió, fuiste separado de un ser querido, te dejaron solo(a) por mucho tiempo, no tuviste suficiente comida, un accidente o enfermedad seria, incendio, mordida de perro, fuiste intimidado(a) por alguien) ¿Qué fue? _______________ ____	☐	☐

REACCIONES: A veces situaciones que son miedosas o molestas afectan la forma como las personas piensan, sienten y actúan. Las siguientes preguntas se tratan sobre cómo te has estado sintiendo y lo que has estado pensando recientemente.

Con qué frecuencia te sucedieron cada una de las siguientes cosas en los últimos 30 días?	**Nunca/ raramente**	**1-2 veces al mes**	**1-2 veces a la semana**	**3+ veces a la semana**
5. Fuertes sensaciones en tu cuerpo cuando recuerdas algo que sucedió (sudoración, latidos rápidos del corazón, sentirse enfermo)	0 ☐	1 ☐	2 ☐	3 ☐
6. Intentas evitar personas, lugares o cosas que te hacen recordar algo que sucedió.	0 ☐	1 ☐	2 ☐	3 ☐
7. Te cuesta trabajo sentirte feliz.	0 ☐	1 ☐	2 ☐	3 ☐
8. Te cuesta trabajo dormir.	0 ☐	1 ☐	2 ☐	3 ☐
9. Te es difícil concentrarte o prestar atención.	0 ☐	1 ☐	2 ☐	3 ☐
10. Te sientes solo/a y alejado/a de las personas a tu alrededor.	0 ☐	1 ☐	2 ☐	3 ☐

Notas:

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CTS

Caregiver Report (Age 6+) – Spanish Version

Child ID: ______________________ Date Completed: ______________ Administered By: ________________

Gender: ☐ Male ☐ Female Age: __________

Eventos: A veces pasan cosas que asustan o alteran a las personas. Estas cosas a veces afectan la forma cómo pensamos, lo que sentimos y lo que hacemos.	**Si**	**No**
1. ¿Alguna vez tu niño/a ha visto personas empujándose, pegándose, o arrojándose cosas las unas a las otras, o apuñalándose, disparándose, o tratando de hacerse daño las unas a las otras?	☐	☐
2. ¿Alguna vez alguien le ha lastimado seriamente? ¿Le ha pegado, dado puñetazos o patadas muy duro, con manos, cinturones u otros objetos, o ha tratado de dispararle con un arma o apuñalarle?	☐	☐
3. ¿Alguna vez alguien le ha tocado en las partes de su cuerpo que se tapan con un traje de baño, de una manera que le hizo o te hizo sentir incómodo(a)? ¿O alguien le ha hecho tocar las partes de su cuerpo que se tapan con un traje de baño, de una manera que le hizo o te hizo sentir incómodo(a)?	☐	☐
4. ¿Le ha sucedido alguna otra cosa que le molestó o le asustó mucho? (p.ej. alguien que quería murió, fue separado de un ser querido, le dejaron solo(a) por mucho tiempo, no tuvo suficiente comida, sufrió un accidente o enfermedad seria, incendio, mordida de perro, fue intimidado(a) por alguien) ¿Qué fue? ________________	☐	☐

REACCIONES: A veces situaciones que son miedosas o molestas afectan la forma como las personas piensan, sienten y actúan. Las siguientes preguntas se tratan sobre cómo su niño/a se ha sentido y lo que ha estado pensando recientemente.

Con qué frecuencia le sucedieron cada una de las siguientes cosas en los últimos 30 días?	**Nunca/ raramente**	**1-2 veces al mes**	**1-2 veces a la semana**	**3+ veces a la semana**
5. Siente fuertes sensaciones en su cuerpo cuando recuerda algo que sucedió (sudoración, latidos rápidos del corazón, sentirse enfermo)	0 ☐	1 ☐	2 ☐	3 ☐
6. Intenta evitar personas, lugares o cosas que le hacen recordar algo que sucedió.	0 ☐	1 ☐	2 ☐	3 ☐
7. Le cuesta trabajo sentirse feliz.	0 ☐	1 ☐	2 ☐	3 ☐
8. Le cuesta trabajo dormir.	0 ☐	1 ☐	2 ☐	3 ☐
9. Le es difícil concentrarse o prestar atención.	0 ☐	1 ☐	2 ☐	3 ☐
10. Se siente solo/a y alejado/a de las personas a su alrededor.	0 ☐	1 ☐	2 ☐	3 ☐

Notas

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Project THRIVE Student Eligibility Checklist/Permission to Exchange Information

(this form is to be submitted immediately to Delaware.THRIVE@doe.k12.de.us)

Date:___________District:_________________ School:_________________________________

Student Name: _____________________________________Grade:_______________________

Date of Birth: ________________Gender: ☐ M ☐ F ☐Other _________________________

Description of service: *Referral for Trauma-Specific Therapeutic Services*

The individual named above has been identified as a student who may benefit from trauma-specific services, including but not limited to prevention, screening, referral for treatment, or related services. These services are provided free of charge to qualified students through Project THRIVE – Delaware's Trauma Recovery Demonstration Grant. *STUDENT IS NOT ELIGIBLE IF COVERED BY MEDICAID OR HAS AN APPLICATION PENDING WITH MEDICAID.*

STUDENT ELIGIBILITY (Please select appropriate box)

Student is:

☐ A *preschool* student enrolled in a Delaware district, charter, or private school.

☐ An *elementary* student enrolled in a Delaware district, charter, or private school.

☐ A *secondary* student enrolled in a Delaware district, charter, or private school.

Student must meet three of the following criteria:

☐ Student has been exposed to trauma (examples: abused parent, been bullied, community violence, death of close family member, emotional neglect/abuse, family mental illness, homeless, natural disaster, parent deployed, parent in jail, parents divorced, physical neglect/abuse, serious injury to self, sexual abuse, student in state custody, substance abuse in family, suicide). *Please do not indicate which one(s).*

☐ Student demonstrates academic, behavioral, attendance or other issues at school.

☐ Students' parents/caregivers or guardians' income is below the poverty threshold as defined by the US Department of Health and Human Services **OR** meets Financial Eligibility below.

FINANCIAL ELIGIBILITY EXAMPLES (inclusion in ***one or more*** of the following federal programs):

☐ Student qualifies for free and reduced lunch (FRL).

☐ Family is eligible for Supplemental Nutrition Assistance Program (SNAP).

☐ Parent or guardian is eligible for TANF benefits.

☐ Student lacks a fixed, regular, and adequate nighttime residence (McKinney Vento Act) and is classified as a homeless youth or youth in transition, **OR**

□ Student is uninsured but meets income eligibility to qualify for Medicaid or other federally or state- subsidized insurance programs, **OR MARK BELOW AND ATTACH COPY OF INSURANCE CARD**

□ Student is insured, but trauma-specific services are not covered.

□ Student is insured, but services are unaffordable because of deductible.

□ Student is insured, but services are unaffordable because cost of service exceeds insurance cap.

PURPOSE OF CONSENT, DISCLOSURE AND EXCHANGE OF EDUCATION RECORDS

One purpose and federal reporting measure of the Project THRIVE is to impact student attendance; therefore, it may be necessary to access a student's educational record to establish a baseline for attendance and track progress. The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of information contained in education records maintained by a school district.

The Health Insurance Portability and Accountability Act (HIPAA) requires health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. This applies to all forms of PHI, including paper, oral, and electronic, etc. The minimum health information necessary to conduct business is to be used or shared.

Please indicate if the parent/guardian gives permission for the school and Delaware Department of Education to share school attendance records to report on attendance gains/losses.

***Note: permission to access attendance records does not need to be given to ensure participation in health care treatment.*

□ Yes, parent/guardian gives permission to access school attendance records.

□ No, parent/guardian does not give permission to access school attendance records AND will provide monthly attendance information to therapist for grant reporting.

Please indicate if the parent/guardian gives permission for the Delaware Department of Education to receive and pay invoices submitted by the provider of their choice, thereby allowing access to protected health information.

□ Yes, parent/guardian gives permission to the provider to invoice the Delaware Department of Education for trauma-specific services rendered on behalf of their child.

□ No, parent/guardian does not give permission to invoice Delaware Department of Education for trauma-specific services rendered on behalf of their child.

Parent/Guardian Name(s):____

Parent/Guardian Signature:____________________________________Date:_____________

Cell Phone:______________________________ Email:______________________________

Project THRIVE Student Well-Being Survey

(to signed and completed **ELECTRONICALLY** at the 1st session, 6 months, and the end of treatment)

This well-being survey is a reporting requirement of the TRDG grant that funds Project THRIVE. It is to be administered at the first treatment session and again, at six months or following the last service. The provider agrees to scan the completed survey to Project THRIVE using our secured and dedicated account at Delaware.THRIVE@doe.k12.de.us.

Suggested Administration Process:

- Pre-K and elementary students: For students who are unable to read the questions, provider or parents are to read the items and graphic representations of response choices and mark accordingly.
- Elementary, middle and high school students: Students answer the questions about their overall well-being/progress.

Student or parent please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question.

Student*:* Select one response for each statement below.	Strongly Disagree	Disagree	Agree	Strongly Agree
I make friends easily.				
My family gets along well together.				
I like being in school.				
When I have a problem, I can come up with lots of ways to solve it.				
I think I am doing pretty well.				

Data collected from this survey will be stored in a secure location within Delaware Department of Education. When reporting data trends to the US Department of Education, all data collected will be de-identified; there will not be any use of Personally Identifiable Information (PII). Parent/Guardian permission is required for the student to participate in the Well-being Survey.

Student Name:____Grade:__________

PLEASE PRINT

Parent/Guardian Name:_______________________________________ Date: ___________

PLEASE PRINT

Parent/Guardian Signature: ____________________________________Date: ____________

Cell Phone: _______________________________Email:______________________________

Project THRIVE Student Well-Being Survey

Respond using one of the options below:

https://forms.office.com/Pages/ResponsePage.aspx?id=hta2IQh_jUO9xr0hTYKb0kZ8JL8nR_xNnYcZSNCSwwdURU5VWVhDMDBFNVJXTEdEVUtNVlY4U0taRC4u

Project THRIVE Student Satisfaction Survey and Instructions

(to be completed **ELECTRONICALLY** at the 1st session, 6 months, and the end of treatment)

*****This satisfaction survey is a reporting requirement of the TRDG grant that funds Project THRIVE.***

Pre-K and elementary students: parents indicate their level of satisfaction with the services that their child(ren) have received; parent answers the survey questions.

Middle and high school students: student indicates their level of satisfaction with the services they have received; students answer the survey questions with written parental consent.

If your student is less than 12 years old and/or you do not want your student to complete the survey, you will need to complete the survey from the perspective of your student. Otherwise, if your student is between 12-17 years old, your written consent is **required** for your student to participate.

At the completion of the first session, please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question.

***Student**: How do you feel about the services you received?*	Strongly Disagree	Disagree	Agree	Strongly Agree
I felt like I was listened to.				
I feel like I have a say in my plan.				
I understand what I am working on with my provider.				
I receive the kind of services I think I need.				
I feel that my service provider understands me.				
Overall, I am satisfied with the help I am receiving.				
Parent: How do you feel about the services your child received?				
The service provider listens carefully to what my child has to say.				
The service provider explains the plan for my child's treatment clearly.				
The service provider understands my child's needs.				
My child receives the kind of services I think he/she needs.				
Overall, I am satisfied with the help my child is receiving.				

Project THRIVE Student Satisfaction Survey

Respond using one of the options below:

https://forms.office.com/Pages/ResponsePage.aspx?id=hta2IQh_jUO9xr0hTYKb0kZ8JL8nR_xNnYcZSNCSwwdUN0xON1FLV1hYT0ZBVkZWSEU5OEZSNkNBWS4u

Childhood Protective Factors Checklist

Please check all that are consistent with your experience in your family, school, and community.

- ☐ I can talk with my family about my feelings.
- ☐ My family is supportive during difficult times.
- ☐ I feel enjoyment and participate regularly in community traditions.
- ☐ I feel like I belong in my school.
- ☐ I feel supported by friends.
- ☐ I have at least two non-parent adults who genuinely care about me.

  Name #1: ____________________

  Name #2: ____________________

- ☐ I feel safe and protected by an adult in my home.