Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Part I: Client/Parent/Guardian

Client Information: ☐Self ☐Child

Client's last name	Client's First name	Middle initial	
Date of birth		Social Security number	
Address			
City	State	Zip	
Home phone	Cell phone	Work phone	
Insurance		Private	Medicaid
Name of person financially responsible			
Address			
City	State	Zip	
Name of emergency contact/Relationship			Phone
Client's primary care physician			Phone
DCF Worker			Phone

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Family Members:

Name	DOB	Relationship to client	Address (if different from client)	Employment/Education

Client Gender:

☐ Male

☐ Female

☐ Other

☐ Transgender

Race:

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or other Pacific Islander

☐ Black or African American

☐ White

☐ Other race

☐ Prefer to not report

Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Prefer to not report

Language:

☐ Chinese – Cantonese

☐ Chinese – Mandarin

☐ English

☐ Haitian Creole

☐ Spanish

Military:

☐ Yes

☐ No

☐ Unknown

Self/Caregiver Marital Status:

☐ Single

☐ Married

☐ Divorced

☐ Widowed

Household Annual Income:

☐ 0-10,000

☐ 10,001-20,000

☐ 20,001-30,000

☐ 30,001-40,000

☐ 40,001-50,000

☐ 50,001-60,000

☐ 60,001-70,000

☐ 70,001-80,000

☐ 80,001-90,000

☐ 90,001-100,000

☐ 100,001 +over

☐ Unknown

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Program_____

Authorization for Release of Protected Health Information

Individual Covered _____ **Date of Birth** _____

Case Name
(if different than above) _____ **Date of Birth** _____

Address

_____

_____

Others covered by this release **Date of Birth**

_____

_____

_____

I authorize the use or disclosure of my protected health information by Child and Family Agency as specified below. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to Child and Family Agency. I understand that a description of my right to revoke my authorization is set forth in Child and Family Agency's Notice of Privacy Practices.

1. Please use or disclose the following health information, if such information exists:

   ___ The entire medical record (all information maintained by Child and Family Agency for the time period indicated below or maintained by the information source named in # 2).

   ___ The following limited health information:

   _____

   ___ To include HIV/AIDS information

   ___ To include drug and alcohol information

   Please be advised that once we disclose/obtain this information per your instructions the information is subject to re-disclosure and may be releasable to a parent/guardian or other service provider upon their request and may no longer be protected by HIPAA.

2. Please specify the information recipient (DCF Staff member) that may obtain or release the information according to the limitations described.

Information Recipient: _____ Address/City: _____

Roles: _____ State: _____

and case-involved staff

3. Please specify the time period the disclosed information should relate to:

   ____ No limitations on time frame ____ From: ____ /____ /_____To: ____ /____ /_____

4. Please specify the purpose(s) for which the information is being requested:

   a. ongoing service planning and coordination, and

   b. provision of information to DCF staff (e.g. caseworkers; supervisors) and DCF's agents and legal representatives regarding client participation in Child and Family Agency's services and progress on service goals.

If no date specified, this release will expire one year from signature date.
Unless earlier revoked, this authorization will expire on the following date: ____ /____ /_____

(Maximum 1 year, or 90 days after discharge, whichever comes first)

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- If I have any questions about disclosure of my protected health information pursuant to this authorization, I may contact the agency Privacy Officer, Richard D. Calvert, MSW, LCSW, CEO at 860-443-2896

Print name of Individual covered or Parent/Legal Guardian	**Signature of Individual covered or Parent/Legal Guardian**	**Date**

If signed by other than client, describe the legal authority of the representative to act on behalf of the individual:

Parent/Other Legal Guardian/DCF Worker: _____

Legal authority of representative verified by: _____

Child and Family Agency Staff Member

STATEMENT REGARDING CONFIDENTIAL INFORMATION

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communication: The confidentiality of this record is required under Chapter 889 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS confidentiality of Alcohol and Drug Abuse Patient Records regulations: 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.

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Program__SBHC____

Authorization for Release of Protected Health Information

Individual Covered _____ **Date of Birth** _____

Case Name
(if different than above) _____ **Date of Birth** _____

Address

_____

_____

Others covered by this release **Date of Birth**

_____

_____

_____

I authorize the use or disclosure of my protected health information by Child and Family Agency as specified below. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to Child and Family Agency. I understand that a description of my right to revoke my authorization is set forth in Child and Family Agency's Notice of Privacy Practices.

5. Please use or disclose the following health information, if such information exists:

   ___ The entire medical record (all information maintained by Child and Family Agency for the time period indicated below or maintained by the information source named in # 2).

   ___ The following limited health information:

   _____

   ___ To include HIV/AIDS information

   ___ To include drug and alcohol information

   Please be advised that once we disclose/obtain this information per your instructions the information is subject to re-disclosure and may be releasable to a parent/guardian or other service provider upon their request and may no longer be protected by HIPAA.

6. Please specify the information recipient (DCF Staff member) that may obtain or release the information according to the limitations described.

   a. Information Source / Destination: _____ Public Schools

   b. Information Source / Destination: School Nurse(s) at _____ Public Schools

   ❑ Information Source / Destination: Youth Officer(s) assigned to this student's school _____

2. Please specify the time period the disclosed information should relate to:

   ____ No limitations on time frame ____ From: ____ /____ /_____To: ____ /____ /_____

3. Please specify the purpose(s) for which the information is being requested:

   Communication between staff of Child and Family Agency's School-Based Health Center staff and the school staff and in-school resources listed above, as part of providing both routine and crisis management services to this student.

If no date specified, this release will expire one year from signature date.
Unless earlier revoked, this authorization will expire on the following date: ____ /____ /_____
(Maximum 1 year, or 90 days after discharge, whichever comes first)

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- If I have any questions about disclosure of my protected health information pursuant to this authorization, I may contact the agency Privacy Officer, Richard D. Calvert, MSW, LCSW, CEO at 860-443-2896

Print name of Individual covered or Parent/Legal Guardian	**Signature of Individual covered or Parent/Legal Guardian**	**Date**

If signed by other than client, describe the legal authority of the representative to act on behalf of the individual:

Parent/Other Legal Guardian/DCF Worker: _____

Legal authority of representative verified by: _____

Child and Family Agency Staff Member

STATEMENT REGARDING CONFIDENTIAL INFORMATION

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communication: The confidentiality of this record is required under Chapter 889 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS confidentiality of Alcohol and Drug Abuse Patient Records regulations: 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.

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Program_____

Authorization for Release of Protected Health Information (DCF)

Individual Covered _____ **Date of Birth** _____

Case Name
(if different than above) _____ **Date of Birth** _____

Address

_____

_____

Others covered by this release **Date of Birth**

_____

_____

_____

I authorize the use or disclosure of my protected health information by Child and Family Agency as specified below. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to Child and Family Agency. I understand that a description of my right to revoke my authorization is set forth in Child and Family Agency's Notice of Privacy Practices.

7. Please use or disclose the following health information, if such information exists:

   _X_ The entire medical record (all information maintained by Child and Family Agency for the time period indicated below or maintained by the information source named in # 2).

   ___ The following limited health information:

   _____

   ___ To include HIV/AIDS information

   ___ To include drug and alcohol information

   Please be advised that once we disclose/obtain this information per your instructions the information is subject to re-disclosure and may be releasable to a parent/guardian or other service provider upon their request and may no longer be protected by HIPAA.

8. Please specify the information recipient (DCF Staff member) that may obtain or release the information according to the limitations described.

Information Recipient: CT DCF and/or its agents and legal rep Address/City: _____
Individuals: State:

_____ _____

9. Please specify the time period the disclosed information should relate to:

____ No limitations on time frame ____ From: ____ /____ /_____To: ____ /____ /_____

10. Please specify the purpose(s) for which the information is being requested:

    a. ongoing service planning and coordination, and

    b. provision of information to DCF staff (e.g. caseworkers; supervisors) and DCF's agents and legal representatives regarding client participation in Child and Family Agency's services and progress on service goals.

If no date specified, this release will expire one year from signature date.
Unless earlier revoked, this authorization will expire on the following date: ____ /____ /_____

(Maximum 1 year, or 90 days after discharge, whichever comes first)

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- If I have any questions about disclosure of my protected health information pursuant to this authorization, I may contact the agency Privacy Officer, Richard D. Calvert, MSW, LCSW, CEO at 860-443-2896

Print name of Individual covered or Parent/Legal Guardian	**Signature of Individual covered or Parent/Legal Guardian**	**Date**

If signed by other than client, describe the legal authority of the representative to act on behalf of the individual:

Parent/Other Legal Guardian/DCF Worker: _____

Legal authority of representative verified by: _____

Child and Family Agency Staff Member

STATEMENT REGARDING CONFIDENTIAL INFORMATION

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communication: The confidentiality of this record is required under Chapter 889 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS confidentiality of Alcohol and Drug Abuse Patient Records regulations: 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.

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Program_____

DCF-ACR or Permanency Team Meeting

Individual Covered _____ **Date of Birth** _____

Case Name
(if different than above) _____ **Date of Birth** _____

Address

_____

_____

Others covered by this release **Date of Birth**

_____

_____

_____

I authorize the use or disclosure of my protected health information by Child and Family Agency as specified below. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to Child and Family Agency. I understand that a description of my right to revoke my authorization is set forth in Child and Family Agency's Notice of Privacy Practices.

11. Please use or disclose the following health information, if such information exists:

    a. _X_ The entire medical record (all information maintained by Child and Family Agency for the time period indicated below or maintained by the information source named in # 2).

    b. The following limited health information:

    _____

    Please be advised that once we disclose/obtain this information per your instructions the information is subject to re-disclosure and may be releasable to a parent/guardian or other service provider upon their request and may no longer be protected by HIPAA.

12. Please specify the information recipient (DCF Staff member) that may obtain or release the information according to the limitations described.

Information Recipient: DCF Address/City: _____
Individuals: State:
(DCF staff member name)

and participants of ACR or
Permanency Team Meeting.

13. Please specify the time period the disclosed information should relate to:

____ No limitations on time frame ____ From: ____ /____ /_____To: ____ /____ /_____

14. Please specify the purpose(s) for which the information is being requested:

___ Treatment planning and coordination of services

_X_ The following purpose: To coordinate treatment with ACR or Permanency Team Meeting team members around diagnosis, attendance, progress in treatment and supports needed to benefit from program.

If no date specified, this release will expire one year from signature date.
Unless earlier revoked, this authorization will expire on the following date: ____ /____ /_____

(Maximum 1 year, or 90 days after discharge, whichever comes first)

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- If I have any questions about disclosure of my protected health information pursuant to this authorization, I may contact the agency Privacy Officer, Richard D. Calvert, MSW, LCSW, CEO at 860-443-2896

Print name of Individual covered or Parent/Legal Guardian	**Signature of Individual covered or Parent/Legal Guardian**	**Date**

If signed by other than client, describe the legal authority of the representative to act on behalf of the individual:

Parent/Other Legal Guardian/DCF Worker: _____

Legal authority of representative verified by: _____

Child and Family Agency Staff Member

STATEMENT REGARDING CONFIDENTIAL INFORMATION

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communication: The confidentiality of this record is required under Chapter 889 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS confidentiality of Alcohol and Drug Abuse Patient Records regulations: 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.

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

RELEASE OF INFORMATION AND

ASSIGNMENT OF BENEFITS FOR INSURANCE COMPANIES

Client name _____

Person financially responsible _____

Primary insurance company name _____

Subscriber ID# _____

Policy holder's name and date of birth _____

Secondary Insurance Company Name _____

Subscriber ID# _____

Policy holder's name and date of birth _____

Tertiary Insurance Company Name _____

Subscriber ID# _____

Policy holder's name and date of birth _____

Address of Policy Holder

(if different than IC) _____

I authorize the release of any medical or other information (including psychiatric, HIV and drug and/or alcohol related) necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____

Client or authorized person's signature Date

I authorize payment of medical benefits to the assigned physician or supplier for services provided at Child & Family Agency of Southeastern Connecticut, Inc.

_____

Client or authorized person's signature Date

*** This authorization is valid for one year**

*** A new authorization is needed if insurance companies change**

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

FINANCIAL RESPONSIBILITY AGREEMENT

COUNSELING SERVICES

Child and Family Agency (CFA) is a sliding fee scale agency. Our full fee per therapy session is $_____. Because CFA recognizes it would be a financial hardship for many clients to pay the full fee at each session, we have designed an alternative payment system, provided the client agrees to the following:

- I agree to submit accurate financial information as requested, i.e. third party coverage, Title XIX, Medicare, and household's gross weekly income minus taxes. I agree to provide the agency with other documentation of income as may be necessary.
- I agree to provide CFA with a Title XIX or Medicare card upon the first visit.
- I agree to provide CFA with a signed major medical insurance form authorizing payment directly to the agency no later than my second visit and understand that I am responsible for any deductible not met.
- I understand that if my child is privately insured under a plan with a high deductible, I will be charged a $25.00 fee per session until the deductible has been met at which time a co-pay will be assessed based on my insurance plan. Should you need a fee adjustment, please discuss this with your child's clinician.
- I agree to pay my client fee at each visit, and if I miss one payment I will remit payment at my next therapy session along with that session's fee. If I pay by check; I understand that I may be required to pay a $20.00 bank service charge if my check is returned for insufficient funds. Should that occur, I may be required to pay for future services in cash. I understand if my account is two or more payments in arrears, service may be suspended until such time as my account is paid in full.
- I understand that I will be charged my sliding scale fee if I fail to cancel my appointment 24 hours in advance.
- I agree to notify CFA promptly of any change in my financial or insurance status which may/may not affect my fee.
- I understand that CFA has the right to request an update of my financial income information and to request validation of hardship before client fee is reduced.

I agree to pay my client fee or sliding scale/co-pay of $_____ at each therapy session. I understand that I may be charged proportionately for sessions that are longer than 50 minutes. I, _____, have read and agree to the above applicable provisions. I understand that failure to comply with any of the above could result in service being terminated.

Clinician Date

Person Financially Responsible Date

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

STATEMENT OF CUSTODY, APPLICATION FOR SERVICE and SERVICE AGREEMENT

I, _____,

_____ (child client) hereby state that I am the legal guardian of the following child, and I have the authority to make decisions about treatment services.

_____ (adult client) hereby agree to engage and participate in Child and Family Agency services.

If client is under 18:

Individual Covered	Date of birth	Relationship to legal guardian

I understand that:

1. Services may include individual therapy, family therapy, group therapy, psychiatric evaluation and medication management.
2. Child and Family Agency does not dispense medication.
3. Mental Health Staff are mandated reporters. In the event of suspicion of abuse or neglect, staff will seek supervisory input and may need to file a report with child protective services or seek emergency response for the safety of my child or others.
4. The Agency is open Monday through Friday, between the hours of 9:00 and 5:00, with additional hours varying by site. In case of urgent/emergent concerns after office hours, the agency provides 24/7 on call support. The on call clinician can be reached by calling 860-823-0893. For life threatening emergencies, families should call 911 immediately.
5. If medical treatment is necessary for any client under the age of 18, Agency staff will seek Parent(s)/Guardian(s) assistance and/or call 911.
6. Parents/Guardians with clients under the age of 12 must accompany the child to the appointment and remain in the waiting room. It has been explained to me and the minor client that if he/she becomes uncomfortable during a session he/she may leave the office at any time and come to me in the waiting room. All parents/guardians may be asked to accompany clients or remain with the client when deemed appropriate by the therapist.
7. My signature below acknowledges I am in receipt of the Agency's Client Grievance Procedures.
8. **My signature below acknowledges that I am in receipt of, have reviewed, and will comply with the Agency's Attendance Policy**.

Client/Legal Guardian signature	Date	Legal Guardian signature	Date
Relationship to Client		Relationship to Client	
Witness signature	Date		

CLIENT'S RIGHTS AND RESPONSIBILITIES

Persons receiving service from Child and Family Agency of Southeastern Connecticut, Inc. or its affiliates are entitled to certain rights and have certain responsibilities.

Client Rights

Confidentiality

No information about you or your treatment will be shared with anyone outside of the Agency without your permission. In order to provide the best coordinated care, CFA staff may share information between agency programs. If more than one adult name is in a case record, all adults would need to give permission for that information to be shared.

The Agency's focus is on the client's mental health and well-being; therefore, we do not get involved in custody disputes or provide written recommendations relating to custody.

If the Agency receives a Subpoena from the court, the Agency must follow state law. Staff do not appear in court unless subpoenaed to do so**. If subpoenaed, the Agency may charge $120.00 per hour per staff member for each court appearance.**

Services

- You have the right to equal treatment without regard to race, color, spiritual beliefs, sex, sexual orientation, national origin.
- You have the right to services that take into consideration your culture and your spoken language.
- You have the right to be actively involved in treatment planning, and ongoing decisions, including type of service.
- You have the right to review the case chart within the limits of confidentiality. This is done in the presence of the therapist and/or supervisor. Clients also have the right to insert statements into the case record. Child and Family Agency is responsible for deciding whether the review or release of particular information would be potentially harmful to a minor child.
- You have the right to request a change in staff assignment following the Agency's grievance procedure.
- You have the right to refuse services at any time. The client should discuss ending services with their assigned staff member.
- You have the right seek another opinion from an individual or organization outside of the Agency regarding diagnosis or treatment planning.
- You have the right to be informed of and refuse any audio/audiovisual taping.
- You have the right to be informed of any possible risks and benefits associated with the treatment or service plan. You have the right to a full discussion of treatment alternatives.
- You have the right to know the professional education of the staff member(s) providing services.

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Client Responsibilities

- You are responsible for helping the Agency maintain a respectful treatment environment. Adults and children are expected to act safely and appropriately towards all staff, family members, and other clients. Rude or obscene language, evidence of intoxication or substance abuse, and or verbal/physical threats will not be tolerated and may result in termination of services. Threats or actions against one's self or others are not protected by confidentiality and may be reported to the appropriate authority.
- You are responsible for providing all financial information necessary for the Agency to provide services, including insurance coverage.
- You are responsible for payment at the time of service, unless otherwise arranged. If you transition from one agency program to another, payment for a previous outstanding balance is expected. Withdrawing from a program with an outstanding balance may also jeopardize future involvement with Agency programs.
- If your child receives medication management through the Agency, you are responsible to give your child's clinician seven days advance notice for medication refills.
- You are responsible to promptly provide any changes in information that relates to treatment, billing and contact (e.g., name, address, telephone number, insurance, employment, family composition.)
- For children under the age of 12, an accompanying adult must remain on the premises during all appointments. For children over the age of 12, the need for an accompanying adult to remain on the premises will be decided upon by the Agency staff member, guardian, and client.
- You are responsible for keeping scheduled appointments. Please refer to the Agency's Attendance Policy.
- Participation in any of the programs at Child and Family Agency is limited to the client, the client's guardian, Agency staff, and any other family member or service provider listed on the treatment plan. Participation in a session by any other individual may not occur without a signed written agreement between the client and the Agency.
- Child and Family Agency constantly strives to create and refine more effective ways to help children and families across its many services. For this reason, we carefully evaluate the effectiveness of our programs and request your permission to use identifying information for internal agency research and statistical purposes, and for satisfying the data submission requirements of our funding sources. Beyond such requirements, any use of identifying Protected Health Information for external research purposes will only occur with your written authorization or through approval from an Institutional Review Board or Privacy Board established in accord with Federal law.

I have read and/or discussed my rights and responsibilities with my assigned staff member and fully understand and agree to them. I hereby request services for myself/child/family.

Client signature Date

Parent/Guardian signature Date Staff signature Date

NPP Acknowledgment and Appointment Confirmation

By signing below, I acknowledge that I have reviewed Child & Family Agency of Southeastern CT, Inc.'s Notice of Privacy Practices currently in effect.

- ❑ I also agree to have my protected health information used to confirm appointments. This will involve leaving the name of the agency, clinician and site along with my appointment time.

  Please leave a voice message at: _____
  and/or
  Please send a text message to: _____

- ❑ No, Please do not confirm appointments.

_____

Print Name of Identified Client Date of birth

_____

Print Name of Individual or Personal Representative

_____

Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual:

_____

Unable to obtain written consent and acknowledgement because:

- ❑ Individual refused
- ❑ Emergency treatment situation
- ❑ Individual not able to sign due to incompetence or other medical reason
- ❑ Other: _____

GRIEVANCE PROCEDURE

You have the right to express concerns with the Agency's services and to request a change in those services. You also have the right to express concerns with the Agency's financial policies, or with agency procedures in general.

Procedure:

1. You will receive a copy of this agency grievance procedure, with explanation, at the start of services.
2. You are expected to verbally express dissatisfaction directly to the staff member working with you and to clearly explain the nature of the dissatisfaction. A copy of this policy will be handed to you at that time, or arrangements will be made for its delivery within 5 working days of the initial verbal complaint.
3. If you and the staff staff member are unable to resolve the issue(s) within the next scheduled and kept appointment, in which the staff member's supervisor is in attendance, then you will be reminded that an appeal process does exist, as reflected in the copy of the policy and procedure already provided to you.
4. From the date of the meeting with the staff member and the supervisor, you have 7 working days to detail in writing or on audiotape to the Chief Executive Officer of the organization the nature of the compliant. The mailing address of the Chief Executive Officer is 255 Hempstead Street, New London, CT 06320.
5. The Chief Executive Officer shall convene a review panel including but not necessarily limited to the Board Chairman, Services Chairman, Chief Executive Officer, and/or their designee. This panel will review the complaint while protecting your rights to confidentiality. Their decision shall be final. Notice of this decision will be sent by certified mail to you and to all other involved parties through interoffice mail. This decision will become part of your agency record.
6. From receipt of the written complaint to the convening of the review panel not more than 30 days shall pass. A written decision shall be rendered not more than 15 days from that meeting.
7. **At all stages in the above-described process, care will be taken to meet any special cognitive or psycho-emotional needs you may have, that you fully understand your rights and the available associated agency processes**. Every reasonable effort will also be made to arrange for the services of a translator to participate in the above processes if language is a barrier. Translated written materials will be provided whenever necessary.

   At all stages in the above-described process, care will be taken to ensure that clients with cognitive or psycho-emotional special needs fully understand their client rights and the associated agency processes that are available to them.

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Attendance Policy

Child & Family Agency is committed to providing clients the best possible care for everyone they serve. For this to be possible regular attendance is essential and therefore the following attendance policy needs to be adhered to:

- If you are unable to attend your appointment, you must cancel your appointments 2 business days prior to the appointment time.
- A pattern of cancellations will be monitored and will result in a referral to the Engagement Specialist (ES)*.
- If you do not cancel your appointment 2 business days prior to the appointment time or do not attend, your appointment will be coded as Did Not Keep Appointment (DNKA). This will initiate an immediate referral to the ES.
- If you are more than 15 minutes late for your appointment, your appointment will be cancelled and coded as DNKA.
- After 2 DNKAs in a 3 month period, you will be mandated to attend a 3 session Change Group before scheduling future appointments.
- The ES will work with you to reduce barriers to help you or your child regularly attend appointments and determine if you or your child are in the appropriate service.
- If you or your child are unable to attend regular appointments, you will not be able to schedule appointments ahead of time. You will need to call to request a same day appointment; same day appointments are not guaranteed.
- If attempts to establish an alternative scheduling protocol or level of care fail, services will be discontinued.

Definitions:

No-Show/Late Cancellation (DNKA) - the client either misses the appointment without notifying us, or notifies us less than 2 business days before their appointment, making it difficult for the provider to arrange another productive use of the appointment time.

Cancellation (CANC) - the client notifies us at least 2 business days in advance that they will miss their appointment; 2 business days' notice usually allows the provider to reschedule their time productively.

Same Day Reschedule (RS) - the client calls and asks for another time on the same day as scheduled appointment AND we can accommodate request.

*Engagement Specialist is charged to work with clients who are struggling to regularly attend their appointments. They will work with you to reduce barriers and determine the best service for you and/or your child; referring to a different service when appropriate.
If you find that you're experiencing difficulties attending appointments, please feel free to reach out to your provider for support.

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

AFTER-HOURS EMERGENCY CALL PROCEDURE

The Agency's on-call service is offered to assist you with a crisis where you may need additional support or guidance outside of regular office hours.

Child and Family Agency's on-call service is phone support only; therefore, if you have a medical or psychiatric emergency and/or feel you or someone else is in immediate physical danger, call 911.

For other kinds of crises, dial 1-860-823-0893 to reach Child and Family Agency's on-call cell phone.

1. In most circumstances the covering On-Call clinician will immediately answer your call and provide assistance. If your call is long-distance and cost is a concern, you may request that the On-Call clinician call you back.

2. In the event that your call is not answered "live", please leave a brief message that includes your name, phone number(s) (including area code) where you can be reached, a brief description of your urgent concern, and which agency program and worker(s) you regularly receive service from.

3. In the event that the On-Call clinician does not call you back within 15 minutes, please call the on-call number again. If your call is still not answered "live", please leave another message.

Please be aware that, while Child and Family Agency has chosen the most reliable cell phone provider for our service area, reception cannot be guaranteed. You should use your judgment as to when to seek other assistance (e.g. 911 to access a hospital emergency room or the police) in the event that you do not successfully connect with the On-Call clinician in a timely manner.

For routine calls:

Your regular Clinician's name and phone #: _____

Community Worker name and # (when applicable): _____

Intake and Developmental Questionnaire

Child's Name _____ Date of Birth _____

Name of Person completing questionnaire: _____Date: _____

Relationship to Child: _____

Please describe why therapy is being requested at this time and what child and caregiver are hoping to get out of treatment:

Problem Checklist (check all that apply)

_____ Aggressive/Assaultive behavior	_____ High Risk Behaviors	_____ Self-Injury (cutting etc.)
_____ Anxiety	_____ Homicidal	_____ Sexual Abuse
_____ Cruelty to Animals	_____ Hyperactive	_____ Sexual Identity Concerns
_____ Distractible	_____ Intrusive thoughts	_____ Toileting problems
_____ Disruption from home/ primary caregiver	_____ Learning problems	_____ Problematic sexual behavior
_____ Witnessed domestic violence	_____ Low Self Esteem	_____ Sleep problems
_____ Witnessed community violence	_____ Low Mood	_____ Stealing
_____ Eating problems	_____ Neglect by caregivers	_____ Substance Use/abuse
_____ Family conflict	_____ Oppositional Behaviors	_____ Suicidality
_____ Fears/phobias	_____ Problems with peer relationships	_____ History of attempted suicide
_____ Fire Setting	_____ Problems relating to others	_____ Seeing/hearing things that others can't see/hear
_____ Grief/Loss	_____ Physical Abuse	_____ Other (describe below)
	_____ Runs Away	
	_____ School problems	
	_____ School Avoidance	

CHILD'S AND FAMILY'S STRENGTHS, CULTURE AND SUPPORTS

What does your child like to do for fun?
Who supports you and your child emotionally? Who would you turn to for help if you needed it?
What do you like best about your child?
What is your child good at?
Does your child take after anyone/named after anyone?
What traditions or beliefs are important to your family? (Religion, holidays, cultural practices etc.)

Current Placement: _____ Parents _____ Foster Care _____ Group home _____ Relatives

_____ Other (describe) _____

Has child been in previous foster care? ____ Yes ____ No

Dates of foster care placements:

Was the child adopted? ____ Yes ____ No If adopted, age at adoption _____

DCF Involvement ____ Never ____ Current _____ Past

DCF worker's name (if applicable): _____ Phone: _____

Please be sure to sign a release of information for the DCF worker if you are seeking help for a DCF related problem.

Psychotherapy and Psychiatric Treatment History *please include inpatient hospital, emergency room visits, partial hospital program, residential care and community based counseling services*

Dates	Name of Facility/provider	Type of Treatment / Reason for Admission

PSYCHIATRIC MEDICATIONS

Current Medication(s)	Dosage	Response
Previous Medication(s)	Dosage	Response

Has your child ever visited an emergency room related to emotional or behavioral struggles? _____

If yes, please describe why and approximate dates of emergency room visits: _____

_____

_____

PLEASE DESCRIBE ANY RECENT OR LIFELONG CRITICAL EVENTS FOR CHILD AND THEIR FAMILY. (Include traumas, unexpected deaths, illnesses, major changes.) PLEASE INDICATE IF THERE ARE EVENTS THAT YOU OR YOUR CHILD CAN'T STOP THINKING ABOUT OR CONTINUE TO FIND VERY DISTRESSING

1.
2.
3.

DEVELOPMENTAL AND MEDICAL HISTORY

Describe any developmental struggles your child had around weaning, eating, walking, speech and toilet training
Did child's mother use alcohol or non-prescribed drugs while pregnant? ____ Yes ____ No Describe:
Did your child attend pre-school? ____ Yes ____ No Describe child's early responses to school
Describe your child's activity level in utero, as an infant, as a toddler and now
Describe any medical problems currently or in the past
Do you or your child's pediatrician have any concerns about your child's diet? ____ Yes ____ No Describe: Has your child had significant weight loss or gain? ____ Yes ____ No Describe:
Does your child have any allergies? ____ Yes ____ No Describe reaction:

Please be sure to sign a release of information for the Pediatrician.

SCHOOL HISTORY

Current Grade _____ On Grade level? ____ Yes ____ No Grades Repeated? ____ Yes ____ No Special Education Support? ____ Yes ____ No Explain:
Comments: (strengths and challenges at school)
Name of School:
School Contact Name:
Name of classroom teacher:
School Phone:

Please be sure to sign a release of information for the school if you are seeking help for a problem that may impact school performance or attendance.

Please bring copies of any test results regarding your child. This includes testing that happened at school or testing completed by another provider.

FAMILY ISSUES *Please describe any family issues which may impact your child biologically or emotionally (losses, physical or mental health issues in family, caregiver employment, marital struggles, divorce or new relationships, substance related issues)*

1.
2.
3.

What are you proudest about as a parent / caregiver to your child?
How do challenges in your life (emotional, physical, relationship problems) impact your child right now?
How do your child's challenges impact you right now?
What else might be important to know about you, your family and your child?