



### CHILD REGISTRATION FORM

Please complete all information on this form. If you need help, please speak to one of our Staff.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by: \_\_\_\_\_ Referral Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Phone: Home: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Contact Preference: \_\_\_\_\_ Cell: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Religious Preference: \_\_\_\_\_

Race: White Black Asian American Indian Alaskan Native Native Hawaiian Pacific Islander Multi-Racial

Ethnicity: Puerto Rican Mexican Cuban Other Hispanic Haitian Mexican American Spanish/Latino  
(check one) None of the Above

Marital Status: Never Married Married Widowed Divorced Separated Domestic Partner Legally Separated

Employment Status: Active Military Full Time FT Self-Employ Part Time PT Self-Employ Unemployed Disabled  
Retired Student Homemaker Leave of Absence Criminal Inmate Not Authorized to Work

Current Grade: \_\_\_\_\_ School: \_\_\_\_\_

Have you ever been known by another name or former alias:  No  Yes Name: \_\_\_\_\_

Do you have a case plan with the court system or Eckerd Community Alternatives:  Yes  No

Residential Status: Independent Living Alone Independent Living-with Relatives Independent Living-with Non-Relatives  
Dependent Living-w/Relatives Dependent Living-w/Non-Relatives Homeless Group Home Jail  
Assisted Living Facility Mental Health Institute Nursing Home Supported Housing Foster Care  
DJJ Facility Crisis Residence Children Residential Treatment Limited MH Licensed ALF Other

Number in Household: \_\_\_\_\_ Have you ever received services here before?  No  Yes

Veteran:  Yes  No If so, when: \_\_\_\_\_

#### IDENTIFY DISABILITY FACTORS:

Developmental Disabilities:  Yes  No Physically Impaired:  Yes  No  
Non- Ambulatory:  Yes  No Visually Impaired:  Yes  No  
Deaf or Hard-of-Hearing:  Yes  No ADL Functioning:  Yes  No  
English Language Severely Limited:  Yes  No (Inability to perform independently day-to-day living)

What auxiliary aids, services, or assistance do you need to help you communicate with us? \_\_\_\_\_

#### PARENT / GUARDIAN

Name: \_\_\_\_\_ Phone: Home: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Work: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Relation: \_\_\_\_\_

Legal Guardian:  Yes  No

Client Name: \_\_\_\_\_ Client #: \_\_\_\_\_

**MEDICAL BENEFITS**

Medicaid #: \_\_\_\_\_

Medicare#: \_\_\_\_\_

Do you have any other insurance? (Other than Medicaid/Medicare)  Yes  No Name: \_\_\_\_\_

I authorize the release of any medical information necessary to process this or a related claim to:	
_____	Date: ____ / ____ / ____
Insurance Company Name and Address	
I authorize payment of benefits to Directions for Living.	
_____	Date: ____ / ____ / ____
Signature	

**MEDICAL INFORMATION**

Primary Care Physician: _____	Phone #: _____
Other Treating Physician: _____	Phone #: _____
Pain Management Specialist: _____	Phone #: _____
Preferred Pharmacy: _____	Phone #: _____
Pharmacy Location: _____	

**SERVICE AUTHORIZATION / CONSENT TO TREAT / CONSENT TO PARTICIPATE**

My signature below certifies that:

- I give permission to staff of Directions for Living to render mental health/substance abuse treatment and/or prevention services to the person named below.
- I have received a copy of the Client Handbook which includes information regarding:
 

▪ Organizational Mission	▪ Hours of Operation
▪ Emergency Procedures	▪ Treatment Services
▪ Client Rights and Responsibilities	▪ Grievance Procedures
▪ Infectious Disease Control	▪ HIV/AIDS Education
▪ Notice of Privacy Practices	▪ Advance Directive
- I have received the HIV/AIDS education information and understand that I may ask for further information regarding testing and other services at any time.
- I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.
- I understand that Directions may be required to submit statistical and demographic information such as my age, social security number and/or income to certain local, state and/or federal agencies in order to provide my services. I also understand that I may ask for more specific information regarding this at any time.
- I am providing this consent to treatment and/or prevention services voluntarily and understand that I have the right to withdraw my consent at any time.

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Client Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature (if applicable)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
Relation to Client

\_\_\_\_\_  
Witness

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

Client Name: \_\_\_\_\_ Client #: \_\_\_\_\_

Our funders require that we collect information on everyone who lives in the household with the child who is receiving services. Please complete the following information about everyone who lives in the child's household.

Household Member	Gender	Relationship to child	Race / Ethnicity	DOB	Highest Education	Language	Citizen Y/N?	Employed Y/N?	Marital Status	For Office Use Only: Service Activity
	<input type="checkbox"/> F <input type="checkbox"/> M	Mother /Guardian					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Father /Guardian					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										

Client Name: \_\_\_\_\_

Client #: \_\_\_\_\_

9600-018c

Rev. 04/05/2013

# OUR COMMITMENT TO YOU + YOUR COMMITMENT TO YOUR CHILD

Welcome to the Children's Outpatient Program...we are very glad you're here and look forward to working with you and your child!

- We have found that in order to have the best results in therapy, it is important to have consistent counseling appointments.
- We understand that sometimes things happen that make it hard to come for appointments.
- We have a high demand for our services and appointment times.
- We ask that you please call us to cancel if you can't keep your appointment. It is our policy that if you repeatedly cancel your child's appointments, his or her chart may be closed.
- An appointment that is not cancelled within 24 hours will be considered a "no show."
- Two consecutive "no shows" or three total "no shows" may result in your child's case being closed.
- Once closed, in order to start services again, you would need to reapply for services and there is no guarantee the same therapist would be available to work with your child.

Keep the following tips in mind when scheduling appointments:

- Consider scheduling therapy and medical appointments on the same day if possible to minimize time missed from school
- Keep in mind, the later in the day you want appointments, the less frequently your child may be able to be seen
- Be aware of your child's school calendar and other important dates that might conflict with therapy or medical appointments, such as exams, field trips, FCATS and doctor's appointments.
- Communicate with your child's teacher if your child will need to miss some school regularly to come to therapy for a while. Most teachers want to be helpful and supportive of this process but need to know how they can do so. Don't forget to ask for an excuse note at the front desk if you need one.

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Parent's Signature

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Date

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Client Name

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Client Number

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

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Participant Name: \_\_\_\_\_ Participant Phone: \_\_\_\_\_

Participant DOB: \_\_\_\_\_ Name of Program or Service \_\_\_\_\_

Participant Address: \_\_\_\_\_

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Child's Name: I, \_\_\_\_\_ (*print participant name*) acknowledge that I am a participant of \_\_\_\_\_ Directions for Living \_\_\_\_\_ (*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 JWB may review all information about me as it specifically relates to any program or service it pays for. I also acknowledge that because JWB provides funds for the program or service in which I am participating, it may review 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 confidentiality of any 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 participants, where no one is identified by name or any other personal characteristic.-

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, 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 authorize the release of any information concerning the performance of any tests, results of those tests, counseling and treatment records. I consent to my minor participating in online or paper surveys that

## Child's Information

will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

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

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. I understand and agree that if I withdraw my approval that it will not apply to any information already released to and used by JWB as a result of this Authorization.

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*Specify Above the Date, Event or Condition for Termination of Authorization*

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.

Child's Name: \_\_\_\_\_ *(print participant name)*

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

\_\_\_\_\_  
Effective Date

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

\_\_\_\_\_  
***Description of authority if signed by participant's authorized representative***

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



## Child's Information

### Juvenile Welfare Board of Pinellas County

14155 58th Street North, Suite 100  
Clearwater, FL 33760  
Phone: 727-453-5600  
Fax: 727-453-5610  
[www.jwbpinellas.org](http://www.jwbpinellas.org)

#### **Written Statement of Purpose(s) for Collection of Social Security Number for Recipients of JWB-funded Programs and Services**

The Juvenile Welfare Board (JWB) invests in partnerships, innovation and advocacy to strengthen Pinellas County children and families. The vision of the Juvenile Welfare Board is that children in Pinellas County will have a future of more successful and satisfying lives because of the efforts of JWB and its partners. JWB was established by Florida statute in 1945 (Special Act 2003-320: F.S. §189.429) and approved overwhelmingly by voters in a referendum in 1946. JWB was created with a mission to provide needed services to children throughout Pinellas County. JWB provides funds to agencies that provide services to children and families in Pinellas County.

The purpose of this document is to provide individuals with written information about how JWB uses the Social Security numbers it collects. JWB is required by Florida’s Public Records law [Fla. Stat. §119.071(5)] to provide this information to you.

Florida law allows JWB to collect Social Security numbers in order to carry out its duties and responsibilities (Fla. Stat. §119.071(5) (a) 2a. (II); Special Act 2003-320: F.S. §189.429). Specifically, it is necessary for JWB to collect Social Security numbers to conduct research, fund services, and to ensure that all services delivered to participants are of the highest possible quality.

In addition, collecting Social Security information is necessary to:

- Identify and match individuals and data to research and improve how services are provided to children and families; and
- Receive reimbursement from Medicaid, if applicable, for providing services.

By law, JWB cannot release Social Security numbers (Fla. Stat. §119.071). JWB follows the highest security standards. All reports produced by JWB provide information about services in general. No individual person is ever identified in any way in any report.

Child's Name: \_\_\_\_\_

Print Participant Name

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent/Guardian Name (if participant is under 18)

\_\_\_\_\_  
Parent/Guardian Signature (if participant is under 18)

\_\_\_\_\_  
Date

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

---

Participant Name: \_\_\_\_\_ Participant Phone: \_\_\_\_\_

Participant DOB: \_\_\_\_\_ Name of Program or Service \_\_\_\_\_

Participant Address: \_\_\_\_\_

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

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## Adult's Information

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Adult's Name: \_\_\_\_\_ *(print participant name)*

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

Effective Date

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

---

***Description of authority if signed by participant's authorized representative***

Witness Signature

Date



## Adult's Information

### Juvenile Welfare Board of Pinellas County

14155 58th Street North, Suite 100  
Clearwater, FL 33760  
Phone: 727-453-5600  
Fax: 727-453-5610  
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Adult's Name:

\_\_\_\_\_

Print Participant Name

\_\_\_\_\_

Participant Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Print Parent/Guardian Name (if participant is under 18)

\_\_\_\_\_

Parent/Guardian Signature (if participant is under 18)

\_\_\_\_\_

Date

## Finding Your ACE Score

### While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...  
Swear at you, insult you, put you down, or humiliate you?  
**or**  
Act in a way that made you afraid that you might be physically hurt?  
Yes No If yes enter 1 \_\_\_\_\_
2. Did a parent or other adult in the household **often or very often**...  
Push, grab, slap, or throw something at you?  
**or**  
**Ever** hit you so hard that you had marks or were injured?  
Yes No If yes enter 1 \_\_\_\_\_
3. Did an adult or person at least 5 years older than you **ever**...  
Touch or fondle you or have you touch their body in a sexual way?  
**or**  
Attempt or actually have oral, anal, or vaginal intercourse with you?  
Yes No If yes enter 1 \_\_\_\_\_
4. Did you **often or very often** feel that ...  
No one in your family loved you or thought you were important or special?  
**or**  
Your family didn't look out for each other, feel close to each other, or support each other?  
Yes No If yes enter 1 \_\_\_\_\_
5. Did you **often or very often** feel that ...  
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?  
**or**  
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes No If yes enter 1 \_\_\_\_\_
6. Were your parents **ever** separated or divorced?  
Yes No If yes enter 1 \_\_\_\_\_
7. Was your mother or stepmother:  
**Often or very often** pushed, grabbed, slapped, or had something thrown at her?  
**or**  
**Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?  
**or**  
**Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?  
Yes No If yes enter 1 \_\_\_\_\_
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  
Yes No If yes enter 1 \_\_\_\_\_
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?  
Yes No If yes enter 1 \_\_\_\_\_
10. Did a household member go to prison?  
Yes No If yes enter 1 \_\_\_\_\_

**Now add up your "Yes" answers: \_\_\_\_\_ This is your ACE Score.**

For your Child's Safety, a parent or guardian MUST be present for the duration of both therapy and Medication management appointments.

Please do not leave the premises.

Client Name:

Client Number: