Directions for Living
LIFE GETS BETTER HERE.

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: (check one) ☐Puerto Rican ☐Mexican ☐Cuban ☐Other Hispanic ☐Haitian ☐Mexican American ☐Spanish/Latino ☐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 T0 PARTICIPATE

My signature below certifies that:

1) **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.**
2) **I have received a copy of the Client Handbook which includes information regarding:**
   - **Organizational Mission**
   - **Emergency Procedures**
   - **Client Rights and Responsibilities**
   - **Infectious Disease Control**
   - **Notice of Privacy Practices**
   - **Hours of Operation**
   - **Treatment Services**
   - **Grievance Procedures**
   - **HIV/AIDS Education**
   - **Advance Directive**
3) **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.**
4) **I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.**
5) **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.**
6) **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
SS#	☐ F ☐ M	Mother /Guardian					☐ Y ☐ N	☐ Y ☐ N		
SS#	☐ F ☐ M	Father /Guardian					☐ Y ☐ N	☐ Y ☐ N		
SS#	☐ F ☐ M	Sibling /Other					☐ Y ☐ N	☐ Y ☐ N		
SS#	☐ F ☐ M	Sibling /Other					☐ Y ☐ N	☐ Y ☐ N		
SS#	☐ F ☐ M	Sibling /Other					☐ Y ☐ N	☐ Y ☐ N		
SS#	☐ F ☐ M	Sibling /Other					☐ Y ☐ N	☐ Y ☐ N		

Client Name: _____ Client #: _____

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.

_____ _____

Parent's Signature Date

_____ _____

Client Name Client Number

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Child's Information

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: _____

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

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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.

_____

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

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

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Adult's Information

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: _____

Adult'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.

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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
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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.

Personal Safety Plan

Your recovery is Directions' top priority. A Personal Safety Plan is a way for your treatment team to know how you would like others to respond if you should begin to feel bad and to help you make choices that won't make things worse.

We want to give you every opportunity to help us understand what works best for you. You are the one who knows that best. Perhaps you can fill this out with your parents/guardians or we can help you share it with them.

Please take a minute to answer the following questions. If you have questions about filling this out, please ask your therapist. If you'd like, you can take this form home and bring it back at your next appointment.

1. When I'm doing well,  I usually:

   Feel: _____

   Do (activities/behaviors): _____

   Sleeping/Eating:_____

2. Some of the warning signs that I am not doing well  are when I am:

   Feeling: _____

   Doing:(Activities/Behaviors):_____

   Sleeping/Eating:_____

Client Name: _____ Client #: _____

Directions for Living
LIFE GETS BETTER HERE.™

3. Some things that may cause me to become very upset are: 

a) _____

b) _____

c) _____

4. Some of the things that help me to cope when I am upset are:

a) _____

b) _____

c) _____

5. List the people who can help you or you can talk to if you are having a hard time:

a) _____ b) _____

c) _____

6. What are 3 things they can do to help you get through a difficult time? 

a) _____

b) _____

c) _____

_____ _____
Client Signature Date

_____ _____
Parent Signature Date

Reviewed by:

_____ _____
Signature and Credentials Date

Client Name: _____ Client #: _____

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: