Directions for Living
LIFE GETS BETTER HERE

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:** _____

Age: _____ **Birth Date:** ____/____/____ **Sex:** _____ **SS#:** _____-____-_____

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

Highest School Grade Completed: _____ **Current School:** _____

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

Total Number of persons living in household _____

Have you ever been known by another name or former alias: ☐ No ☐ Yes **Name:** _____
Preferred Name/Nickname: _____

Referred by: _____ **Referral Phone:** _____

Do you have an open Child Welfare case plan: ☐ Yes ☐ No **Veteran:** ☐ Yes ☐ No

Have you ever received services here before? ☐ No ☐ Yes **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? _____

_____

☐ EMERGENCY CONTACT/ ☐ PARENT/ ☐ LEGAL GUARDIAN (check one)

Name: _____ **Phone: Home:** _____

Address: _____ **Apt #:** _____ **Work:** _____

City/State/Zip: _____ **Relation:** _____

MEDICAL BENEFITS

Do you have any insurance? ☐ Yes ☐ No **Medicaid** ☐ **Medicare** ☐ **Commercial PPO/HMO** ☐

I authorize the release of any medical information necessary to process this or a related claim to:

_____ Member ID: _____

Insurance Company Name and Address

I authorize payment of benefits to Directions for Living.

_____ Date: ____/____/____

Client Signature

MEDICAL INFORMATION

Primary Care Physician: _____ Phone #: _____

Other Treating Physician: _____ Phone #: _____

Pain Management Specialist: _____ Phone #: _____

SERVICE AUTHORIZATION / CONSENT TO TREAT / CONSENT TO 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 either in person, or through telehealth or telephonic.**

2) **I have received a copy of the Client Handbook, which is also available for download here http://directionsforliving.org/your_visit/ which includes information regarding:**
   - **Organizational Mission**
   - **Emergency Procedures**
   - **Client Rights and Responsibilities**
   - **Advance Directive**
   - **Notice of Privacy Practices**
   - **Infectious Disease Control**
   - **Hours of Operation**
   - **Treatment Services**
   - **Grievance Procedures**

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 consent to be contacted via phone, email, or text in regards to my appointments.**

5) **I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.**

6) **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.**

7) **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**

_____ _____ _____

Parent/Guardian Signature (if applicable) **Date** **Relation to Client**

_____ _____

Witness **Date**

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 ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		

Client Name: ______________________ **Client #:** ____________

9600-018c
Rev. 01/27/2017

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

Child's Name: I, _____
_____ (*print participant name(s)*)
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.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that as necessary to carry out the purposes listed herein, JWB may review all information about me, including my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB generally provides no direct services to me, except in certain circumstances may facilitate service delivery I further acknowledge that JWB does not provide medical diagnoses to me and 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, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, any information concerning the performance of any tests, results of those tests, and counseling and treatment records, as allowed by all state, federal and local laws, including, but not

limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42. I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program, or with respect to information used in research, or for compliance and quality review activities performed by JWB or its agents, upon completion of the last research project or compliance/ quality review, whatever occurs latest. 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.

_____ _____

Witness Signature Date

Child's Name: _____

(print participant name)

_____

Effective Date

_____

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

○ Participant ○ Parent ○ Guardian

○ Personal Representative (Legal Documents Required)

(print participant name)

Effective Date

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

○ Participant ○ Parent ○ Guardian
○ Personal Representative (Legal Documents Required)

(print participant name)

Effective Date

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

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Effective Date

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○ Participant ○ Parent ○ Guardian
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(print participant name)

Effective Date

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

○ Participant ○ Parent ○ Guardian
○ Personal Representative (Legal Documents Required)

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

CHILD'S INFORMATION

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 JWB 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 and families throughout Pinellas County. JWB funds services for 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 prescribed by law (Fla. Stat. §119.071(5) (a) 2a. (II); Special Act 2003-320: F.S. §189.429). Specifically, it is imperative 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 in order to coordinate, plan, and improve services for children and families in Pinellas County;

Social Security numbers held by JWB are confidential and exempt from disclosure except as specifically authorized by law (Fla. Stat. §119.071) (5) (a) 5.). 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 without JWB first obtaining that person's written consent.

Child's Name: _____

Print Participant Name	Participant Signature Date
Print Parent/Guardian Name (If participant is under 18 years of age)	Parent/Guardian Signature Date (If participant is under 18 years of age)
Print Participant Name	Participant Signature Date
Print Parent/Guardian Name (If participant is under 18 years of age)	Parent/Guardian Signature Date (If participant is under 18 years of age)

Juvenile Welfare Board

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Print Participant Name	Participant Signature	Date
Print Parent/Guardian Name (If participant is under 18 years of age)	Parent/Guardian Signature (If participant is under 18 years of age)	Date
Print Participant Name	Participant Signature	Date
Print Parent/Guardian Name (If participant is under 18 years of age)	Parent/Guardian Signature (If participant is under 18 years of age)	Date
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Authorization and Consent for Disclosure,
Receipt, and Use of Confidential Information
by the Juvenile Welfare Board of Pinellas County

Adult's Name: I, _____
_____ (*print participant name(s)*)
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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I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

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_____ _____

Witness Signature Date

Adult's Name: _____

(print participant name)

_____

Effective Date

_____

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

○ Participant ○ Parent ○ Guardian

○ Personal Representative (Legal Documents Required)

Juvenile Welfare Board
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______________________ (print participant name) ______________________ Effective Date	______________________ Signature of Participant or Participant's Authorized Representative (check one): ○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)
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______________________ (print participant name) ______________________ Effective Date	______________________ Signature of Participant or Participant's Authorized Representative (check one): ○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)

Juvenile Welfare Board of Pinellas County
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Clearwater, FL 33760
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ADULT'S INFORMATION

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Adult's Name: _____

Print Participant Name _____ Participant Signature _____ Date

Print Parent/Guardian Name (If participant is under 18 years of age) _____ Parent/Guardian Signature (If participant is under 18 years of age) _____ Date

Print Participant Name _____ Participant Signature _____ Date

Print Parent/Guardian Name (If participant is under 18 years of age) _____ Parent/Guardian Signature (If participant is under 18 years of age) _____ Date

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Print Participant Name | Participant Signature | Date

Print Parent/Guardian Name
(If participant is under 18 years of age) | Parent/Guardian Signature
(If participant is under 18 years of age) | Date

Print Participant Name | Participant Signature | Date

Print Parent/Guardian Name
(If participant is under 18 years of age) | Parent/Guardian Signature
(If participant is under 18 years of age) | Date

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(If participant is under 18 years of age) | Parent/Guardian Signature
(If participant is under 18 years of age) | Date

Print Participant Name | Participant Signature | Date

Print Parent/Guardian Name
(If participant is under 18 years of age) | Parent/Guardian Signature
(If participant is under 18 years of age) | 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 parent/caregiver:
   Often or very often pushed, grabbed, slapped, or had something thrown at him/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 or misused their prescription medication?
   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: ____0____ This is your ACE Score.

Client Name: Client Number:

Mental Health Advance Directive

Client Name: _____ Client ID: _____

This is an advance directive. It allows you to make decisions in advance for your mental health treatment. It is important that you identify your preferences and identify friends or family you would like contacted to inform them of your hospitalization.

1. If I have to go to the hospital, I prefer to go to _____.
   I understand that my preference may not be able to be met.

2. I would like the following person identified if I am hospitalized:

   Name: _____ Phone Number: _____ Relationship: _____

_____ _____ _____
Client Signature Date Print Name

_____ _____ _____
Parent/Guardian Signature Date Print Name

_____
Relationship to Client

_____ _____ _____
DFL Provider Date Print Name

Directions for Living
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FINANCIAL FEE FORM

Date: _____

Payment Based on:

☐ Medicare ☐ Medicaid ☐ Pin. Cty Health Plan ☐ Self-Pay/No Insurance

☐ Commercial:_____ **Name of Insurance:** _____

Client Monthly Income: $_____ Other Monthly Income: $_____

Annual Household Income: $_____

Total number of people supported by annual household income: _____

Income Verification Type:

☐ Pay Stubs ☐ Unemployment Stub ☐ W2/ 1099
☐ Letter of Support ☐ SSI Stub ☐ Self-Report
☐ Other:_____

Income verified by (Staff Name) : _____

**Income verification noted above must be copied and placed in client's record*
***To be completed quarterly except TANF which is every 30 days*

The below to be completed with FSR for AOP/COP/Medical:

Qualify for IDP: ☐ Yes ☐ No

Self-Pay $:_____ Sliding Scale %: _____

Reason for the Full Fee: _____ (Name of Insurance We Don't Accept)

Therapy Service Fees
Assessment: $ _____
Group Therapy: $ _____
Therapy: $ _____

Medical Service Fees
Psychiatric Evaluation $ _____
Medication Follow-Up Visits $_____

_____ _____
Financial Svcs. Rep. Signature Date

_____ _____
Client / Guardian Signature Date

**Please give a copy to the client and place the original in the client's file.*

Client Name: _____ Client #: _____