Directions for Living
LIFE GETS BETTER HERE

REGISTRATION FORM

Please complete all information on this form. If you need help completing this form, please speak to a Team Member for assistance.

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 health 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 -the team members 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.**
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 & 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 the use of augmented and artificial intelligence (AI) may be utilized as a tool to support various elements of clinical practice, such as documentation or summarizing clinical information that will be stored electronically in my health record and to facilitate sound clinical decision-making; however, such usage requires human oversight and my direct care provider is responsible for reviewing and approving all augmented or AI-generated documentation for accuracy prior to it being filed electronically in my health record.**
6) **I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.**
7) **I understand that Directions for Living may be required by law to submit statistical and demographic information such as my age, social security number and/or income to certain local, state and/or federal agencies as outlined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I also understand that I may ask for more specific information regarding this at any time.**
8) **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 client who is receiving services. Please complete the following information about everyone who lives in the client'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#	○ M ○ F	○ Child ○ Mother ○ Father ○ Sibling ○ Guardian					○ Y ○ N	○ Y ○ N		
 SS#	○ M ○ F	○ Child ○ Mother ○ Father ○ Sibling ○ Guardian					○ Y ○ N	○ Y ○ N		
 SS#	○ M ○ F	○ Child ○ Mother ○ Father ○ Sibling ○ Guardian					○ Y ○ N	○ Y ○ N		
 SS#	○ M ○ F	○ Child ○ Mother ○ Father ○ Sibling ○ Guardian					○ Y ○ N	○ Y ○ N		
 SS#	○ M ○ F	○ Child ○ Mother ○ Father ○ Sibling ○ Guardian					○ Y ○ N	○ Y ○ N		
 SS#	○ M ○ F	○ Child ○ Mother ○ Father ○ Sibling ○ Guardian					○ Y ○ N	○ Y ○ N		

Client Name: ____ **Client #:**_________

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 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.

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

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 that in certain circumstances JWB 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 use treatment information from my medical health record, any information concerning the performance of any tests, results of those tests, developmental-alcohol, drug abuse, 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 456.057; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42, Part 2. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I am signing this Authorization voluntarily. I may decline to sign this Authorization. However, refusal to sign does not stop the use or disclosure of confidential information, including protected health information, that is otherwise permitted to be used or disclosed by law without my specific authorization. Refusal to sign this Authorization will not lead to an impact on my participation in the program or service listed above.

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. I may revoke this Authorization by submitting my request in writing to the place where I submitted this Authorization but understand that such revocation will not apply to actions already taken prior to my revocation. I also understand that once my confidential information is disclosed based on this Authorization, it may be further used or disclosed and will no longer be protected by state or federal privacy laws.

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

_____ _____

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

○ Participant ○ Parent ○ Guardian

_____ ○ Personal Representative (Legal Documents Required)

Effective Date

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

RECIPIENTS OF INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION: PLEASE BE ADVISED THAT YOU ARE STRICTLY PROHIBITED FROM FURTHER DISCLOSING ANY SUCH INFORMATION WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PARTICIPANT OR THEIR LEGAL REPRESENTATIVE, UNLESS OTHERWISE EXPRESSLY PERMITTED BY APPLICABLE LAW. 42 C.F.R. PART 2 PROHIBITS UNAUTHORIZED DISCLOSURE OF THESE RECORDS.

FINANCIAL FEE FORM

Date:_____

Client Name: _____ Client #:_____

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

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

Total Annual Household Income: $_____

Total number of people supported by above annual household income: _____

Income Verification Type Provided (if applicable):

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

_____ _____
Client / Guardian Signature Date

_____ _____
Team Member Signature Date

**New FFF to be completed when there are coverage changes, or at minimum annually (except TANF which is every 30 days)*

****SUBMIT COMPLETED FORM TO reimbursement2@directionsforliving.org**

To be completed by reimbursement department (reviewed with client)

Sliding Fee Scale Eligible: ☐ Yes ☐ No

Flat Rate: $_____ **OR** %: _____ Qualify for IDP (Adults only): ☐ Yes ☐ No

Calculated Fees (Copay, Coinsurance, Full-Fee, or Non-Par Provider):

Assessment: _____ (non-par) _____ Psych Eval (MD): _____ (non-par) _____
Counseling: _____ (non-par) _____ Psych Eval (APRN): _____ (non-par) _____
Group: _____ (non-par) _____ Med Management: _____ (non-par) _____

Notes: _____
_____

_____ _____
Team member signature (attestation of review with client) Date